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Migration and Nursing in Ireland: An Internationalist History

Nicola Yeates

Faculty of Social Sciences, The Open University, UK (Email: n.yeates@open.ac.uk)

Abstract

Recent research and policy interest has focused on the changing composition of the nursing workforce in the Republic of Ireland, which has seen an increase in the number and importance of overseas-trained nurses. This is the most recent episode of the importance of migration in the history of nursing in Ireland which stretches back to the emergence of nursing in Ireland in the early 19th century. Delineating the intersecting histories of Irish nursing and migration, this article situates Irish nursing history within an internationalist framework involving the movement of people, ideas and practices across borders. The relevance of an internationalist analysis is demonstrated through an examination of the close connections between the British and Irish nursing institutions and labour forces and the significance of Catholic religious orders and religious migration in the development of nursing in Ireland and overseas. This analysis of the history of Irish nursing from the early nineteenth century to the mid twentieth century draws particular attention to the significance of female religious migration as a previously neglected chapter in the history of the international nurse migration in the Irish context, and it highlights the existence of the 'global nursing care chain' (Yeates, 2004, 2006, 2009) that linked Ireland to the international economy and to the development of nursing services at home and abroad.

Introduction

Recent changes in the nursing workforce in the Irish Republic and elsewhere in the 'developed' and 'developing' worlds have focussed attention on the importance of migrant healthcare workers in the operation and development of healthcare systems. Ireland is one example of a growing number of countries which are dependent on non-nationals for the operation of their healthcare systems (Bach, 2003; Buchan, Kingma and Lorenzo, 2005; Kingma, 2006; Yeates, 2006). International academic and policy interest in this issue has resurged at various times: prior to the early 2000s, it was expressed in the 1970s (Mejia, 1976).

The inter-connections and inter-dependencies engendered by global dynamics pre-date this recent historical period, however, and it is these issues that this article addresses. It does so through a consideration of the history of nursing migration in the Irish context from the early nineteenth century to the mid twentieth century. During this period, the development of the nursing labour force was infused by extensive and sustained internationalism. This internationalism is examined through the migrations of intending and qualified nurses into and out of Ireland. This migration, I argue, amounted to more than the sum of travel and work choices on the part of individual

women: it was organised, extensive and sustained, and was formative of the Irish nursing profession and nursing institutions, at home and abroad. It was entwined with and conditioned by Ireland's position as a British colony, such that developments in Irish nursing were connected with, and influenced –if not directed- by British policy and institutions, during and after Independence. In addition, the Catholic Church played a formative role in Irish nursing. Nursing was especially connected with female religious orders, some of which developed into international (health-related) organisations. These developments included both religious orders founded in Ireland which extended their operations into other countries, and religious orders founded abroad – primarily in France - which set up operations in Ireland.

The discussion is organised around a consideration of three key dimensions of this internationalism. Section one examines the relationship between the Catholic Church and nursing in Ireland, wherein the involvement, and influence, of overseas and domestic female religious orders on nursing institutions and practices in Ireland are reviewed. Section two turns to consider how Irish nursing was shaped by Ireland's subject status as a British colony, through a focus on the dominance of Britain for nurse training and employment. The colonial theme resonates in Section three where the discussion focuses on the internationalism of Irish religious orders, through a focus on Irish missionary orders providing nursing care around the world.

The Catholic Church, nursing and women in Ireland

In the first part of the nineteenth century, following the loosening and subsequent repeal of the Penal Code, the Irish Catholic Church became active in establishing education, health/nursing and poor relief services, providing care for the elderly, the insane and the “fallen” (Inglis, 1998; Luddy, 1995; Magray, 1998; McKenna, 2006). Since nuns were cloistered, and therefore forbidden from active community service, these services were initially provided by pious laity (generally women). Religious involvement in public nursing focused in the main on home visitation of the sick poor by active female orders such as the Daughters of Charity and the Sisters of Mercy (Luddy, 1995). Building on home-based nursing services, in the 1860s female religious orders made a concerted advance into public nursing, staffing and managing public and private hospitals, workhouse hospitals, hospices and dispensaries (Magray, 1998). They operated in a field of work that was otherwise undertaken by poor and untrained women who worked in return for shelter and support from their institution (Luddy, 1995).

The experiences of Irish orders which had practised overseas was formative in the advance of the religious within nursing in Ireland. The Mercy Sisters, returned from the Crimea in 1856 and keen to build on their nursing successes there, began working in workhouse hospitals¹, heralding the way for nuns to provide nursing labour for workhouses run by Poor Law Unions from 1861. By the Sisters of Mercy's own account, “[b]y 1873 there were 26 nuns employed in 8 workhouse hospitals, of which 23 were from the Mercy order. In addition, some hospitals originally set up by Protestants later had their nursing departments administered by Mercy nuns, including Dublin's Charitable Infirmary and Cork's South Infirmary”.² In the latter part of the century, the number of workhouse hospitals under the care of female religious orders

¹ http://www.rootsweb.ancestry.com/~irlcar2/Sisters_of_Mercy.htm (accessed 17th July, 2009)

² http://www.rootsweb.ancestry.com/~irlcar2/Sisters_of_Mercy.htm (accessed 17th July, 2009)

increased from eight (1873) to 73 (1898) to 84 (1903) (Clear, 1987: 104; Luddy, 1995: 49); at the turn of the century half of workhouse hospitals were staffed by nuns (Magray, 1998: 80). The religious also managed Catholic hospitals that they founded (e.g. St. Vincent, 1834, the Mater, 1861, Dublin; Mercy, 1857, Cork). In 1882, 10% of convents were attached to hospitals, growing to 22% by 1900 (Luddy, 1995). By the turn of the century, nursing nuns tended to work for local authority city infirmaries and workhouse hospitals.

The entry of Irish female orders into nursing was part of a wider European trend. While the close connections between nursing and the religious built on a longer historical association dating back to the 3rd century, the medieval and renaissance periods were particularly important periods. In the 16th century alone, ‘more than 100 female orders were founded specifically to do nursing’ (Donahue, 1985: 216, cited in O’Brien, 2007: 37). Over the following centuries, the growth of nursing communities continued and came to occupy a central position in emergent health care institutions in several countries. In France, for example, active female congregations had built a ‘formidable presence’ of nursing sisters in French hospitals by the 17th century. The Daughters of Charity in particular became France’s most important nursing community, changing the practice of poor relief and medical care through their hospital work in Paris and elsewhere in France. By the end of the 17th century, it was common for active female congregations to run hospitals, which depended on their work as nurses and administrators (Rapley, 1990: 8; Dinan, 2006: 16). By the 19th century, the involvement of the Catholic Church, and female religious in particular, in the provision of nursing across Europe and North America was extensive. The involvement of the religious in the nascent health and welfare institutions is captured in the following quote:

Catholic schools, hospitals, orphanages and other similar institutions multiplied and flourished...and in many instances anticipated the development of similar services by emergent welfare states. In some countries (such as Ireland), the church eventually entered into various forms of partnership with the state in jointly providing social services; in others (such as the United States), it created independent systems which paralleled and in some ways competed with state provision. In any event, no other organisation in the modern western world came as close as did the Catholic Church to matching the capacity of the present-day welfare state to fund and deliver mass social services. (Fahey, 1998: 412)

Prefiguring the orientations of later Irish female orders (see Section 3), *many congregations of active religious were consciously internationalist in their outlook and operations. As regards the French orders, this derived from the missionary orientation of their founders and their internationalism was facilitated by governance structures (Rome rather than the local bishop was the chief authority) which in turn resulted in their rapid spread to other parts of Europe, to the expanding European empires and economic spheres of influence in Australia, Canada, India, Latin America and Africa, and to the United States. French congregations were in many ways typical of this religious internationalism, with religious orders being the most internationalising at the time; indeed, ‘all health-related international organizations founded before 1870 are exclusively religious orders’* (Inoue and Drori, 2006: 206). However, Catholic *female* orders were among the most internationalising of religious orders, and they spread rapidly and widely in the 19th

The French Daughters of Charity were particularly successful in this regard, spreading throughout the 19th century to Australia, the US, and various European countries such as Austria, Hungary, Turkey, Portugal, the UK, and Ireland, where they proved influential in the development of nursing. They *trained women from other countries, providing religious formation before the women returned to found their own congregations in their home countries* (O'Brien, 1997). Thus, in 1813 Irish nuns travelled to the French Vincent de Paul's Daughters of Charity order to learn their system of service to the poor. Within two decades after setting up an Irish congregation in 1816, the Irish Daughters of Charity had not only instituted nursing services for the poor but had also founded and were running the first hospital in Ireland for the Catholic population, St. Vincent's (1834) in Dublin (Clear, 1987: 57, 125, 102).³

While the Daughters of Charity stand out in the nursing field, they were not alone. Various French nursing orders arrived in Ireland in the mid-nineteenth century. Amongst these were the Bons Secours (1861) and the Little Sisters of the Assumption (1891), both of which initially concentrated on home nursing for the sick poor. English nursing orders came to Ireland too, such as the Little Company of Mary which arrived in 1888 one year after being founded in England to provide home and hospital nursing. In addition, overseas congregations which were not established originally as nursing congregations also set up in Ireland and undertook nursing work in workhouse hospitals. These included the aforementioned French Daughters of Charity, the French Congregation of Mary and the English Poor Servants of the Mother of God; the last two arrived in Ireland in the 1870s (Clear, 1987: 107).

Overseas religious orders – whether this meant of foreign origin or of Irish origin that had practised abroad - were therefore instrumental to the establishment of a religious nursing labour force in Ireland and they paved the way for the Catholic capture of the emergent system of hospital and health-related poor relief and public nursing. Nursing nuns were restricted in what duties they were able to perform: they were not allowed to nurse maternity cases, male patients, or do night duty, which hampered their contribution to the profession (Clear 1987:127). Despite these disadvantages, nuns were welcomed as public hospital workers and managers. Thus, Caitriona Clear (1987) quotes O'Riordan to the effect that 'although only a certain number of sisters were paid in any Union hospital, several others habitually worked for no wages'; their regularity, discipline and their reputation as good economic managers, as well as their 'adherence to the Victorian ideal of the nurse as co-operative and obedient servants to male doctors' clearly worked in their favour (Clear, 1987: 129-130). Religious orders came to form 'the central nucleus of the administrative and supervisory nursing service' that emerged, with general nursing care in Catholic hospitals being provided by a 'considerable number' of lay Catholic women (Henry, 1998: 1). Although it was not until the end of the nineteenth century that an emphasis was placed on nursing sisters themselves acquiring formal nurse training, the nuns' involvement was

³ In other (non-nursing) religious orders, too, such internationalism was evident. For example, while planning her order, '[Fanny] Taylor toured Europe as far as Poland and stayed with other congregations to investigate their methods' (O'Brien, 1988: 132). For the laundry business Taylor obtained technical advice from the Servants of the Sacred Hearts of Jesus and Mary in Antwerp to learn what the best form of organisation would be, subsequently sending sisters to Antwerp to learn specialised ironing methods (O'Brien, 1988).

credited with raising standards of care, not only in hospitals but also in the health services they provided in schools and asylums (Inglis, 1998; Luddy, 1995).

The Catholic Church, and female orders in particular, thus became a key force the development of institutional health (and other) services, in particular for women and children. This institutional domination, enabled by having secured the public trust of the wealthy and the deference of the poor (Magray, 1998), ensured what Magray (1998) terms 'cultural authority' and what Inglis (1998) terms 'moral control' over their patients. Home visitation and hospital care, for example, was not only to relieve the 'corporeal' wants of the sick and dying, but also their spiritual needs, and 'in many cases the care of the soul was thought more important' (Magray, 1998: 94, 95). The religious' domination in health also gave them a high degree of influence and control over nurse training and practice. Nurse training at the time was through apprenticeship with learning taking place on the job, and Catholic hospitals and workhouse hospitals were where intending nurses acquired their training and experience (Fealy, 2005). The increased emphasis on formal nurse training at the turn of the twentieth century did not eclipse the importance of this system of apprenticeship nurse training, and in any case the domination of the religious in health care provision effectively meant that they continued to exert authority and control. Indeed, religious control of Irish health professions and service provision lasted for most of the 20th century; as late as 1983 Dwyer (1983: 22) reported 'To a large extent, basic general training [of nurses] in Ireland remains under the control of religious orders.'

Nursing sisters thus played a crucial role in the provision and organisation of nursing services, but it was not until after Independence that an organised *Catholic* nursing cadre emerged with the foundation of the Irish Guild of Catholic Nurses (IGCN) in 1922. The aims of the IGCN were 'to place Spritual and social advantages at the disposal of its members' at home and abroad; it also held aspirations to contribute to professional development at a time when other occupations were developing professional codes of conduct (Henry, 1998: 2). Realising this mission to organise a sodality of Catholic nursing labour⁴ that transversed individual hospitals involved the articulation and promotion of Catholic nursing ethics and practices. Outlets for this included organised IGCN lectures on medical and nursing ethics and other professional nursing matters of interest to the membership, the publication of an IGCN journal (*Journal of Irish Nursing*); various social and spiritual activities were also organised for its membership, which were often held on Convent premises (Henry, 1998).

The IGCN proved influential in Catholic and Irish nursing diasporas. The IGCN joined, and became active in, the International Guild of Catholic Nurses in 1925, with Irish guild members occupying key positions in it. The *Irish Journal of Nursing*, for its part, 'became a highly acclaimed publication among the Guilds of many countries' (Henry, 1998: 8), and as Henry emphasises, 'it was especially appreciated by Irish Missionaries and emigrant nurses throughout the world' (ibid: 8). Although missionary nursing sisters were not initially eligible to join as full members of the IGCN (this was changed in the 1950s), the IGCN supported them from the outset

⁴ The IGCN constitution prohibited it from becoming involved in political activism ('The Guild shall be absolutely non-political') (Henry, 1998: 5). Issues of nurses labour and pay were taken up the Irish Nurses' Union (founded in 1919), later renamed the Irish Nurses' Organisation.

through sending supplies of medicinal, surgical and general hospital equipment, along with the journal. Thus, while the IGCN contributed to the formation of the medico-ethical regime (Inglis, 1998), it is also important to emphasise its role in fostering a community of Irish Catholic nurses practising in Ireland and abroad. The IGCN's internationalism was fully consistent with the nature of professional nurse training and practice trajectories in which emigration was a central reality for Irish intending and qualified nurses.

The nature and importance of emigration in professional nursing from the mid nineteenth to mid twentieth centuries is taken up in detail in the following two sections, but it is worth prefixing that discussion by briefly commenting on the social conditions that generated the supply of female labour for mobilisation into nursing. The Catholic Church's influence on Irish society was formative and enduring, and ensured the production of care labour. This production began with the socialisation of Irish females in 'caring' social roles and continued by channelling them into professions and vocations that were ideologically consistent with these roles – notably nurses, midwives, teachers and nuns (Clear, 2000; Daniels, 1993; Inglis, 1998). In the mid nineteenth century, teachers far outnumbered either nurses or nuns⁵, but by the turn of the century (1911 Census), nuns had come to outnumber teachers and the numbers of nurses had nearly tripled⁶. The professions of teacher, nurse/midwife and nun accounted for a sizeable proportion of the active female labour force (8% in 1926, rising to nearly 16% by 1971) and together accounted for over 90% of professional women (Table 1).

Table 1 Females in selected professional occupations, Ireland

	Teachers			Nuns(a)			Nurses(b)		
	No.	% active female labour force (c)	% of women professionals (d)	No.	% active female labour force (c)	% of women professionals (d)	No.	% active female labour force (c)	% of women professionals (d)
1926	11,225	3.3	38	9,423	2.7	32	6,958	2.0	24
1936	11,130	3.2	34	10,609	3.0	32	8,373	2.4	25
1946	9,596	2.9	26	12,710	3.8	34	11,164	3.3	30
1951	10,065	3.1	26	11,937	3.7	31	12,493	3.8	32
1961	11,261	3.9	27	13,392	4.7	32	13,060	4.6	32
1971	14,869	5.2	29	13,151	4.6	26	16,590	5.8	33

Sources: Censuses of the Population 1926 to 1971. Notes: (a) Includes professed nuns and other religious occupations (in training). (b) Census categories vary: before 1951 nurses and midwives are recorded as separate occupational categories; 1951 and 1961 Censuses distinguish between trained nurses and midwives, probationer nurses and nurses in training, and mental nurses and attendants. These groups have been added together for the purpose of this table. 1971 simply records nurses. (c) 1926 the active labour force was defined as those aged 12 years and over; 1936 onwards it was defined at those aged 14 years and over. (d) Calculated for each occupation as a proportion of total women in the Professional category (or in later years, Professional and Technical) in the Census.

Nursing in particular enjoyed high social esteem in Ireland, being associated with middle-class status, and it constituted one of the few socially acceptable and available vocational opportunities for women outside the performance of a lifetime service of religious care. That said, many thousands of women did enter

⁵ 8,900 teachers, 2,609 nuns and 492 nurses (Fahey, 1987).

⁶ 8,500 teachers, 8,887 nuns and 1,411 nurses (Fahey, 1987).

into such a lifetime service within the Catholic Church (see Table 1). But rather than this service necessitating women abandoning their professional lives, joining the religious order (MacCurtain, 1995). Religious life gave women the chance to claim a professional place in society, as that life was regarded as a profession in itself and registered as such in the Census. Religious life afforded opportunities for professional training in nursing (as well as teaching and social work) which was often not otherwise available to many women, and it was a means of joining 'the largest and most powerful group of professional women in Ireland' (McKenna, 2006: 1). Congregations were often very large international institutions with sophisticated organisational and professional infrastructures offering the possibilities of a career and high-powered positions in administration and management. *Religious service was, therefore, entirely compatible with professional (nursing) life.* Nursing was not just as an expression of a spiritual and social vocation, it was also a professional vocation as religious service was a (if not the) means of practising nursing and having a career. *Indeed, many women who entered religious service had previously trained and practised as nurses. Although numbers of nursing sisters who were already trained as nurses are difficult to calculate, qualitative studies indicate this religious-nursing continuum. For example, respondents in McKenna's (2006) study of missionaries were qualified nurses prior to entering religious orders. Indeed, the impetus for founding religious nursing orders often came from qualified nurses. The example of Mother Mary Martin who was a practising nurse prior to founding the international nursing order, Medical Missionaries of Mary (MMM) can be instanced, and the MMM drew on student and qualified nurses (and other health workers) for its labour force (Henry, 1998; Walsh, 2002). In addition to the qualified nurses who continued to practise nursing as nursing sisters must be added those women who trained and qualified as nurses after joining religious orders (McKenna, 2006). To this day, religious orders involved in nursing care resource members' training in professional nursing and allied professions.*

Nurse recruitment, training, and employment: the British dimension

In addition to the influence of the Catholic Church on the development of nursing in Ireland the effects of Ireland's status as a British colony must be mentioned. Britain was both a location of training and employment for Irish intending nurses, as well as an influence on the development of nursing in Ireland. For example, nurses were trained for district nursing in Ireland by the Queen Victoria's Jubilee Institute for Nurses (QVJIN), whose Dublin committee was set up in 1890 as part of an initiative in England to provide community nursing for the sick poor. The importance of England for nurse training even at that time is illustrated by the fact that between 1890 and 1900, half of those accepted by the QVJIN for further training in Ireland had received previous training in England (Wickham, 2005).

The continued connections between Britain and Ireland after Irish Independence were principally expressed in the significant number of Irish women migrating to train as nurses in the UK. As nurse training was apprenticeship training, with learning taking place 'on the job', trainee nurses were junior members of hospital staff. Thus, if positions were unavailable locally, it would be understandable for an intending nurse to head for the nearest country, the United Kingdom, where jobs would be available – whether this meant crossing the Irish Sea to England, Scotland or Wales, or simply crossing the border to Northern Ireland. Thus continued a tradition that endured throughout the 20th century where many young Irish women went to UK hospitals for their training.

This author's analysis of the *Irish Register of Nurses* further demonstrates these close professional training connections across the two islands. As Table 2 shows, the numbers of Irish-registered nurses who had received training outside the Republic as a proportion of total registered increased in the decades following Irish Independence, from about 15% in 1929 to 26% by 1951. By the 1960s, 32% of Irish-registered nurses had trained abroad (Scanlan, 1991). The overwhelming majority of the nurses who were registered in Ireland listed their place of training in the UK; in 1929 Northern Ireland and Britain together accounted for 88%, and by 1951 they accounted for 99% of Irish-registered nurses (Table 3). Table 3 also shows the declining importance of Northern Ireland as a training location and the increasing importance of England, Scotland and Wales for Irish nurse training. Thus, by 1951 these latter three countries had become the place of training for 95% of Irish-registered nurses compared with 55% in 1929 (corresponding figures for Northern Ireland are 33% in 1929 and 8% in 1951). As many of those who undertook nursing training in England, Scotland and Wales remained there after qualifying, the supply of Irish student nurses became an important source of nursing labour for English, Scottish and Welsh hospitals. In fact, these figures do not fully capture the magnitude of emigration to Britain to train as nurses, since many would not have bothered registering in Ireland as they did not expect to return. Some insight into the sheer volume of student nurse emigration is gleaned from the *Irish Nurses Magazine* [XIII (62): 9 July 1946], which noted that '3,000 young Irish women went to England in 1945 to take up nurse training' (Scanlan, 1991: 361). Substantial flows of Irish trainee nurses in England continued in the following years, and made significant contributions to hospital labour forces. Scanlan (1991: 172) cites the example one English hospital in 1957 where some 300 Irish nurses were in training.

Table 2 Place of training of Irish nurses registered with General Nursing Council, selected years, 1929-1951

Year	Total registered	Total trained abroad	Trained abroad as % of total registered	NI	ESW	N. America	France	Africa	Australia/New Zealand	India
1929	2,244	344	15.3%	113	190	5	28	2	4	2
1934	2,320	395	17.0%	116	241	9	22	2	3	2
1939	2,788	493	17.7%	122	341	9	13	2	4	2
1944	3,164	713	22.5%	82	610	6	9	2	2	2
1949	3,676	876	23.8%	90	766	4	5	3	6	2
1951	4,060	1058	26.0%	88	952	4	4	3	5	2

Source: Yeates (2009) table 5.5. NI = Northern Ireland; ESW = England, Scotland and Wales.

In addition to being a key place of training for a significant minority of Irish nurses, Britain also drew substantially on Ireland for nurse labour to sustain its civilian and military populations, whether based at home or abroad. Thus, *Irish nurses contributed to sustaining the British military labour force, with substantial numbers of them travelling to nurse the British army (about one-third of whom were Irish) at war.* At the outbreak of World War 1, Queen Alexandra's Imperial Military Nursing Service (which replaced the British

Army Nursing Service in 1902) had a complement of 293 nurses, of whom 34 – i.e. 12% - were from Ireland (McEwen, 2006:45).

The nursing connections between Ireland and France must also be noted. The influence of French orders on Irish nursing has already been noted, and, after the UK, France was the most important destination for Irish nurse training (Table 2). With the outbreak of the war, Irish nurses volunteered for the Croix-Rouge and the French Flag Nursing Corps to nurse soldiers in France: ‘the extent of professionally trained nurses offering their services was described by the Irish Correspondent of the *Nursing Times* as “hardly a nurse to be got here for private cases for love or money – all volunteering”’ (McEwen, 2006: 55). The importance of France in the formation of Irish nursing is further discussed in the context of religious influences later in this article.

In terms of employment, Table 3 indicates that over the period from 1929 to 1951 anywhere between 8% and 14% of Irish-registered nurses were working abroad. England, Scotland, Wales and Northern Ireland together accounted for 96% of such nurses working abroad in 1929 and 89% in 1951. Over this time the numbers practising nursing in Northern Ireland decreased, while those in England, Scotland and Wales increased, indicating how the health systems in partitioned Ireland grew apart, while the ties between Ireland and Britain continued, even strengthened. Of note is that North America increased its importance as an employment destination over those years, although the numbers are small.

Table 3 Country of residence of nurses registered with Irish General Nursing Council, 1929-1951

Year	Total registered	Total abroad	NI	ESW	N. America	Africa	Asia	Other	Total abroad as % of total registered
1929	2,244	271	133	127	7	3	1	-	12.0%
1934	2,320	290	105	149	17	14	5	-	12.5%
1939	2,788	360	107	202	35	6	6	4	12.9%
1944	3,164	435	121	196	12	4	1	1	13.7%
1949	3,676	369	99	235	19	12	1	3	10.0%
1951	4,060	347	99	209	25	12	1	1	8.5%

Source: Yeates (2009) table 5.4. NI = Northern Ireland; ESW = England, Scotland and Wales.

These figures tend to under-estimate nurse emigration: Irish nurses who emigrated (especially over long distances) did not tend to maintain their presence on the Irish register as they did not expect to return to Ireland to work, emigration at that time being more permanent than it is now. That very few Irish nurses who emigrated expected to return to practise nursing in Ireland is further underlined by the numbers of Irish women issued with travel documents to take up nursing employment in Britain (Table 4). The data in Table 4 covering 1940 to 1951 show the numbers issued with such documents and as a proportion of total female emigrants to Britain. The numbers of emigrant nurses to Britain alone run to thousands during the war years and their immediate aftermath, and even though the numbers dipped to several hundred in the years thereafter this still greatly exceeds the numbers of nurse emigrants maintaining a presence on the Irish Register of Nurses (as indicated in Table 3).

Table 4 Irish females issued travel documents to go to nursing employment in Britain, 1940–1951

Year	Nurses	Nurses as % total female migrants
1940	1,634	18.4
1941	785	23.9
1942	2,233	15.5
1943	2,838	14.9
1944	1,125	19.1
1945	3,523	33.2
1946	3,893	20.2
1947	2,531	13.5
1948	912	4.9
1949	440	3.4
1950	321	3.6
1951	543	5.8

Source: Calculated by the author from *Commission on Emigration and Other Population Problems*, table 31, p. 32 (Yeates, 2009).

Migration from Ireland to the UK for the purposes of nurse training and employment was therefore a tangible expression of enduring historical (colonial) ties between the two countries. The nurse trade between Ireland and Britain was partly facilitated by general factors channelling Irish emigrants to Britain: Britain was a popular destination for Irish emigrants due to easy access (Irish citizens have a right of free entry into Britain and Northern Ireland), cultural and linguistic similarities, available employment and the cheap, frequent transport links between the two countries (Delaney, 2002). The volume of Irish nurse migration to Britain was in addition facilitated by state immigration laws: trained and intending nurses and midwives were exempt from British wartime restrictions on Irish immigration (Daniels, 1993). This volume was sustained by recruitment systems and practices by British state/labour authorities and hospital authorities which directly recruited Irish nurses through Irish labour exchanges and through the Irish national and local press: 65 per cent of Irish nurses recruited to work in the NHS were recruited while still living in Ireland (Ryan, 1990). Recruitment campaigns included ‘coupon publicity’⁷ and open recruitment methods (the latter at least was in contravention to institutional channels and procedures⁸) (Yeates, 2009: 134). Assisted by these historical ties between Britain and Ireland and by the labour and social networks that channelled and sustained Irish migration to Britain, Irish nurses forged a niche position in the British nursing labour market and maintained this position for most of the 20th century.

⁷ This was conducted via England’s newspapers circulated in Ireland. Coupon publicity was a means of generating people’s registration at labour exchanges indicating their willingness to work in England and attend interviews in Ireland following nomination by employer hospitals.

⁸ Such recruitment campaigns being carried out by British hospitals in Ireland resulted in concerns being raised by the Eire High Commissioner in London: as the Department of Labour in London wrote, these concerned ‘the question of the extent to which Employing authorities in this country [England] will be tolerated if they go browsing about Eire trying to persuade Eire girls to come to their hospitals’ (S.M Stopford, 16/10/46 covering letter, LAB 8/1301) (Yeates, 2009).

The dynamics of colonial ties is further evidenced in the case of the British Colonial Nurses Association (CNA). Between its foundation in 1896 and 1966, more than 8,400 women applied to join the CNA (renamed the Overseas Nurses Association in 1919) to practice nursing in Britain's overseas colonies, looking after British colonists' health and providing training for indigenous women in the colonies in British nursing. Ultimately, this latter role would prove enduring, with the CNA/ONA 'creating a workforce capable of contributing to the British National Health Service' (Rafferty, 2005). While most of the CNA recruits were drawn from Britain, nearly 6% of applicants had an Irish address.⁹ This is a likely underestimation of the numbers of Irish nurses applying to or employed by the CNA since Irish nurses based in Britain would have applied directly from there. Nevertheless, although these numbers are modest, we can appreciate that Irish nurses were involved in complex colonisation dynamics: as colonial subjects themselves, they also participated in Britain's colonial nursing services that sustained British colonists, shaped the development of nurse training in other British colonies, and laid the foundations for continued out-migration of intending and qualified nurses from the current and former colonies to Britain for generations to come.

Irish nurses overseas: religious nursing migrants and missionaries

If Britain dominated as a destination for many intending secular nurses, religious nursing migration was more extensively internationalist. Table 3 hints at this in the data on Irish-registered nurses living in Africa and Asia. In fact, many Irish orders were internationalist in orientation. *The Sisters of Mercy*¹⁰, *the Presentation Sisters*¹¹ and *the Sisters of Charity*¹² were all particularly quick-spreading international orders, but other orders were involved too (e.g. the Ursulines from Cork went to Georgetown, British Guiana, in 1839; the Irish Loreto Sisters went to Mauritius in 1840 and Calcutta in 1841). This internationalisation of Irish orders was influenced by the same missionary orientation and governance structures that influenced the French orders, but in the Irish case it was given further impetus by the sustained mass production of a professional female religious cadre. From the mid 19th the recruitment of women into the Church grew at a phenomenal rate. The number of female religious in Ireland rose from 120 in 1800 to over 8,000 by 1901,

⁹ Source: Rosemary Wall, personal correspondence, based on data communicated to the author from a sample of 567 nurses applying to the CAN. Of these, 32 gave an address in Ireland when applying for the CAN; 10 of these applied from Northern Ireland.

¹⁰ Following the setting up of their first convent in Baggot Street in Dublin in 1831, by 1841 the Sisters of Mercy they had set up ten convents in Ireland, and two convents in England – the first Catholic convents to be opened in England since the Reformation. The first Sisters of Mercy went to Newfoundland in 1842; in 1843 they opened a foundation in Pittsburgh; in 1846 they opened a convent Perth, Western Australia, and three years later (1849) they opened two further Oceanic convents, Glasgow, and Auckland. Steady expansion followed in the following decades: in 1856 at Buenos Aires, in 1860 at Brisbane, in 1880 at Adelaide, in 1883 in Belize, in 1890 in Jamaica and in 1897 in South Africa. By 1927, there were 20,000 Sisters of Mercy throughout the world (Seymer, 1957: 72), and by 1955 the Sisters of Mercy had 1509 foundations worldwide, about half (861) of them in the United States (Boland, 2003).

¹¹ The Presentation Sisters founded by Nanc Nagle (1718–1784) went to Newfoundland in 1833 and set up 12 foundations there by the turn of the century. By then, there were also 17 Presentation convents in the United States and 14 in seven Oceanic jurisdictions. In 1841, Presentation Sisters went to Madras to manage an orphanage there and further groups from Presentation convents followed in the 1850s and 1880s. Irish Dominican Sisters went to New Orleans in 1860, Cape Town in 1863 and Adelaide in 1868, Port Elizabeth in 1867, Danganra, New Zealand in 1867, Perth, Western Australia in 1899 and New South Wales in 1887 (Hegan, 1992: 16–17).

¹² The Sisters of Charity, after consolidating the order in Ireland, founded houses in Africa, Australia and the Americas (Boland, 2003), setting up in the Philippines in 1862.

and they came to represent an increasing proportion of Catholic religious (6% in 1800; 71% in 1901). The number of women religious increased over the course of the twentieth century (Table 1), peaking in the late 1960s. The 1971 Census recorded over 13,000 nuns in Ireland; they represented 4.6% of women 'gainfully occupied' and 26% of female professionals (Table 1). To these figures must be added many thousands more women religious who had emigrated: McKenna (2006: 1) estimates that in the late 1960s a 'further 15,000 Irish nuns [were] living as members of both Irish and foreign congregations outside Ireland'.¹³

This mass production of female religious and its export helped absorb a surplus female population created by a patriarchal colonial social structure. The migration of Irish female religious and their involvement in nursing care overseas took place in a context of the prevailing social conditions for women in Ireland as well as general migration from Ireland prompted by the effects of colonial rule and neo-liberal orthodoxy (Jackson, 1984; Mac Laughlin, 1987; Yeates, 2004). As noted in Section 1, joining a religious order offered women the prospect not only of economic independence but also a career and an opportunity to acquire or practice professional skills. Missions in particular gave women the opportunity to become involved in an important international project of the Catholic Church without the negative connotations that often accompanied leaving Ireland (McKenna, 2003). They proved attractive to poorer Irish girls: religious emigration (especially to the US and Australia) opened up the possibility of becoming a choir sister and practising a profession whereas remaining in Ireland would have meant serving as a lay sister and performing domestic labour (Magray, 1998). The missions also offered the possibility of both adventure and heroism, if not in life then perhaps in death. Indeed, while social and economic factors help explain the huge numbers of Irish women who joined religious orders at home and abroad, it is impossible to avoid the conclusion that piety, the desire to do good and to save souls were driving forces behind their emigration.

The extensive global institutional infrastructure of the Catholic Church enabled it to respond to Irish emigrants' needs as well as facilitate further emigration. On the first of these, mass Irish emigration had major impacts on the destination countries. In the United States, for example, foreign-born populations, especially Irish, were over-represented in health, welfare and penal institutions as clients, patients and prisoners. This generated pressure on the Catholic community to set up parallel institutions (to Protestant ones and civil/non-denominational ones) specifically for Catholics – including hospitals, nurse training centres and professional societies (Nelson, 1997: 13) as well as schools, orphanages and other social services. So the Catholic Church developed health services for Irish Catholic emigrants overseas, a response that was also framed by a concern by the Catholic Church that Irish emigrants might 'lose' their religion.¹⁴ The first wave of Irish missionaries thus migrated to provide religious and social, health and educational care to Irish diasporic communities in the US, as well as in Australia, Canada and England and many other countries to which the Irish emigrated. From

¹³ This mass recruitment and production of nuns in Ireland was mirrored in their male counterparts. Between 1850 and 1890, the number of Irish priests, monks and nuns almost tripled, at a time when the Irish population decreased by one third (Hirschman, 2004: 18).

¹⁴ This was also a concern and motivation for the Catholic Church in relation to Irish emigrants in England. Kanya-Forstner (2000), for example, notes how the involvement of the Church in welfare provision in Liverpool in the 19th century was in part motivated by perceived/anticipated effects of proselytising Protestant religious who would persuade Irish Catholics to switch sides.

1812 to 1914, between 4,000 and 7,000 Irish women are estimated to have emigrated as nuns to the US alone, where they comprised about 10 per cent of the total number of nuns (Hoy, 1995).¹⁵ As Nelson (1997) argues, they ‘followed their flock, establishing schools, orphanages, hospitals and hospices’ there in the US and around the world (Nelson 1997: 9). Female religious were often the only source of support for female emigrants as

[W]ithin the Catholic Church which provided most of the help to Irish immigrants when they arrived in the US, the male and female spheres were so sharply set off from one another that the only source of real service and sustenance for the widows, the abandoned and the abused women came from the nuns. (Diner, 1983: 120–121)

The nuns provided nursing care as well as other social welfare services such as sickness and death benefits, housing, social care for children and the elderly, and training and employment services for Irish women emigrants abroad just as they did for women in Ireland. In addition to sustaining the physical and spiritual welfare of Irish emigrants abroad, the Catholic Church actively facilitated and channelled Irish emigration and ensured supplies of nursing care labour to staff services set up by Irish Catholic overseas orders. In her study of Catholic nurses in the US, Barbara Wall (2005) describes the Sisters of Charity of the Incarnate Word as being particularly aggressive in its recruitment of Irish women, instancing an ‘open recruitment’ mission by Mother Mary John O’Shaughnessy among local communities across Ireland resulting in 40 women going to San Antonio to staff nursing services, while in 1904 another open recruitment mission led to another 38 women heading out to Texas for the same purpose. According to Wall ‘an intense spirit of competition occurred among women’s communities in obtaining Irish recruits’ (Wall, 2005: 29). In the 1870s, for example, a recruitment trip by Mother Angela Gillespie of the Sisters of the Holy Cross visited Cork, Kildare, Limerick, Waterford and Kilkenny, from this last of which she recruited 25 women. Two other examples should suffice: in 1873 of 93 women who entered the Holy Cross order, 61 were born in Ireland, while in 1898 57 women left Ireland to join the Sisters of St. Joseph of Carondelet in St. Louis (Wall, 2005; see also Hoy, 1995, on international recruitment drives by Catholic female orders).

Alongside open recruitment drives conducted by individual orders, the Irish Catholic Church set up training schools to systematically channel religious migration. Nelson (2001: 20) and Hoy (1995: 77) instance the example of St. Brigid’s Missionary School, Kilkenny (1884–1958), which trained in excess of 1,900 young women for convents overseas, primarily in Australia, New Zealand and the United States. Although these were not trained specifically for nursing orders, many of the missionary recruits would nevertheless have been involved in providing nursing and other care to Irish emigrants in those countries subsequently, supplementing existing provision and often providing a rural focus that was overlooked by the urban tendencies of state healthcare provision at the time, such as it was. It must be said that *the Church’s involvement in training for export was not confined to female orders. While in 1811, St*

¹⁵ Many countries other than the US were important destinations for nuns due to the Catholic Church’s missionary activities around the world. The statistics on numbers of nuns emigrating from Ireland do not include women who left Ireland in a secular capacity and who were subsequently recruited into the Church while abroad.

Kieran's College Kilkenny began accepting students for foreign dioceses, it was the foundation of All Hallows College in Dublin in 1842, aimed specifically at training priests for the foreign missions, that spurred the Irish export of priests throughout the world, leading to eventual Irish domination of the Catholic church hierarchies in Australia, New Zealand and the United States. In the US, these priests supported the recruitment drives back in Ireland by US-based Irish Catholic female orders seeking additional labour for their expanding social and health care provision (Hoey, 1995: 76).

With the export of this labour came the export of the values and mores of Irish Roman Catholicism which had a major impact across English-speaking countries. As Larkin notes, "not only did Roman Catholic Churches in England and Scotland become essentially Irish, but the Churches in the United States, English speaking Canada, South Africa, Australia and New Zealand were all strongly influenced by the developing values and mores of Irish Roman Catholicism" (Larkin, 1984, quoted in Hirschman, 2004: 18). Magray (1998) alludes to the importance of sodalities in the spread of Irish Roman Catholic values worldwide when commenting on their role in preparing emigrants:

Membership in the sodality was thought to be foolproof insurance against the many dangers encountered by single emigrant women, especially estrangement from Irish Catholic social values and mores. . . They were guided before they left to be devout, chaste and obedient Catholic girls, and after they arrived in their new surroundings, they continued to be coached by the nuns. Young sodality women who emigrated were encouraged to maintain regular contact with the nuns back home in Ireland.' (Magray, 1998: 104)

It was not just religious and moral values that were exported, but also social teaching and practices. Recent research emphasises the formative effect that migrant sisters had on general welfare services and programmes. Fitzgerald (2006) argues that, rather than the immaculate conception of welfare services in the Progressive era in the United States, which gave birth to welfare services from the efforts of elite (and mainly Protestant) social reformers, in New York, at least, this period was preceded by one during which 'elite Protestants and mainly working class Irish sisters struggled over poor relief. During these struggles, the Irish sisters set up a range of welfare services in New York that prefigured and predated later reform efforts. Luquet (2005) also suggests, more hesitantly, that the work of the Sisters of Mercy in their Bermondsey convent in London, which preceded the Protestant settlement movement, represented a major contribution to the development of health and welfare services in England.

In nursing the export of Irish Roman Catholic values and practices was evident in various ways. The aforementioned Irish Guild of Catholic Nurses was influential within the International Catholic Nurses Guild, and within the Irish nursing diaspora more generally as a result of their internationalism, one important outlet for which was their journal, *Irish Journal of Nursing*. Irish Catholic nurses were also encouraged to join Catholic Nurses' Guilds in the country to which they emigrated; no doubt this was motivated by the same concerns as applied to other emigrants for whom service provision was made, namely that emigrant Catholic nurses would be at risk of 'losing their religion'. The involvement of Irish nuns in nursing during two wars that were central to the development of nursing in the 19th century - the American Civil War and the Crimean War - can also be instanced. This dependence on Irish recruits began at an early stage. During the American Civil War, when 20% of the nurses for both sides were Catholic nuns (Fialka, 2003: 5), nearly two-thirds of

the nearly eighty Holy Cross¹⁶ sisters who nursed the soldiers were Irish-born (Maher, 1989: 36). Maher (1989: 69) also estimates the minimum number of sisters engaged in nursing during the American Civil War at 617 drawn from 21 communities run by 12 orders. These sisters comprised one-fifth of all sisters in the US at the beginning of the war. The majority of them were Irish (320 were Irish-born or of Irish descent); 200 were born in the US while the remainder were mainly born in France or Germany (Maher, 1989: 70). In the Crimean War (during which one third of the British army were Irish), 33 Irish Sisters of Mercy and Sisters of Charity went as nurses (Bolster, 1964; Luddy, 2004; Murphy, 2002). Nuns' involvement in wars such as these made the Catholic Church seem patriotic, dealt with allegations of national disloyalty arising from its ultimate allegiance to Rome, and was used to counter anti-Catholic prejudices in Victorian Britain (and elsewhere; for an account of this in the US context see Fialka, 2003: 5).

Irish emigrant nuns thus represented an important source of nursing labour, and they made substantial contributions to the development of health institutions, running nurse training centres, staffing and managing hospitals and home nursing services, often under the aegis of poverty administration. Many Catholic congregations of Irish women were 'particularly active' in opening and operating hospitals in the US (Wall, 2005:19). Between 1840 and 1870, nuns from 34 different orders opened or took charge of over 70 acute hospitals; from 1870 to 1920, 275 acute hospitals were set up by 189 different Catholic congregations. Wall (2005) notes the dependence of hospital operating orders on Irish recruits. In the case of the Sisters of Charity of the Incarnate Word, which set up in protestant Texas, between 1872 and 1900, some 45% of the sisters were recruited from Ireland, compared with 21% from Germany and just 16% from the US. This tendency to draw on Irish female religious labour increased over the coming decades. For the period 1901-1920, the Irish recruits increased to 47% of the total; German recruits remained at 21%, US recruits declined to 14%, while recruits from Mexico increased to 14% from their previous level of 4% (Wall, 2005: 30). As Nelson argues, 'The Irish nuns colonised new countries, ran efficient hospitals open to all, managed famine relief and epidemic nursing, while at the same time attending to their own spiritual self-formation' (Nelson, 1997: 9), and she goes on to note that

'within a period of two to three decades from the founding of their orders, the nuns had established hospitals throughout the world. The formidable administrative pragmatism ... is what sets the Irish nuns apart. They did not have to choose [sic] between the secular or the spiritual domain, rather they colonised the secular while maintaining firmly their position in the spiritual.' (ibid: 9)

Conclusions

By drawing attention to key aspects of the internationalism that shaped the development and practice of Irish nursing from the nineteenth to mid twentieth centuries, I have emphasised the significant historical precedents of contemporary nurse migration. The international connections and dependencies are most tangibly expressed through successive migrations of women intending to become or already qualified as nurses, whether secular or religious, travelling alone or as part of organised missions. This expansion of traditional analyses of Irish nursing to also encompass the religious highlights the close relationship between the two professional

¹⁶ A French order which went to the US in 1843.

domains, and underlines the necessity of attending to religious and secular migration as mutually reinforcing of one another. Approaching these histories as entwined enables an appreciation that the care labour that nurses, both secular and religious, supplied globally was an important feature of the 'global care chain' (Yeates, 2009) operating at the time.

The Catholic Church was central to this global care chain, and the nursing migration associated with it travelled both directions, both into and out of Ireland. By staffing and managing nursing care services, the sisters not only pioneered women's involvement in the profession but also pioneered the development of such services in Ireland and overseas. As regards Ireland, the discussion drew attention to the influence of overseas female orders (French ones in particular) and Irish orders previously involved in nursing overseas. Irish religious migration to staff services overseas was initially confined to services for Irish Catholic migrants in destination countries, but later developed into services for the general population in these countries. The global reach of the Catholic Church proved especially crucial in this care chain, providing as it did an institutional infrastructure that mobilised, channelled and sustained the organised emigration of religious and secular nursing (and other care) labour and its settlement into the host society.

Matching this religious colonialism, particularly evidenced in missionary work, was the state colonialism that operated in the sphere of 'secular' nursing where the inter-connections and –dependencies of Ireland and Britain's nursing institutions and labour forces were evident across the period examined. Ireland functioned as a pool of nurse labour for British hospitals, which looked to Ireland for both trainee and qualified nurses. Nurse recruitment practices operated by these hospitals were both direct (e.g. open recruitment campaigns) and indirect (e.g. leveraging transnational labour and social ties of Irish nurses). The involvement of Irish nurses in British nursing institutions was not limited to experience of training and working in the island of Britain but extended to working on its behalf in its other overseas colonies. Through the work they undertook in their capacity as employees of the Colonial Nurses Association they helped lay the groundwork for future generations of nurse recruitment to Britain. The confluence of state and religious colonialism is perhaps most tangibly expressed in these overseas terrains, with religious Catholic missionaries' providing nursing and other care services to Irish emigrants including those working with the CNA.

This meeting of the secular and religious in the domain of nursing is not merely an historical footnote: the legacy of involvement of Catholic orders in nursing and other welfare provision internationally remains evident today. Worldwide, the Catholic Church runs nearly 6,000 hospitals alongside nursing homes, specialised clinics and dispensaries (Coleman, 2007); many of these Catholic nursing institutions continue to recruit Catholic staff from overseas. In Germany, for example, 'around 2,000 foreign members of religious orders have been employed annually over the past five years' (ICMPD, 2005: 89). The legacy of female religious orders remains to the current day. As O'Brien notes, "Today the Daughters of Charity comprise one of the largest international Catholic communities of women in existence, with approximately 28,000 Daughters worldwide.... In the United States, the Daughters of Charity National Health Services (DCNHS) is one of the most extensive health care systems

in the world, with Sisters serving primarily in the areas of administration, nursing and pastoral care” (O’Brien, 2007: 39).

This legacy is also evident closer to home, in Ireland, in the development of separate sectarian healthcare provision. Following the foundation of the first Catholic hospital in 1834, healthcare provision continued to develop within a system that prioritised sectarian provision, with the Catholic capture of health institutions continuing under the new regime until the end of the 20th century. Although the harsher edges of sectarian institutions were rounded during reorganisation of the Irish health system in the 1990s, one essential precondition for the merging of hospitals was the assurance of the continuation of the “ethos” of separate institutions. This ethos was a euphemism for religion. Finally, the legacy of Catholic religious orders’ involvement in nurse migration is also evident in the countries from which Ireland currently recruits. Most of Ireland’s migrant nurses have been recruited from the Philippines and India. At one level, Ireland is just another country to which Filipino and Indian labour is exported, but the religious connections between these countries are not insignificant. All have long histories of Catholic presence, colonisation even, and many Filipinos and Keralese were educated by Irish Catholic missionaries. If ‘[t]he Philippines is a sort of Catholic Ireland located off the coastline of Asia’ (Fitzgerald, 2000), then Kerala for its part is an Irish Catholic enclave on the coastline of India.

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