THE CONSTRUCTION OF THE LABOUR MIGRANT'S BODY: FEDERAL GERMANY'S MEDICAL SELECTION OF LABOUR MIGRANTS FROM TURKEY BETWEEN 1961 AND 1973

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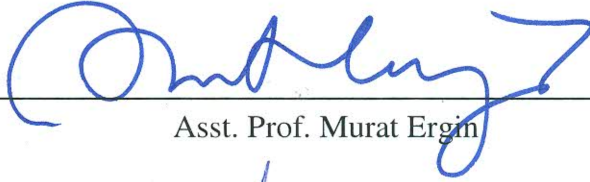

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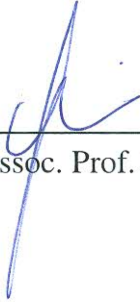

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THE CONSTRUCTION OF THE LABOUR MIGRANT'S BODY: FEDERAL GERMANY'S MEDICAL SELECTION OF LABOUR MIGRANTS FROM TURKEY BETWEEN 1961 AND 1973

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This thesis focuses on a distinct moment of Federal Germany's recruitment of migrant labour in the period from 1961 to 1973: the medical selection examinations of labour migrant applicants from Turkey. These examinations, which aimed at the selection of physically fit and healthy labour migrants for the West German labour market, were conducted by West German health officers in so-called 'German recruitment offices' in Istanbul and Ankara between 1961 and 1973. Drawing on in-depth interviews with former labour migrants and examining physicians as well as on a discourse analysis of primary sources dating from the period in question, I concentrate on the question of how in relation to the requirements of industrial labour and public health politics the body of the labour migrant was shaped and defined in the medical examinations. Combining concepts taken from the work of Foucault, constructionist body theory and disability studies, I trace how certain conceptualisations of the labour migrant's body emerged along the lines of health, disease, bodily ability and disability. Furthermore, I analyse how this construction process of the body overlapped in various ways with notions of race and gender. I argue that these examinations were no neutral scientific endeavour. Rather, in accordance with industrial requirements and national health politics, they served as a selection procedure combining inclusionary and exclusionary power mechanisms with the logic of risk management to rationalise, normalise and commodify the labour migrant's body.

Keywords: Labour migration, public health politics, body politics, Federal Germany, Turkey.

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GÖÇMEN İŞÇİNİN BEDENİNİN İNŞASI: FEDERAL ALMANYA'NIN 1961 VE 1973 YILLARI ARASINDA TÜRKİYE'DEN GELEN GÖÇMEN İŞÇİLERİNE UYGULADIĞI SAĞLIK MUAYENESİ

MARIA KRAMER

Bu tez Federal Almanya'nın 1961-1973 dönemindeki göçmen işçi alımının belirli bir anı olan Türkiye'den yapılan göçmen işçi adaylarının sağlık muayenelerine odaklanmaktadır. Batı Almanya iş pazarı için fiziksel açıdan "fit" ve sağlıklı göçmen işçilerin seçilmesini hedefleyen bu muayeneler Batı Almanya'dan gelen sağlık çalışanları tarafından İstanbul ve Ankara'da yer alan sözde "Alman İrtibat Büroları"nda 1961 ve 1973 yılları arasında gerçekleştirilmiştir. Bu çalışmada o dönemki göçmen işçiler ve muayeneleri gerçekleştiren doktorlarla yapılan derinlemesine görüşmeler ile dönemin birincil kaynaklarının söylem analizi üzerinden sağlık muayenelerinde, endüstriyel iş gücünün gerekleri ve kamu sağlığı politikalarıyla ilişkili olarak göçmen işçinin bedeninin nasıl şekillendirildiği ve tanımlandığı sorusuna odaklanıyorum. Foucault'nun eserlerinde yer alan kavramlar, toplumsal inşacı beden teorisi ve sakatlık çalışmalarını bir araya getirerek göçmen işçinin bedenine dair belirli kavramsallaştırmaların nasıl sağlık, hastalık, sağlamlık ve sakatlık bağlamlarında ortaya çıktığının izini sürüyorum. Bunların yanında bedenin bu inşa sürecinin nasıl ırk ve toplumsal cinsiyetle örtüştüğünü analiz ediyorum. Bu muayenelerin nötr bir bilimsel girişim olmadığını iddia ediyorum. Aksine, endüstriyel gereklilikler ve milli sağlık politikalarına paralel olarak bu muayeneler, dahil edici ve dışlayıcı güç mekanizmalarını risk yönetimi ile birleştirerek göçmen işçinin bedenini rasyonelleştiren, normalleştiren ve metalaştıran bir seçim süreci işlevi göstermiştir.

Anahtar Sözcükler: İş göçü, kamu sağlığı poltikaları, beden politikaları, Federal Almanya, Türkiye.

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1 Introduction

> *Nothing has prepared him for this situation. It is unprecedented. And yet it is already normal. The humiliating demand to be naked before strangers. The incomprehensible language spoken by the officials in command. The meaning of the tests. The numerals written on their bodies with felt pens. The rigid geometry of the room. The women in overalls like men. The smell of an unknown liquid medicine. The silence of so many like himself. The in-turned look of the majority which yet is not a look of calm or prayer. If it is normal, it is because the momentous is happening without exception to them all* (Berger and Mohr 2010, 56).

A series of black-and-white photographs taken by Jean Mohr in the early 1970s and published in the book *A Seventh Man* stood at the beginning of this thesis because they first confronted me and brought me into contact with its central topic. They show a dozen men standing in a row, naked but for their underwear, with numbers written on their chests, first flexing their arms, then bending down while a physician in a white coat paces in front of them, touches them, examines them, even pulls down their underwear scrutinising the most secluded parts of their bodies. Meanwhile, the men avert their eyes, not knowing where to look.

These photographs, which have an unsettling effect on the spectator because of the associations they evoke, are historical snapshots of a pivotal moment in the process of Federal Germany's recruitment of labour migrants from Turkey during the 1960s and early 1970s: the medical examination of prospective labour migrant applicants at the German recruitment offices in Turkey. When I came across these pictures while reading *A Seventh Man* one and a half year earlier I felt stunned, not only with respect to the moments they had preserved. I was taken aback that despite the omnipresence of discussions evolving around the 'Turkish-German minority' in the German public and despite my interest in questions of migration it had taken me so long to learn about the existence of such examinations. No public awareness of or reflection on these examinations exists in contemporary Germany's society. The reason for this can be found in a certain ahistorical approach in today's public and political

discourses in Germany which often problematise Turkish migration to Germany along the lines of diaspora and identity formation, cultural (non-)integration or social inclusion and exclusion while omitting from public consciousness the very processes and procedures through which the first generation of labour migrants from Turkey, the so-called 'guest workers', were actually incorporated into the West German labour market. By concentrating on the medical examination of labour migrant applicants from Turkey, this thesis will focus on a specific moment of this incorporation process which is situated at the intersection of body politics, public health, labour and migration.

Conducted by mostly German physicians and public health officers in the so-called German recruitment office in Istanbul (*Deutsche Verbindungsstelle in der Türkei*; lit. German Liaison Office in Turkey) and for a short time also in a branch office in Ankara, the medical examination formed an intrinsic part of the vast bureaucratic recruitment apparatus established by the Turkish and Federal Employment Services to realise Federal Germany's state-supervised import of more than half a million migrant workers from Turkey between 1961 and 1973. Every labour migrant applicant who wanted to enter the Federal Republic via the official state-regulated recruitment process had to pass the medical examination at the German recruitment offices as an obligatory stage in that process. Including several medical tests and a detailed body check-up, the medical examination constituted a thorough selection process which aimed at assessing the applicants' work suitability and general health condition.

1.1. The Body as a Central Unit of Analysis

Specifically, my thesis is structured around the question of how the body of the labour migrant was constructed in the course of these examinations. Taking into account labour market and public health requirements, I will analyse what conceptualisations of the body determined who was accepted as a labour migrant by the recruitment offices' medical staff

and who was not. In other words, I will trace the inclusionary and exclusionary logics emerging in the examination procedure by concentrating on the varying conceptualisations of the labour migrant's body which underlie these logics. Thus, the perspective of this thesis shifts the primary focus of analysis away from a problematisation of the labour migrant her- or himself to a problematisation of the very context of Germany's recruitment and employment of foreign labour which produced the labour migrant in the first place.

I adopt an approach which takes the body of the labour migrant as a lens through which the recruitment context and its inherent power relations generative of the very category of 'labour migrant' become apparent. Hence, I pursue an approach which allows me to politicise the very process of Turkish labour recruitment on part of Federal Germany. Michel Foucault has identified the body as a target of power technologies which 'categorise' and 'create individual subjects' (Foucault 1983, 212). I take the 'Turkish labour migrant' to be one such specific subject category in need of problematisation. By focusing on the construction process of the labour migrant's body in the medical examination, this thesis will illustrate how this specific subject category was created through certain processes of categorisation and classification.

By choosing the body of the labour migrant as a starting point to trace the dynamics of public health politics in the context of labour migrant recruitment, I adopt a perspective which has been largely neglected by studies on Federal Germany's post-war incorporation of migrant labour into the national labour market. [1] Throughout this thesis, I approach the body from various theoretical angles which highlight the centrality of the body to issues of health and illness, gender and sexuality, disability as well as risk and danger. I move largely, although not exclusively, within a Foucauldian framework. By making recourse to the

[1] Significant exceptions to this neglect are Hisashi Yano's article on Federal Germany's medical examination of labour migrants between 1955 and 1965 (Yano 2001) and Monika Mattes' work on the gendered politics of Federal Germany's 'guest worker' labour recruitment (Mattes 2005).

theoretical writings of Michel Foucault (Foucault 1994, 1995, 2003a) and scholars directly influenced by Foucault like Judith Butler (Butler 2010), François Ewald (Ewald 1991), Robert Castel (Castel 1991) or Shelley Tremain (Tremain 2006), I problematise certain dichotomies relating to the body which evolved in the context of the medical examination determining the selection outcomes, such as 'the healthy/ill body', the 'normal/pathological body', the 'able/disabled body', the 'female/male body' or the 'dangerous/secure body'. I furthermore stay within a Foucauldian framework when discussing the question of subversion and resistance during the examination process by referring to the work of James Scott (Scott 1985, 1990).

Although I adopted a largely Foucauldian approach, I moved beyond this framework by drawing additionally on the theoretical work of non-Foucauldian authors whose writings are greatly illuminating for the topic at hand. I especially benefitted from the work of anthropologist Mary Douglas (Douglas 1984) and public health scholar Alison Bashford (Bashford 2004) when discussing how boundaries of hygiene, purity and danger become mapped on the body of the migrant during medical inspections. Furthermore, I drew on the work of disability scholars like Douglas Baynton (Baynton 2001), Roxana Galusca (Galusca 2009), Robert McRuer (McRuer 2006) and Rosemarie Garland Thomson (Garland Thomson 2006) to entangle how the imperative of 'the able body' pervaded both industrial and public health regulations which in turn shaped the structure of the medical examination at the recruitment offices.

Reliance on such a varied theoretical framework does not necessarily entail a negation of the above listed writers' varying and sometimes contradictory understandings of the body. What makes such a multifold theoretical approach to the body possible is the unifying element in the writings of these scholars, who all refuse the idea of a purely biological body. Instead, they conceive the body as an entity which is both shaped by and which reflects the

social, cultural and political context in which it is located, be it in terms of power-knowledge-relations as stated by Foucault, in terms of symbolic representation as argued by Mary Douglas or in terms of socio-political and economic transformations resulting in ableist lines of inclusion and exclusion as described by disability scholars like Baynton, Galusca or Garland Thomson.

Choosing a diversified theoretical approach drawing on various authors, both of Foucauldian and non-Foucauldian alignment, proves to be highly fruitful for the topic at hand. Thus, unlike most studies on public health and migration control, which focus exclusively on one or two dimensions of public health examinations of migrants, [2] my thesis illustrates the mutual dependence and interrelation of questions of the body and questions of race, class, gender/sexuality, (dis-)ability, risk and danger in the context of the medical selection of migrant workers.

The central argument of my thesis states that the medical examination, which incorporated aspects of labour selection, migration regulation and public health control, followed a complex and multilayered logic. Drawing both on the physical examination of workers, a major technique in industrial medicine which had emerged in the 19th and early 20th century, and on medical immigrant inspections, which had spread as a significant form of border control during the great migration movements at the turn of 19th and 20th centuries, the medical examination at the German recruitment offices combined aspects of both these examination types.

[2] For instance, Alan Kraut concentrates mainly on the correlation of notions of disease and race in the context of nation building in medical immigrant inspections at Ellis Island (Kraut 1995). Similarly, Amy Fairchild focuses on the overlapping of disease categories with conceptualisations of class and race in medical immigrant border inspections at the late 19th and early 20th centuries (Fairchild 2003), whereas Eithne Luibhéid (Luibhéid 2002) analyses the significane of sexuality categories in US migration entry regulations from the late 19th century onwards. Disability scholars like Roxana Galusca (Galusca 2009) or Douglas Baynton (Baynton 2001) in turn prioritise disability as a central factor determining acceptance or rejection of immigrants in US medical immigrant inspections.

It was this specific combination which allowed for shifting patterns of inclusion and exclusion to unfold during the examination as notions of health and disease overlapped in varying ways with notions of race, class, gender and bodily (dis-)ability. Instead of simply constituting a means of exclusion and control, the medical examination was guided by a multifold logic of inclusion, exclusion and risk management which corresponded to a trifold conceptualisation of the labour migrant's body as an industrious machine, a potential carrier of latent disease and a commodity. Ability concerns with regard to physical productivity, latency fears with respect to disease and risk considerations concerning the value of the migrant's labour power undergirded the examination which aimed at the selection of physically fit and productive as well as healthy and non-diseased working bodies which would prove employable and live up to the expectations of future employers who had 'ordered' labour power via the recruitment offices. Thus, the medical examination had to fulfil the complex task of operating at the same time as an instrument of disciplinarisation, a security tool and a means of bodily commodification.

As I further illustrate in this thesis, the logics of the examination were sustained by certain discursive representations which informed discussions in the West German public and political realm concerning the recruitment of migrant labour during 1960s and 1970s. Significantly, these discursive representations depicted the labour migrants as essentially non-modern, backward and prone to carry or catch diseases and health disorders, thus bolstering and legitimising the institutionalisation of the medical examinations at the German recruitment offices abroad.

1.2. Current State of Research

The topic and central questions of this thesis arise out of the overlapping gaps and desiderata in the various research fields upon which this thesis touches. These are primarily

studies on migration from Turkey to Germany, on public health and migration as well as on industrial labour and the worker's body.

A vast amount of literature from the various disciplines of sociology, political science, pedagogy, psychology, economic science, migration studies, anthropology and history deals with questions of migration from Turkey to Germany. Several paradigmatic shifts and research tendencies within this field of literature can be discerned. Whereas publications concentrating on Turkey as the sending country have largely dealt with the effects of labour export on the Turkish economy and society (Gökmen 1972, Paine 1974, Abadan-Unat 1976), research on Federal Germany as the receiving country has largely focussed on questions of German migration policies and the formation of a Turkish diaspora within Germany. With respect to the literature concentrating on the impacts of migration from Turkey on German society and politics, migration scholar Sabine Hess differentiates between two 'master narratives' which have predominantly shaped research in the field from the 1970s onwards (Hess 2010, 10-15): Earlier sociological, psychological and pedagogical studies during the 1970s and 1980s have primarily been influenced by an understanding of 'migration as a problem'. In these studies, migrants and their children are mostly perceived as a socially, psychologically and educationally deficient group which threatens the stability and homogeneity of the Federal German state. [3] During the 1980s, migration studies underwent a process of increasing culturalisation. Migration now came to be interpreted mainly as an 'experience of cultural difference'. As a critical response to previous 'problem studies', academic research shifted its focus to the migrants' cultural identity and the cultural transformations this identity underwent in a German context (Straube 1987, Schiffauer 1991). Often adopting an ethnomethodological or biographical approach, these studies tended to a marginalisation and ethnicisation of social, political and economic inequalities which

[3] For a thorough review of early publications on migration from Turkey to Federal Germany dating from the 1960s to the 1980s, see Boos-Nünning 1990.

characterised the life experiences of migrants in Germany. A recent transnational approach emerging in the 1990s seeks to overcome the pathologising and culturalising impasses of these two master narratives which dominated research between the 1970s and 1990s (Hess 2010, 12-13). Rejecting an essential and homogenous understanding of culture, it localises migration experiences in a transnational space which straddles multiple national contexts (Simsek-Caglar 1994, Kaya 2001, Mandel 2008).

All of these differing approaches share a rather ahistorical perspective which neglects the organisation and realisation of recruitment procedures as the starting point of large-scale labour migration from Turkey to Federal Germany. In contrast to the burgeoning sociological and anthropological literature, historical works on Germany's import of migrant labour from the 1950s to 1970s remain comparatively few. Significant historical studies published during the 1980s and 1990s concentrate primarily on continuities and changes in Federal Germany's 'foreigner policy' over the 19th and 20th centuries (Dohse 1981, Bade 1983, Bade 1984, Herbert 1986, Pagenstecher 1994). Unlike these German-language studies which focus on temporal (non)continuities of migration politics within Germany, John Bendix adopts a comparative approach by analysing similarities and differences between Federal Germany's 'guest worker' program and the US mass import of migrant workers from Mexico, the so-called 'bracero program' (Bendix 1990). However, despite the highly insightful comparisons over time and/or geographical space which these studies provide, they do not give a detailed account of the recruitment processes' practical realisation.

Detailed research concerning the organisational realisation and the various stages of the recruitment process, including the medical examination, became only feasible with the end of the 30-years protection period for relevant archival documents in the 1990s and early 2000s. The availability of archival material initiated a series of new studies on Federal Germany's post-war recruitment of migrant workers which approach migration as an integral part of post-

war German history, underlining the close connection between migration movements and the formation and development of Federal Germany after WW II (Motte, Ohliger and von Oswald 1999, Dunkel and Stramaglia-Faggion 2000). Of central importance to this thesis is the pioneer work of the Documentation Centre and Museum for Migration to Germany in Cologne (DOMiD, formerly DOMiT). Documenting the history of Turkish recruitment and migration to Germany, its anthology *Fremde Heimat/Yaban Sılan Olur* (1998), which is based on archival research as well as expansive interviews with former labour migrants and recruitment staff members, proved to be a rich source for this thesis. Especially two articles on the proceedings at the German recruitment office in Istanbul and the medical examination provided valuable starting points for my research (Eryılmaz 1998a, Jamin 1998b). Of similar significance to my research were two studies by Karin Hunn and Monika Mattes. Systematically analysing the history of migration from Turkey to Germany between 1961 and 1984, Hunn's work constitutes so far the most extensive study on the topic, including a chapter on the various recruitment procedures which migrant workers from Turkey underwent to enter Germany (Hunn 2005, 79ii). Like her earlier articles from 1999 and 2003 (Mattes 1999, Erdem and Mattes 2003; article from 2003 in cooperation with Esra Erdem), Mattes' study concentrates on the labour migration of the 'guest workers' from a gender perspective which emphasises how not only the organisation of the labour market, but also the very process of recruitment were structured along gender lines (Mattes 2005).

Although the studies by Eryılmaz, Jamin, Hunn and Mattes do consider the practical realisation of recruitment procedures, they do not offer a detailed analysis of the medical examination of labour migrant applicants because they aim at larger overviews which deal with the examination as only one aspect of recruitment among others. An article concentrating exclusively on the recruitment and medical surveillance of 'guest workers' by Hisashi Yano provides so far the most extensive analysis and contextualisation of the medical examination

(Yano 2001). However, his article focusses less on the medical examinations conducted in the sending countries at the German recruitment offices and more on medical surveillance practices and public health regulations within the Federal Republic. Nevertheless, this thoroughly researched article constitutes a valuable source providing several reference points for this thesis.

So far no extensive study on the medical examination of labour migrants from Turkey has been written. Those articles and book chapters which concentrate on the examination refrain from analysing it as an explicit site of body politics. Especially the works by Yano, Jamin and Hunn do not move beyond an interpretation of the examination as a means to manage latent fears of dangerous diseases which were associated with 'foreigners' (Yano 2001, 82-83, Jamin 1998a, 73-75, Hunn 2005, 56-57). In contrast, Eryılmaz and Mattes take a more differentiated approach. They underline that the implementation of the examination was informed both by the desire to protect the nation against diseases imported by 'foreigners' and by economic efficiency calculations which were directed at a selection of only those applicants promising to be productive labourers and not to become burdensome for the social service system (Mattes 2005, 73, Eryılmaz 1998a, 117-118). It is such a differentiated approach emphasising the multiple logics of the medical examination which I will adopt in this thesis. With regard to the existing literature on migration from Turkey to Germany, my thesis will thus contribute to this corpus of literature in a two-fold way: first by concentrating on the medical examination as the central topic of this thesis and second by introducing the body of the labour migrant as a new level of analysis which allows me to discern and entangle the various logics inherent in the examination and the creation of the 'labour migrant'.

As this thesis is situated at the intersection of migration and public health, I have greatly benefitted from public health studies which concentrate on medical immigrant inspections conducted at the borders of major immigrant countries, especially the US, Canada and

Australia, during the late 19th and early 20th centuries. These studies have analysed in detail the non-neutral role of medicine in these inspection procedures. Responding to the requirements of nationalism, eugenics, labour and citizenship regulations, medical practices at the borders of nation states have repeatedly intermingled with notions of race (Yew 1980, Kraut 1995, Markel ve Stern 1999, Fairchild 2003, Bashford 2004), class (Sears 1990, Fairchild 2003), gender/sexuality (Luibhéid 2002) and disability (Baynton 2001, Baynton 2006, Galusca 2009, Dolmage 2011), thus generating certain inclusionary and exclusionary dynamics. Not all aspiring immigrants were considered racially, mentally, physically or morally fit for the nation and medicine served as a legitimising instrument for keeping out those deemed unfit while including those regarded as desirable for the nation project.

The majority of studies on public health and migration focus on questions of permanent immigration while they neglect the link between public health practices and temporary forms of labour migration, especially in the context of state-organised migrant labour recruitment. Consequently few studies on the topic exist. The work of migration scholar Natalia Molina counterbalances this marginalisation of labour migration in public health literature. In her studies, she traces how during the early 20th century conceptualisations of the Mexican labourer's body in US politics and the US public have oscillated between an ascription of unique physical fitness and suitability for manual labour on part of migration advocates and a demonisation of the Mexican worker's body as a carrier of dangerous diseases on part of those advocating migration restriction (Molina 2006). Furthermore, focusing on medical practices and examination procedures towards first seasonal Mexican workers in the early 20th century, later state-recruited Mexican bracero workers and finally 'illegal' Mexican immigrants in contemporary US society, she points out the continuities in US public health practices towards Mexican migrants over the 20th century (Molina 2011). A different perspective on the intersection of migrant labour recruitment, state policies and health is

provided by Deborah Cohen's dissertation on the bracero program which contrasts Mexican state logics informing the implementation of the program with the bracero workers' own experiences, interpretations and resistances with regard to these logics (Cohen 2001). Cohen depicts the medical selection of suitable bracero workers by Mexican and US public health officers as a transitional rite enacted by the Mexican state to incorporate members of the rural population into the citizenry and modernity (ibid, 241ii). However, she does not embark on a detailed discussion of notions of disease and health informing the medical selection of migrant workers. My own thesis will contribute to the sparse literature in the field by focusing on the case of Federal Germany's recruitment of migrant labour from a perspective which combines questions of state-organised labour migration with questions of public health and body politics.

A third field of relevant literature upon which my thesis touches are those studies which concentrate on industrial labour and its effects on the worker's body. Labour historians and political economists have analysed how the rise of industrial production technologies and rational management strategies has lastingly altered the work process through the introduction of new work rhythms and surveillance methods (Thompson 1967, Braverman 1998, Meyer 1981, Nelson 1995). Scholars like Herbert Gutman, David Montgomery and Stephen Meyer have emphasised how mass immigration to the US at the turn of the 19th and 20th centuries has crucially shaped the formation of the US industry and led to a stratification of the labour force into a professional, skilled work force of mainly American, English and German origin and a largely unskilled labour forced drawn from the Eastern and Southern parts of Europe (Gutman 1976, Montgomery 1979, Meyer 1981). However, the works of all of these scholars have only implicitly been concerned with the body. Although they point out how transformations in the production process have affected the body of the worker by requiring ever more standardised

and disciplined bodily performances, these studies refrain from treating the body as a central unit of analysis.

More recent studies have shifted their focus directly on the relation between the body and industrial labour. In *The Human Motor* (1992), Anson Rabinbach concentrates on a specific conceptualisation of the body as a 'human motor' which informed both the European science of work and Taylorism (Rabinbach 1992). In *Bodies of Work* (2008), Edward Slavishak concentrates on public representations of the male worker's body which symbolise contesting imaginations of Pittsburgh's character as a major site of industrial production between 1880 and 1914 (Slavishak 2008). Similarly, the various articles of the anthology *Kontrollierte Arbeit – Disziplinierte Körper*, edited by Lars Bluma and Karsten Uhl, identify the body of the worker as the central locus on which industrial labour transformations in 19th and 20th century Germany became explicit. Conceptualising the work space in a Foucauldian manner as a power-knowledge-matrix, these articles analyse how the body and the identity of the worker are created through measures of rationalisation and discipline, public hygiene and social reform programs (Bluma 2012). Another insightful approach to questions of industrial labour which takes the body as its starting point is provided by disability scholars who emphasise the close connection between the modern concepts of 'disability' and 'physical ability' and the rise of capitalist modes of production (Oliver 1990, Garland Thomson 1996, Davis 2006). With the exception of Slavishak's *Bodies of Work*, the studies quoted above which aim at a historicisation of body conceptualisations within the context of industrial labour transformations concentrate on the body of the national work force while neglecting body conceptualisations with regard to migrant workers. My thesis will tap into this research gap by focusing on a body construction process which is fundamentally informed by the migrant character of the workers in question.

1.3. Methodology

In terms of methodology, this thesis is based on a qualitative analysis of both written and oral primary sources concerning the recruitment process and medical examination procedures of prospective labour migrant applicants as well as the historical context in which these took place. The written sources include contemporary primary literature published during the 1960s and 1970s such as the annual reports of the Federal Employment Service on the recruitment and employment of 'foreign workers' as well as German-language books, anthologies and articles in scientific journals and public newspapers which deal with the adaptation of the recruited labour migrants to the modes of industrial production and industrial society, with the significance of labour migrant recruitment for the national German economy and with the medical surveillance of labour migrants, their health condition and the dangers they were thought to pose to the health of the national population.

Furthermore, this thesis greatly draws on archival documents which I mainly collected from the Federal Archive in Koblenz and to a lesser extent from the Siemens Archive in Munich and the DOMiD Archive in Cologne. The archival sources which I used for my research include documents and unpublished annual reports about the internal proceedings at the recruitment offices in Turkey, especially with regard to the medical selection procedures, and correspondences of the German recruitment office in Istanbul with Turkish and German ministerial institutions, German company representatives, health experts and insurance companies.

The analysis of these written documents, both published and archival, allowed me to trace indices about the practical realisation of the medical examination procedures and to contextualise these with regard to the development of the German recruitment offices in Turkey and the wider system of Germany's recruitment of migrant labour. Furthermore, such an analysis enabled me to identify multiple discursive formations linking the body of the

labour migrant to certain imaginations of health, disease, (dis)ability, race, gender and class which in their varying overlappings shaped the construction of the labour migrant's body in the examination. To avoid confusion, I want to point out that I use the term 'discourse' in a Foucauldian sense referring to subsystems of ideas, laws, techniques and practices which give rise to certain material ideas such as 'the healthy body', 'the able body', 'the diseased body' etc. (Rabinbach 1992, 18, Mills 2003, 262).

Besides written sources, my research is also based on oral narratives of former labour migrants who underwent the medical examination and of former staff members of the Istanbul recruitment office. I considered it necessary to expand my data collection to oral sources to get a 'thicker' picture of the processes I wanted to analyse. I do not intend to romanticise oral memory as a 'subaltern voice of truth' which necessarily rewrites official histories. However, restricting one's research to official documentary material preserved in the archives entails the imminent danger of producing many white spots. The archival documents communicate mainly formal, often sanitised and idealised accounts of the proceedings at the recruitment offices. In contrast, oral narratives, exactly due to their subjectivity, can offer in combination with textual sources a more nuanced picture of the procedures in the medical examination and the people involved.

The oral sources I relied on consist on the one hand of interview recordings with former staff members of the Istanbul recruitment office, among them the last director of the recruitment office and assistants from the recruitment office's medical service who participated in the conduction of the medical examinations, which are kept at the DOMiD Archive. These interviews were conducted in the 1990s in preparation for an examination on the history of migration from Turkey to Germany and are available to researchers in the DOMiD Archive.

Additionally, I conducted myself interviews in Berlin, Hamburg and Bremen with five male and seven female former labour migrants who underwent the medical examination at the recruitment office in Istanbul between 1963 and 1973, with most of my interview partners being recruited between 1969 and 1973 in the years with the largest recruitment numbers. The findings of nine of these interviews found entrance into this thesis. I contacted my interview partners partially via acquaintances (especially those in Bremen and Hamburg) and partially via the following associations in Berlin: the Turkish Women's Association Berlin (*Türkischer Frauenverein Berlin*), the Turkish Community of Berlin (*Türkische Gemeinde zu Berlin*), the Community Centre of the Workers' Welfare Association in Berlin-Kreuzberg (*AWO Begegnungszentrum Kreuzberg*) and the Family Centre Adalbertstraße (*Familienzentrum Adalbertstraße*). I conducted the interviews with former labour migrants exclusively in Turkish as this was more convenient for my interview partners. Most of the interviews were recorded with an audio recorder and later transcribed; however, I had to reconstruct four interviews from my notes and my memory (all four interviews were cited in this thesis) because my interview partners felt uncomfortable with recording so that I refrained from using the recorder.

The interviews were semi-structured in-depth interviews which usually lasted between 30 and 90 minutes. I concentrated in the interviews on three main subject areas: questions concerning the participant's personal life background and her or his motives in becoming a labour migrant to contextualise the participant's experiences in the medical examination, questions concerning the participant's detailed experiences of the recruitment process, especially the events in the recruitment office and the medical examination to gain insights into the impression those events left on the participants and questions which aimed at initiating a reflection and evaluation of the medical examination on part of the participants to better understand how they made sense of the examination procedure.

Conducting the interviews with former labour migrants proved to be more difficult than I had initially expected. The medical examination stirred up unpleasant and sometimes even traumatic memories among my interview partners who were often reluctant to talk in detail about the examination preferring instead to linger on more comfortable topics such as their work life experiences in Germany or their family memories. Also, to remember and talk about the procedures at the recruitment office and the initial years of migration turned out to be an emotionally intense experience for some of my interview partners who became very angry and indignant when talking about the examination and sometimes even had to fight back tears. It necessitated a lot of probing on my part, which I felt quite uncomfortable with, to hear more detailed narratives of the examination while simultaneously keeping my questions as discreet as possible so as not to violate the participants' feelings of privacy and shame. Unsurprisingly, my own gender identity influenced the interview situation in so far as female participants usually talked more freely and in a more nuanced way about the examination procedures and their feelings with regard to these than male participants. Despite these difficulties, the interviews allowed me to gain various insights into the interview partners' perceptions and interpretations of the medical examination.

In addition to the interviews with former labour migrants, I conducted three telephone interviews with former physicians who used to work at the Istanbul recruitment office between 1972 and 1973 to include further perspectives on the examination in addition to the perceptions of the labour migrants and the medical assistants. The decision on telephone instead of face-to-face interviews arose out of necessity. I only managed to finally contact former physicians towards the final phase of my research at a time when I had already finished my field work in Germany. With regard to financial and time limitations, I had no other choice but to opt for telephone interviews, all of which lasted between 90 minutes and two hours. Two of the physicians I interviewed had been responsible for conducting the

clinical group examinations at the recruitment office, whereas the third one had been employed as a radiologist for the evaluation of the applicants' chest x-rays. Again, these in-depth interviews were semi-structured in character and divided into three main question groups: questions concerning the physicians' motivations for working at the recruitment office and the preparation and initial training they had received for doing this job, questions concerning their work routine, the selection criteria they had to apply, their cooperation with other staff members, especially the medical assistants, as well as their perceptions of the applicants, and finally questions concerning their personal interpretations and perceptions of the medical examination's function and of their own role in the recruitment context.

I initially contacted the former physicians by looking up their names, which I had either learned from the archival documents or from the DOMiD interviews with former medical assistants, in the German telephone register. Once I had established initial contact, I was put in contact with further members of the medical staff by those with whom I had already made acquaintance. The physicians with whom I conducted interviews were no public health officers of the Federal Employment Service who had dominated the recruitment offices' medical team during the 1960s, but young physicians who were specially contracted by the Federal Employment Service on a short-time basis to join the recruitment office's medical team for one or two years during the final period of recruitment. Consequently, my interview partners are not representative of the medical team's changing composition over the years. Nevertheless, the interviews I conducted with these former physicians allowed me to gain valuable insights into the physicians' motivations for choosing to work at the recruitment office, their perceptions of their own role within the recruitment process and various details of the examination procedures, all of which I could never have derived from the official written documents.

I have based my research deliberately not only on the Federal Employment Service's official documents, reports and correspondences with ministerial institutions and representatives of the economy in Turkey and Germany, but also on public media publications, written documents by health experts and civil society representatives as well as personal narratives of the Istanbul recruitment office's staff members and former labour migrants. Such an approach allowed me to avoid an exclusive state-centred perspective and to identify instead multiple 'sites of meaning production' (Kirk and Colquhoun 1989, 421) which are not only located in state institutions but also in the overlapping realms of civil society, labour and the health sector.

I purposely restricted my research to German-language primary sources and documents from German archives. Whereas my neglect of so far undetected valuable material lying in Turkish archives was dictated by feasibility concerns (it simply would have exceeded the time frame of a master thesis to systematically search the Turkish archives in addition to the German ones), my concentration on German-language published literature and articles form the 1960s and 1970s was the result of both feasibility concerns and a methodological consideration. As the implementation of the medical examination was requested by the West German state, the medical examination procedures were bound to be largely shaped by discussions and discourses within the realm of the Federal Republic which in turn would mainly find expression within German-language publications. I do not claim that this thesis offers an exhaustive account of the medical examination of labour migrants from Turkey. Rather, my thesis concentrates on those aspects of the examination and recruitment context which were decisive in shaping the construction of the labour migrant's body in the course of the examination procedures.

1.4. A Comment on Terminology

A final remark on terminology will be in place. Whereas the Federal Employment Service officially referred to the labour migrants recruited via bilateral agreements between 1955 and 1973 as 'foreign employees' (*ausländische Arbeitnehmer*), 'guest worker' (*Gastarbeiter*) was and still is the most commonly used term for these labour migrants in the German public. In a depoliticising way, both terms deliberately sought to create a distance between the post-war employment of non-native workers in the German economy and the history of forced labour during the era of National Socialism which the negatively connotative term 'alien worker' (*Fremdarbeiter*) evoked. Also, both 'guest worker' and 'foreign employee' emphasised the labour purposes of the migration process in question and the migrants' primary social role in the Federal Republic as workers. Most significantly, these terms underlined the intended temporary character of the migration process. In this thesis, I avoid both these terms because of their depoliticising and programmatic effects and use instead the terms 'labour migrant' or 'migrant worker' to indicate the migration dimension of Federal Germany's labour recruitment and to acknowledge the possibility of comparison with other labour migrant phenomena across time and space. To avoid confusion, I furthermore gave preference to the expression 'migrants from Turkey' instead of 'Turkish migrants'. Whenever I make use of the term 'Turkish', I do not understand it as a definition of ethnicity, but refer to citizens from the Turkish state who were recruited as 'Turkish labourers' by Federal Germany and perceived as such in the German public.

1.5. Chapter Overview

This thesis consists of six further chapters and a final conclusion. In chapter 2, I outline my theoretical approach to the body, which borrows from Michel Foucault and constructionism, and situate this approach within the wider field of body theory. I then

concentrate on the relation of constructionism, medicine and the body by discussing 'the constructed body' within medical sociology (or the sociology of health and illness) as well as Foucault's understanding of the relation of body, power and medical knowledge/practice.

Chapter 3 focusses on the links between industrial labour, public health and the worker's body. After a short discussion of the reconfiguration of labour in the context of industrialisation, I consider what changes both on the level of the individual worker and the whole population this reconfiguration has entailed. These changes involve the disciplinarisation and mechanisation of the worker's body in an increasingly rationalised work process, the emergence of the 'population' as a distinct interest and economic value for the state and the rise of public health measures which seek to control and manage this economic value by regulating the physical condition and productivity of the population. The chapter concludes with a discussion of the rise of industrial medicine as a branch of public health, which is directly concerned with the health of the working population, and the implementation of physical examinations of workers as a practical method of industrial medicine in which public health concerns with the population converge with the disciplinarisation and control of the individual worker.

Chapter 4 focuses on the international dimension of public health measures and population control: the enforcement of medical immigrant examinations along the borders of major immigration countries at the turn of the 19th/20th centuries to safeguard and maintain the nation state's health boundaries. Through a combinative reading of leading studies in the field of migration and public health, I trace how in these examinations medical practice was informed in a complex way by notions of race, class, gender/sexuality and disability to legitimise the exclusion of certain migrants and the inclusion of others.

In chapter 5, I move from the large-scale developments in the fields of labour, public health and migration, without which Federal Germany's medical selection of labour migrants

would be unthinkable, to the narrower context of Federal Germany's recruitment of migrant labour after WW II. I shortly discuss the structural characteristics of this recruitment and its major phases, the specific historical context which led to the signing of the German-Turkish recruitment agreement in 1961 as well as the legal status and work situation of labour migrants in Germany. In addition to this rather institutional-based perspective, I focus on certain discursive formations which have informed and sustained the incorporation of migrant workers into the German labour market and society. With regard to my central thesis topic, I trace especially two such discursive formations which played a pivotal role in shaping the implementation of the medical examination: first, the modernisation discourse which represented the labour migrants as essentially backward and non-modern because of their lack of industrial experience; and second, health discourses which constructed the labour migrants both as a special risk group easily prone to fall ill due to the conditions of labour migration and as potential threat to the health of the national population.

Chapter 6 outlines the practical organisation of recruitment, the role of the German recruitment offices in Turkey within this recruitment process and the organisational characteristics of the medical examination. In chapter 7, I finally trace and entangle the complex logics of inclusion, exclusion and risk management inherent in the medical examination by analysing how the labour migrant's body was constructed in a trifold way: as an industrious machine, a potential carrier of latent disease and a commodity. With regard to this trifold construction process, I argue that the medical examination functioned simultaneously as an instrument of disciplinarisation, a security tool and a means of bodily commodification. The chapter concludes with a discussion of incidences of resistance against the examination's multiple logics. The conclusion summarises and combines the various strands of this thesis, evaluates its findings and outlines possibilities for future research.

2 Body, Power and Medical Knowledge: the Body in Sociological Theory

After being confined to an 'absent presence' [4] in classical sociology, the body has been experiencing an upsurge of interest in sociological theory and research since the 1980s. This upsurge coincided with the rise of second-wave feminism, global shifts in demographic patterns, the rise of consumer culture and the emergence of post-structuralism as a challenge to positivist thinking (Williams and Bendelow 1998, 16). However, while recent studies converge in their shared focus on the body as a central unit of analysis, they vary greatly in their theoretical conceptualisations of this entity called 'the body'. Consequently, a clarification concerning my theoretical approach will be in place. In the following chapter, I will first specify my theoretical approach to the body focusing especially, though not exclusively, on social constructionism and the work of Michel Foucault. Second, I will discuss the influence of social constructionism and Foucault's work on the conceptualisation of the body within medical sociology and the challenges these influences have posed to the medical model of the body.

2.1. Formulating a Theoretical Approach to the Body

In current sociological studies two main approaches to the body can be discerned: social constructionism and phenomenology (Crossley 1995, Williams and Bendelow 1998, Shilling 2003). [5] Both theoretical traditions arose as a challenge to naturalistic conceptualisations of

[4] Chris Shilling uses this term to indicate how a certain implicit concern with the body was present in classical sociological writings while an explicit focus on the body remained missing, Shilling 2003, 10.

[5] A distinction between theoretical approaches always remains crude and artificial up to certain extents. Some theoreticians do not fit easily into a single tradition, for instance the work of Erving Goffman has been seen as both contributing to social constructionism, Shilling 2003, 62, and phenomenological body theory, Williams and Bendelow 1998, 49, 55ii. Also various attempts to reconcile different theoretical traditions within a single framework exist: Structuration theory as advanced by the works of Bourdieu and Giddens constitutes an attempt to overcome the dualism between social constructionism and phenomenology by focusing 'on the bodily basis of action and identity *within* its social contexts', Shilling 2005, 60. Shilling has developed the concept of 'corporeal realism' which seeks to combine social constructionism, phenomenology and structuration theory, Shilling 2005, 9ii, whereas Crossley opts for a symbiosis of social constructionism and

the body. Based on the Cartesian mind/body dualism, naturalistic approaches share a notion of the body ‘as a pre-social, biological basis on which the superstructures of the self and society are founded’ (Shilling 2003, 37). Gaining dominance from the 18th century onwards, naturalistic conceptualisations of the body were especially influential during the 19th century and experienced a renaissance in 20th-century sociobiology. The affinity of naturalistic approaches to biological reductionism renders this theoretical tradition highly problematic for critical body theory (ibid, 37ii).

It was primarily scholars influenced by social constructionism such as Bryan S. Turner who contributed to a new awareness of the body in social theory by opposing naturalistic body/mind dualism (B. S. Turner 1992, B. S. Turner 2008). Gaining popularity from the late 1960s onwards with the publication of Berger and Luckmann's *The Social Construction of Reality* (1966), the rise of the Sociology of Science and Technology and the spread of post-modern and post-structuralist thinking, social constructionism has become a major influence in sociological studies on the body since the 1970s/80s. Various theoretical positions are subsumed under 'social constructionism', which differ primarily in their understanding of what constitutes 'reality' and their definition of what is actually 'constructed' in the process of constructionism. Without delving in depth into the various strands of constructionism, suffice it here to draw a broad distinction between 'strong' and 'weak' forms of constructionism which can be differentiated according to their acceptance or denial of certain universal realities. Whereas ‘strong’ notions of constructionism reject the existence of any form of external reality or knowledge, less radical forms of constructionism adhere to certain universal realities or materialities which are then mediated through social practices (Nettleton 1995, 28-29).

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phenomenology through a complementary reading of Foucault and Merleau-Ponty to overcome Cartesian Dualism, Crossley 1995.

Social constructionist conceptualisations of the body have in common that they challenge the naturalistic, purely biological imagination of the body as a physiological system distinct from social contexts. They emphasise that all knowledge and understanding of the body is contingent on and mediated by social processes. However, although social constructionist approaches converge in their emphasis on the primacy of society and their understanding of the body 'as a receptor of social meanings' (Shilling 2003, 62), no homogenous social constructionist position towards the body exists. The existent approaches differ especially in their understanding of how much of a social product the body actually is (ibid).

Current social constructionist writing on the body draws on authors as different as Norbert Elias (1978, 1982), Mary Douglas (1996, 1984), Erving Goffman (1968, 1969) or Michel Foucault. Among these scholars Foucault is the primary theoretician on the relation between body, power and knowledge. Covering a wide range of interest fields and written over a time span of several decades, Foucault's work is not without major shifts. Whereas his early work concentrates on the relation of discourse, knowledge and the emergence of modern sciences which take 'man' as their object of study, his later work focuses on the emergence of the modern individual through the inter-relation of knowledge, power and the body (Dreyfus and Rabinow 1983).

For Foucault, bodies are not determined by biology; instead, he treats them as the historically contingent products of shifting power-knowledge-relations (Williams and Bendelow 1998, 34). His conceptualisation of the body, which as an object of study gradually moved into the centre of his analyses (Vigarello 1995, 166), is closely linked to his understanding of power. It is one of the major contributions of Foucault's work to have rethought the concept of power as being creative and productive rather than repressive. In his analyses, Foucault treats power as 'circulating' and relational in character, not as the

'possession' of an individual or a group (Foucault 2003a, 29-30). Consequently, Foucault studies power not at the level of institutions, intentions and decisions, but at the level of 'practical application and effective practices' (ibid 28). The body emerges in Foucault's work as the primary site where these 'local social practices are linked up with the large scale organization of power' (Dreyfus and Rabinow 1983, 111). The gradual shift of the body to the centre of the exercise of power, which Foucault traces, is historically connected to changing modes of government and production which are co-emergent with modernisation.

With the rise of modernity, power is no longer exercised in a sovereign mode over territory, but is increasingly articulated on the body of the individual and the population through the growth of technologies of power (Foucault 2003a, 35-36; 242-46). These technologies of power which aim at normalisation emerge around two different poles: disciplinary power (or anatomo-politics) invests the body of the individual to discipline and correct. The means through which disciplinary power is achieved are surveillance and training. The aim of disciplinary power, which became effective in the closed institutions of the 19th century such as factories, prisons, schools, military barracks and hospitals, was to maximise the productivity and efficiency of bodies by turning them docile. As Foucault states, 'a body is docile that may be subjected, used, transformed and improved' (Foucault 1995, 136), and 'the body becomes a useful force only if it is both a productive body and a subjected body' (ibid 26). A fundamental tool of disciplinary power is the examination which turns every individual into a single case in a row. It combines hierarchical observation (the individual is being exposed to the evaluating and classifying gaze of the expert, while at the same time a clear hierarchy is installed between the expert who objectifies through his/her gaze and the subject being objected by that gaze) and normalising judgement (a judgement enforcing normalisation), (Foucault 1995, 184ii). Bio-politics as the second pole of power technologies is directed at the regulation of the biological characteristics of the population's

collective body (Foucault 2003a, 242-46). Emerging during the 18th/19th century, bio-politics are directly related to the 'discovery' of the biological qualities of the 'population' as an economic and political value for the modern state. As a security mechanism, bio-politics aims to control and regulate these biological qualities thereby striving to normalise what comes to be perceived as 'anomalies'. Statistics which emerged in 19th century to rate and scale biological processes of the population and new scientific branches such as public health serve as powerful means of bio-politics to achieve these aims (Foucault 2003a, 244-45).

In short, whereas disciplinary power centres on 'the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and docility, its integration into systems of efficient and economic controls', bio-politics focuses on 'the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary' (Foucault 1978, 139). Although their interests are different, both technologies of power are normalising in character (ibid 253). Through either correction or regulation they strive to establish a norm, thereby constituting what Foucault calls 'dividing practices': practices which allow for dualistic differentiations such as between what counts as 'normal' or 'deviant from the norm' (Foucault 1983, 208).

In contrast to social constructionism and studies in the tradition of Foucault, phenomenological approaches to the body emphasise 'the ontological primacy of social actors over social systems' (Williams and Bendelow 1998, 49). Whereas constructionist studies are mainly concerned with the question of 'what is done to the body', phenomenological approaches ask for 'what is done by the body' (Crossley 1995, 43). In other words, they place great emphasis on questions of embodiment and agency. Influenced by the work of Merleau-Ponty and his concern with embodied existence as the basis for intentional and purposeful

engagement (Shilling 2005, 55), phenomenological approaches focus on the 'lived body' instead of the 'inscribed body' (Crossley 1996, 99). They 'seek highly detailed, in-depth descriptions of subjective human experiences in specific contexts' to understand how the body links 'the self and the world in an on-going dynamic inter-relationship' (Allen-Collinson 2009).

The question of the theoretical approach or paradigm to choose in the context of a specific research is largely dependent on the nature of the problem at hand and the research question. Bryan Turner has referred to this necessity of choice as 'methodological pragmatism' (B. S. Turner 1992, 57). As I am interested in analysing the power relations inherent to the process of Federal Germany's Turkish labour recruitment and the way in which these power relations show in the form of medical categorisations of (and on) the labour migrant's body, a constructionist approach influenced by the work of Foucault will provide a powerful framework for analysis. Such an approach will help to arrive at a critical understanding of the role and function of the medical examination in the context of the recruitment of Turkish labour.

Whereas phenomenological approaches to the body are without doubt highly valuable to arrive at a corporeally grounded understanding of human (inter-)action, they are of limited usefulness for a political analysis of power relations due to the 'extremely weak understanding of power' in Merlau-Ponty's theoretical framework (Crossley 1993, 410) on which most contemporary phenomenological approaches to the body are based. Also, phenomenological approaches often produce a more individualised and less social conceptualisation of the body by focussing primarily on the ways in which the individual self relates to the environment and the world through his or her body. In contrast, in my thesis I deliberately concentrate on the reverse case. With regard to the medical examination, I want

to inquire how the social context of labour recruitment relates to the body and produces certain body conceptualisations in accordance with the requirements of this specific context.

Having outlined my approach to the body as constructionist in character, the question remains of what I exactly mean by 'construction of the body'. The question is of central importance as my main research question asks for the 'construction of the labour migrant's body' in the course of the examination. In the given context, I specifically use the term 'construction of the body' to refer to the phenomenon that our knowledge and experience of the body and bodily reality cannot be directly deduced from a given biological essence, but is rather contingent on social practice and varies therefore according to the socio-historic context. Without denying the materiality of the body, I conclude that our ideas and understanding of the body are the result of the complex interplay of values, beliefs, institutions, practices and techniques which are shared and implemented in a given socio-historic context.

Ian Hacking points out the necessity to differentiate between the construction of an object itself and the idea of that object (e.g. a certain classification, category or 'kind'; Hacking 1999, 9-11). Transferring Hacking's distinction to my own case, I am not concerned with the individual reality of the labour migrants' bodies. Rather, I am interested in how along the lines of health, disease, able-bodiedness and disability a certain idea or concept of the labour migrant's body came into existence through the medical examination. In other words, I am interested in what kind of body (or bodies) the requested labour migrants had to possess and what concepts of health, disease, able-bodiedness and disability determined who was considered a suitable labour migrant and who was not. Furthermore, I will enquire in what ways the idea of the labour migrant's body overlapped with concepts of ethnicity, gender and citizenship. To talk of the 'construction' of an idea or category does not imply that no social, political or economic consequences arise from this construction process. Recognising these

consequences, I will also in the following chapters enquire about national economic and political dynamics which shaped the course of the examination as well as the interests and motives of the various actors involved in the medical examination's implementation. However, before turning to these questions, it will be necessary to discuss the path-breaking impact of social constructionist thinking and the work of Foucault on the conceptualisation of the body within the field of the sociology of health and illness.

2.2. The Body in Medicine: Medical Sociology, Social Constructionism and Foucault

Questions of society, the body and medicine are closely intertwined. Not only do medicine and sociology both share a common interest in the body, medical practice also forms an integral part of social life. The discipline most directly concerned with the interrelationship of these three phenomena has been medical sociology (or the sociology of health and illness). However, until the 1970s/80s no critical perspective on medicine as a field of knowledge was developed within the discipline. This was partially due to the dominance of Talcott Parsons's functionalist understanding of medical practice until the 1960s which emphasised the benevolent role of the doctor in helping the patient to regain his or her normal social role (Lupton 2003, 7ii; Parsons 1991, 288ii). Medical sociology's lack of a critical stance towards medical knowledge and practice, however, was also the result of the discipline's self-understanding. Being initially positivist in character, medical sociology was 'more a derivative of social medicine than a sub-discipline of critical sociology' (Lupton 2003, 6). The bio-medical model of the body was adopted by medical sociology from the medical sciences and remained dominant until the late 1960s and 1970s which saw the impact of post-structuralist/post-modern thought and feminist as well as Foucauldian critiques of medicine. Pre-supposing a Cartesian mind-body dualism, the bio-medical model 'assumes that illness can be explained in terms of determinate causes operating on the body, which is

conceptualized as a machine', it 'treats the body as an ensemble of specialized parts, which require separate specialized interventions' and 'negates the idea of the patient as an embodied subjectivity' (B. S. Turner 1992, 24). It was not before the late 1960s, when medicine entered into a crisis of legitimation, [6] that challenges to medicine as a neutral, objective endeavour and the medical model of the body began to arise within medical sociology.

A major challenge constituted the criticisms of political economy scholars within medical sociology which emerged during the 1970s and 1980s as a reaction to functionalism. Political economy scholars criticised mainly the biological determinism of medical practice which led to a neglect of social, political and economic causes of disease (Lupton 2003, 8ii). Closely related to this criticism were concerns with growing medicalisation (Zola 1972, Illich 1976). Most vehemently, functionalism's notion of medicine's benevolent social role was refuted by political economy scholars who claimed that such an understanding of medicine masked both political struggles over resource allocation (Freidson 1970) and medicine's role in maintaining the dominant capitalist order (Waitzkin 1986). Despite their contributions to critical medical sociology in emphasising the political, economic and social dimensions of medical practice, political economy approaches can be criticised for conceptualising medical practices and the medical encounter in primarily economic and solely oppressive terms (Lupton 2003, 11). Furthermore, while they problematise the practical application of medical knowledge, political economy approaches do not question the foundations of medical knowledge itself. It was under the influence of social constructionism, which became the major theoretical position in medical sociology from the late 20th century onwards, that the very basis of medical knowledge was opened for critical enquiry.

[6] This crisis of modern medicine was centred on questions of effectiveness, access and distribution, the neglect of social and environmental factors as important causes for disease, hospitalisation and the patient image in medicine to name a few central issues; for a detailed account see Nettleton 1995, 5ii; Lupton 2003, 8ii.

Social constructionist thinking as advanced by Foucault and post-modern scholars like Kristeva, Derrida, Deleuze and Guattari gained influence in medical sociology from the 1970s/1980s onwards posing a challenge to medicine's positivist 'truth claims' in several significant ways: First, social constructionist scholars questioned the notion of a purely 'natural' body which constitutes a closed biological system distinct from social processes. Second, they emphasised that all knowledge, including medical knowledge and our understanding of the body, is socially contingent, e.g. the product of social practices and historical processes (Nettleton 1995, 14). Several consequences arise out of these two theoretical standpoints: The notion of medical knowledge being the result of objective scientific progress is refuted. Instead scientific facts are seen as the products of scientific communities just as the boundaries of the medical profession are regarded as the outcome of socio-political struggles. Both the work of the 'forefathers' of the Sociology of Science and Technology, Fleck, Kuhn and Bloor (Fleck 1935, Kuhn 1962, Bloor 1976), as well as the work of Foucault (Foucault 1994) have been highly influential in bringing about such a position.

Transferred to the field of medicine, this refutation of knowledge production as an objective endeavour leads to a reconceptualisation of disease categories not 'as natural realities in themselves, but as the outcome of social practices and social reasoning' (Nettleton 1995, 20). In other words, disease categories are no longer thought to relate in an unproblematic way to anatomical dysfunctions in the body, rather they are acknowledged to be dependent upon the socio-historical setting in which they are created and employed.

Directly related to the problem of social contingency and historicity of disease categories is the question of neutrality. Social constructionist scholars reject the assumed neutrality of medical practice (a point they share with political economy scholars) and medical knowledge (Nettleton 1995, 24ii). Disease categories structure and mediate social

relations through the creation and reinforcement of social stratifications and power inequalities just as certain socio-historic contexts may lead to the emergence of specific disease categories. However, the social contexts and consequences of disease categorisation are masked by the natural language of medicine, a phenomenon Michael T. Taussig refers to as 'reification' (Taussig 1980). Influenced by Foucault, Turner points to a further political dimension of medicine: its power to act as a guardian of morality and social order. As the language of disease involves judgements about what is desirable and what not, medicine is ultimately concerned with moral prescriptions of what is 'good' or 'bad', 'right' or 'wrong' (B. S. Turner 2008).

The work of Foucault has been especially significant in bringing about the constructionist turn in medical sociology. As Foucault's writings dealt in manifold ways with 'the relation between the discourse of scientific knowledge and the exercise of professional power' (B. S. Turner 1995, 10), medicine formed a core interest area of his work. Consequently, a closer look at the intersection of the body, medical practice/knowledge and power in Foucault's writing will be in place.

Foucault regarded medicine as a system of knowledge and power which constitutes bodies and defines disease. A major contribution of his work lies in his refutation of the medical model of the body: For Foucault, no 'authentic' body outside the realm of medical discourse and practice exists (Lupton 1997, 99). Rather, our contemporary medical understanding and conceptualisation of the body is the outcome of concrete socio-historical processes. As Foucault illustrates in *Birth of the Clinic*, the contemporary medical mapping of disease on the anatomical body is inextricably linked to the rise of new forms of medical knowledge and practice in the 18th and especially 19th century such as the rise of the clinic as the primary site for practicing and teaching medicine, the development of new medical

technology and the growing influence of pathological anatomy in medical practice (Foucault 1994).

> For us, the human body defines, by natural right, the space of origin and of distribution of disease: a space whose lines, volumes, surfaces, and routes are laid down, in accordance with a now familiar geometry, by the anatomical atlas. But this order of the solid, visible body is only one way—in all likelihood neither the first, nor the most fundamental—in which one spatializes disease. There have been, and will be, other distributions of illness. (…) The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy (Foucault 1994, 3-4).

In other words, modern medicine's understanding of the workings of disease in the body and the categories used to describe these diseases do not reflect a given biological reality, they are rather the result of the forms of medical knowledge and practice employed to conceptualise and treat disease. It is new forms of knowledge which serve new social practices and in turn allow for the fabrication of specific objects of study (Williams and Bendelow 1998, 29).

The question of what constitutes an object of medical study leads to a further contribution of Foucault's work: the insight that knowledge is inextricably linked to the exercise of power and that consequently medicine constitutes no neutral endeavour. I have already pointed at the normative role of medicine in maintaining social order. However, there is a further aspect to this non-neutral character of medicine: In medical practice, power operates directly on the body which is turned into an object for examination and analysis. A distinct power hierarchy exists between the examiner and the one examined which is achieved through the way in which knowledge is acted on the body through the classifying gaze of the doctor:

> What is modified in giving place to anatomo-clinical medicine is not, therefore, the mere surface of contact between the knowing subject and the known object; it is the more general arrangement of knowledge that determines the reciprocal positions and the connexion between the one who must know and that which is to be known. The access of the medical gaze into the sick body (…) is the result of a recasting at the level of epistemic knowledge (*savoir*) itself (Foucault 1994, 137).

Although medicine contributes to the objectification and subjugation of the body, Lupton is critical of a merely 'repressive' reading of the medical encounter between the body and the gaze. Keeping Foucault's conceptualisation of power as 'relational' and 'productive' in mind, she points out how many 'followers' of Foucault tend to over-emphasise doctors as 'figures of domination' while neglecting both the productive capacities of power and the individual's ability for resistance (Lupton 1997, 100-101). To avoid such a one-sided reading of the relation between medical knowledge/practice and the body, I will treat the medical examination not only as a tool of control and subjugation but also as a procedure which serves the formation of new a subject category. Furthermore, I will enquire what strategies of resistance were employed by the labour migrant applicants to avoid the probing gaze of the physician.

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To conclude, the analytical concepts of Foucault will prove helpful for my thesis in a twofold way. First, I will adopt Foucault's rejection to treat the healthy and the diseased body as a biological given. Rather, without neglecting questions of agency and resistance, I will focus on the process of how a specific scientific medical discourse subjugated and objectified the labour migrant's body by classifying it along the lines of the healthy versus the diseased. Second, I will use Foucault's concepts of disciplinary power and bio-politics to analyse what formations of power undergirded the medical examination at the German recruitment offices and the scientific discourses produced in it.

Combining Foucault's insights on the workings of power technologies and medical knowledge on the body, medical examinations emerge as a powerful tool of both disciplinary power and bio-politics. Functioning on the basis of surveillance, observation and individuation, they constitute an example of disciplinary power par excellence. However, when conducted in a context of public health, they may simultaneously serve as a bio-political

tool for the regulation and safeguarding of the health of the general population. The practice of medical screenings and health checks in the sphere of work or on the borders of nation states from the 19th century onwards are supreme examples of this two-fold character of the medical examination. It is this implementation of medical inspections in the context of public health both in the work place and at the nation border that I will turn to in the following two chapters.

3 Industrial Labour, Public Health and the Invention of the 'Normal' and 'Healthy' Body as an Economic Value

Industrial labour, public health politics and the body are closely intertwined. With the emergence of industrial means of production, profound changes in the conceptualisation and political targeting of the body took place. In the following chapter, I will discuss the industrial reconfiguration of labour and its effects both on the level of the individual's and the population's body. In detail, I will analyse how with the transition to industrial labour the need for a disciplined and able-bodied labour force arose while simultaneously the health of the population emerged as a distinct economic value for the state which it sought to regulate and control through the implementation of public health measures. Finally, I will illustrate how the modern nation state's concern for a healthy population and modern industry's desire for a disciplined work force converged in the rise of industrial medicine and its primary technique, the industrial physical examination of workers.

3.1. The Industrial Reconfiguration of Labour and the Creation of a Disciplined and Able-Bodied Workforce

With the transition to industrial labour and modern forms of production, a multi-dimensional re-configuration of the work process occurred. The emergence of first work houses and later factories throughout the 17th to 19th centuries required a transformation of the pre-industrial spatial and temporal organisation of work. The introduction of centralised employment and regular work hours enhanced control over the labour process. The assemblage of all workers under a single roof entailed a separation of workplace and private sphere as well as wage labour and reproductive work (Braverman 1998, 45, Shilling 2005, 78). Furthermore, the introduction of fixed work hours brought about new work rhythms, which detached the dependence of the work day on day light and seasonal conditions, just as

the incorporation of the clock into the work process facilitated the 'synchronization and control of activities across space' (Shilling 2005, 78, 80).

As a result of this spatial and temporal reorganisation of the work process, a qualitative reconfiguration of labour took place. Together with the formation of new rhythms of work, a growing mechanisation and rationalisation of the labour process occurred. New industrial technology allowed for an increase in production speed and efficiency and simultaneously led to an increasing transfer of skill from workers to the machine which enabled largely unskilled workers to perform formerly complicated tasks (Meyer 1981, 21-24). However, the major shift in the quality of labour constituted the emergence of the concept of 'labour power' which lies at the heart of the commodification of labour in the form of wage labour. As Harry Braverman points out, what the worker sells 'is not an agreed amount of labour but the power to labour over an agreed period of time' (Braverman 1998, 37). Consequently, time functions as the 'key meter for the commodification of labour' as the power to labour is sold over the duration of fixed work hours (Shilling 2005, 80). As 'labour power' means effectively the body's power to labour, the concept of 'labour power' is closely linked to an imagination of the body as a 'human motor' which serves as a medium for the transformation of natural forces into 'forces propelling society' (Rabinbach 1992, 2-3). This intimate link between labour power and the body makes apparent that the commodification of labour cannot be separated from the commodification of the worker's body.

The trifold re-organisation of labour in terms of space, time and labour power in the context of growing industrialisation entailed an increase of management control exerted on the working process and the workers themselves. However, with the rise of Scientific Management and Fordism at the turn of the 19th to 20th century, this control of the labour process reached an unprecedented level. As Braverman has made apparent, the main characteristic of Scientific Management consisted in the separation of intellectual activity

from manual labour. As the control of the labour process became increasingly monopolised in the hands of the management, the majority of the workers experienced a growing restriction to the mere execution of manual, non-intellectual labour (Braverman 1998, 77-78). Originating in the USA in the 1880s and based on the work of Frederick W. Taylor, Scientific Management strove to reorganise the work process to increase efficiency and enhance productivity by 'breaking down the work process into constituent parts which could then be standardized, timed and separated into different tasks' (Shilling 2005, 81-82). The principles of Scientific Management quickly spread to other industrialised countries in Europe, so that already before WW I the principles of Scientific Management had been adopted by various firms in Germany such as Bosch, Siemens-Halske and Daimler-Benz (Rabinbach 1992, 254).

Fordism, which emerged during the early 20th century under the guidance of Henry Ford, incorporated the principles of Scientific Management into the world's first modern mass production system. [7] Central to Fordism was the introduction of the assembly line which in combination with a distinct organisation style developed by Henry Ford allowed for a subordination of the working body's rhythms to the rhythm of the assembly line, thereby enabling a great increase in production speed and efficiency (Shilling 2005, 82). Closely connected with Keynesian welfare, high employment rates and economic growth, Fordism remained the epitome of the culmination of industrialisation until the global economic crisis in the 1970s (Shilling 2005, 82-83).

The restructuring of labour with the transition to industrialism had profound effects on the individual worker's body. The changed production methods imposed new demands on the working body. A process of disciplinarisation of the worker and her or his body took place

[7] David Hounshell is critical of the assumption that Henry Ford was directly inspired by Taylor's principles of Scientific management. He does argue that Ford was generally influenced by rationalisation measures such as work analyses and the scientific selection of workers which were promoted by Taylor among many other manufacturers. However, he questions a direct influence of Taylorism on Fordism, Hounshell 1994, 249ii.

which sought to transform and adapt pre-industrial work rhythms and patterns of work sociability to the new industrial mode of production. Such a transformation was partly brought about through overt physical coercion such as physical punishments for idleness in factories (Shilling 2005, 79).

However, as Foucault has pointed out, direct physical coercion was only partially used to produce a disciplined work force. Rather, the implementation of disciplinary power mechanisms through the reorganisation of time and space in the factory brought about the effect of creating docile, productive bodies which could then be subjected to specific operations for the formation of a positive economy. With the transition to industrial production, a new mode of distributing bodies in space according to the principle of individualised partitioning, new methods for the extraction and accumulation of time and body forces as well as new mechanisms for the composition of multiple human and mechanic forces into a single productive machine all lastingly shaped and changed the role of the body in the production process (Foucault 1995, 141-167).

The introduction of new time schedules and centralised surveillance methods, the breaking down of the work process into meticulous elements, the training of standardised body movements to carry out these elements in order to maximise efficiency and productivity and the integration of the single body's labour power into complex, multi-segmented production processes led to a new relation of body and machine (ibid, 141ii). In a mechanised production process, the body had to function in analogy with or even as an extension of the machine to perform standardised stages in the work process with machine-like regularity and speed. Foucault identifies this effect as a mechanism of disciplinary power which he calls the 'technique of body-object-articulation':

> Over the whole surface of contact between the body and the object it handles, power is introduced fastening them to one another. It constitutes a body-weapon, a body-tool, body-machine complex. (…) This disciplinary power appears to have the function not so much of

> deduction as of synthesis, not so much of exploitation of the product as of coercive link with the apparatus of production (ibid, 153).

In a production system which established a 'coercive link' between the body and its apparatus of production, a powerful image emerged which conceptualised the body itself as a machine or 'human motor' (Rabinbach 1992, 35) reducing it to its mere monitorable physical capabilities.

This metaphor of the 'body machine' has two significant implications. First, it conveys an ideal image of the body as being strong, productive and physically able. Second, it prescribes an ideal of normativity: in order to perform normed work processes in analogy with a machine, the body has to be normed itself. As Lennard Davis points out,

> Industrial mentality saw workers as interchangeable and therefore sought to create a universal worker whose physical characteristics would be uniform, as would the result of their labors – a uniform product' (Davis 2006, 9).

Rosemarie Garland Thomson makes a similar statement by emphasising how the normed character of industrially produced goods was mirrored by a desire for normativity in bodies:

> Modernization and industrialization reconstituted and refigured the body: changes in the mode of production, labour and technology introduced new rhythms and schedules according to which bodies were governed and managed, efficiency as an originally mechanical value was now applied to bodies and sameness became a cultural value whereas singularity in products and bodies was termed as deviance (Garland Thomson 1996, 11).

Linking the two implications of the 'machine' metaphor, it becomes apparent that the restructuring of labour through mechanisation and industrialisation has fuelled the equation of the healthy and able body with the 'normal' body. The following tautological definition of 'normalcy' by Franz Koelsch, the author of a classic German textbook on industrial medicine,[8] neatly summarises this conceptualisation of the healthy and able body as the 'normal' one:

[8] The textbook written by Koelsch was in wide use in Federal Germany in the second half of the 20th century. It also formed part of the medical library in the German recruitment offices, Ärztliche Handbücherei bei Dt. Kommissionen (Medical Library at the German Commissions), BArch, B 119/5057 (1).

> We may regard a human being as 'normal' when all of his organs are regularly formed in such a way as we have come to define as 'physiological', and when all of these organs co-function with each other in the physiologically defined way and in complete harmony with each other while reacting normally to external impulses (Koelsch 1963, 15). [9]

The equation of able-bodiedness and health with normalcy means effectively that in industrial society able-bodiedness and productivity are turned into normative and compulsory values for every individual. Simultaneously, this normative prescription of health and ability produces disability through the social devalorisation, marginalization and exclusion of all forms of physical (or mental) deviance from this norm. Robert McRuer has coined the term 'compulsory able-bodiedness' in analogy with 'compulsory hetero-sexuality' to describe this process which in everyday life and culture institutionalises in multifold ways able-bodiedness as a normative and compulsory value while it marginalises disability and pressures it to rehabilitate (McRuer 2006, 301-302).

This pressure towards compulsory able-bodiedness is especially pervasive in the field of industrial labour where disability is ever present as a feared source of precariousness. In a context where the able body serves as the main resource of the worker, the loss of physical capabilities evokes the imminent threats of poverty, social isolation, uselessness and inability to fulfil the role of bread-winner. Consequently, the pressure to 'restore' the disabled body is especially prominent in an industrial context as the emergence of a burgeoning prosthesis business at the turn of the $19^{th}/20^{th}$ century shows (Slavishak 2003, 370ii). Such a necessity for rehabilitation of the worker's body underlines how disability and disease are turned into disruptive factors in the process of industrial production, a devalorisation process which in turn enforces the normativity of the able and healthy body.

The intimate connection between industrial modes of production and the emergence of the concept of disability makes apparent that able-bodiedness, disability and physical impairment do not constitute essential, static entities. Rather, these concepts have to be

[9] All English translations of primary and secondary German-language sources by the author.

contextualised and historicised. As Garland Thomson has neatly put it, 'the body becomes disabled when it is both incongruent in space and the milieu of expectations' (Garland Thomson 2006, 267). The conflation of able-bodiedness and bodily normalcy and the consequent casting of disability as deviant from and inferior to this norm must be seen as closely related to the industrial reconfiguration of labour and modern industry's need for a disciplined, machine-like and able-bodied labour force.

3.2. Public Health and the Emergence of the Population as an Economic Value

After discussing the implications of the transition to industrial labour for the body of the individual worker, I will concentrate in the following on the effects of the industrial reconfiguration of labour for the collective body of the population. To fully grasp these effects, it is necessary to consider the alterations in the evaluation of labour which went hand in hand with the emergence of capitalism and beginning industrialisation. Under the influence of Calvinism and Enlightenment philosophy labour was ennobled 'as the origin of all wealth and the legitimate basis of property and selfhood' (Rabinbach 1992, 7). Associated with a morally upright way of life, labour became the principal structuring element of social life in Western societies from the 17th century onwards. In the context of the declaration of work as a moral obligation, productivity became imperative whereas idleness was condemned as sinful behaviour (Rabinbach 1992, 4, 7-8, Foucault 2003b, 54). As a consequence of the imperative of productivity, throughout the 17th to early 19th century massive campaigns and confinement measures were launched in Europe and the colonised parts of the world against those elements of the population who were not engaged in productive labour and deemed to lead an unmoral way of life such as the poor, the 'insane', beggars or vagabonds (Rabinbach 1992, 7-8, Foucault 2003b, 35ii).

Co-emergent with the recasting of labour as the main ordering principle of society and the moral prescription of productivity was a new concern with the population on part of the modern state. Just as the body was discovered as an object of scientific inquiry with the rise of the natural and life sciences in the 18th century, the state gained an interest in a numerous and healthy population (Vögele and Woelk 2002, 122). Economic wealth, state power and the health of the population's collective body became inextricably linked when the population was incorporated into economic calculations as a biological resource for the state.

It is this new concern of the state with the biological qualities of the population which Foucault identifies as the shift from a sovereign to a bio-political mode of power. Sovereign power which is based on a legal juridical system established in the Middle Ages was exercised over a defined territory, that is over land and its products. In contrast, bio-politics which emerged as a new technology of power from the 18th century onwards is applied to the body of the population and concerned with the quality of the population's life (Foucault 2007, 5-6, 11). Directed at man as both a political and biological problem, at 'man-as-species' (Foucault 2003a, 242-243), bio-politics has spawned the emergence of a whole set of new disciplines such as statistics, public health, eugenics or social and racial hygiene which are concerned with the measurement and evaluation of the biological characteristics of the population.

Although the formation of a bio-political mode of power cannot be reduced to economic changes in the 18th century, a strong connection between bio-politics and economic concerns exists: through the establishment of regulatory security mechanisms, bio-politics sought to control, extract, and maximise the forces of the population at exactly the same moment when the de-skilling and mechanisation of labour had turned the body's labour power into the main resource of the unskilled worker and when work ability, health and vitality of the population had become defined as the greatest resource of state wealth and power. It is in this context

that the 19th-century emergence of large-scale public health measures must be seen which constitute one such distinct security mechanism to regulate and control the health of the population.

Replacing former systems of quarantine, new public health regimes in the form of sanitary science, social medicine and personal hygiene developed at the turn of the 19th and 20th centuries which took the population as both its object and subject. As a governmental apparatus and a system of expert knowledge, these new public health regimes were concerned with the calculation and elimination of risks pervading human life and the improvement of health through regulation (Petersen ve Lupton 1996, 6, 18). David Armstrong has developed a helpful categorisation of public health regimes which I will use in the following to trace the shifts within public health politics from the 19th century onwards. He identifies quarantine as a 'system of classifying localities' (Armstrong 1993, 395). In systems of quarantine, illness was thought to reside in places. Consequently, within quarantine measures no individual bodies were identified but only anonymous masses bound to a place whose passage between defined localities had to be prevented by the 'cordon sanitaire' (ibid, 395, 405).

During mid-19th century, a shift occurred from quarantine measures and the regulation of spacialities to the regulation of 'separable and calculable individuality in the form of anatomical/corporeal space in the crowd' (ibid, 405). In sanitary science, which constitutes the 'Golden Age of Public Health', strategies of hygiene 'shifted their attention from monitoring movement between one place and another place to between the human body and its environment' so that the human body entered 'as a new space of hygiene into the geographical diagram of public health' (ibid, 396). In other words, in sanitary science the human body became a distinct target of hygienic rules. The body was seen to be located in a certain environment, characterised by various factors such as soil, climate, buildings, clothing

etc., which exerted potentially harmful or beneficial influences on the body. Hence, hygiene was no longer concerned with the separation of spaces through spatial exclusion; rather, it relocated its focus on the way in which body and environment interacted and policed these interactions through various measures such as the management of dirt, whose passage in and out of body became the target of control, or the regulation of urban pollution through sanitary measures.

At the beginning of the 20th century, this public health concern with the body was further refined with the emergence of social medicine and personal hygiene. Under the growing influence of germ theory, the focus of public health measures shifted away from the boundary between body and environment and the new target of hygienic concerns became the interpersonal space between bodies. In other words, there was a shift from environmental to interpersonal disease causes (ibid, 403-404). As a consequence of such a reconceptualisation of bodies as the carriers of disease, every individual, including those apparently healthy, were seen to be at risk of infection through contact with infections persons. Furthermore, certain 'risk groups' were identified such as children, the poor or immigrants who became especially associated with the transmission of disease and who were consequently exposed to rigorous surveillance and medical supervision. Social medicine with its emphasis on prevention through personal and state-supervised hygiene and on the identification of certain social risk groups remained the dominant public health regime until the 1970s/80s when a further shift to 'the new public health' regime, as Armstrong terms it, occurred (ibid, 404ii). Inverting the 19th century concern with the non-corporeal environment, the 'new public health' politics associated danger 'no longer with the intrusion of 'nature' into bodies, but the incursion of the activities of those bodies into nature' (ibid, 405). Thus, the main focus area of these new public health politics was not the space between body and nature or between multiple bodies, but the potentially dangerous by-products of economic and social activity threatening to

pollute the purity of natural environments (ibid, 405). However, as this period lies beyond the temporal scope of my paper, I will not focus in further detail on these recent developments within the field of public health.

The shift in public health regimes from quarantine systems to sanitary science and personal hygiene during the 19th and 20th centuries as outlined by Armstrong mirrors the shift from sovereign power to bio-power and the growing interest of the state in the population as a biological problem. Just as with the transition to bio-power the exercise of power was redirected from territory to the body, public health measures during the 19th and 20th centuries turned from the regulation of geographically defined spaces to the control and government of bodies and their movements. It is exactly this shift which Foucault characterises as the transition from the 'safety of the Prince and his territory' to the 'security of the population' (Foucault 2007, 65).

As outlined above, this concern with the health of the population which finds expression in public health measures is directly, though not exclusively, linked to a desire on part of the state to preserve and maximise the national labour power. Nowhere is this link between public health politics and economic interests clearer articulated than in the field of industrial medicine on which I will focus in the following.

3.3. The Emergence of Industrial Medicine and the Physical Examination of Workers

Industrial medicine or occupational medicine, which emerged in industrialising countries during the 19th and early 20th century as a new sub-discipline of medicine in the context of the spread of the public health movement, is directly concerned with maintaining and ameliorating the health of the industrial labour force. The formation of industrial medicine brought about a profound change of the role of the doctor. During the 19th century, physicians in industry had been in a marginal position being responsible mainly for

emergency surgery for injured workers. However, at the turn of the 19th/20th century their influence and prestige greatly expanded as their field of expertise shifted towards preventive medicine and general medical care of the personnel in factories and plants (Nugent 1983, 578-579). Franz Koelsch in his textbook on industrial medicine defines the aims of the discipline as follows:

> It is the task of industrial medicine to preserve and improve in an optimal way the health and productivity of the working man, to prevent premature loss of energy, to prevent and compensate for the hazards of work (Koelsch 1963, 1).

Being part of the welfare system in industry, industrial physicians were responsible for the regulation and management of life. Through the provision of health care and medical supervision, they maintained the productivity and efficiency of the workers, as the quotation above underlines. Thus, the industrial physicians' prestige stemmed mainly from their newly assumed roles as guardians of the productivity of the working body's labour power and as the gate-keepers of industry who selected the physically fittest workers for vacant positions.

This new role of the industrial physician makes apparent the positioning of industrial medicine at the direct intersection of economic interests and public health concerns. The practitioners of industrial medicine strove to maintain the health of the working population in order to maximise its labour power and to guarantee economic growth as the following quotation by Koelsch exemplifies:

> The general public, that is the state, has – as mentioned above - greatest interest in health and safety protection at the workplace, as this is closely connected to national health, national strength and the national economy. The economic balance sheet of a country is the better the more healthy country-men can be found who are able and willing to work. Every disease, every premature invalidity, every premature death means a loss for the national wealth which weighs the heavier the earlier disease or death enters life (Koelsch 1963, 3).

Industrial medicine was primarily concerned with the health of the industrial worker's body because it constituted the worker's main resource on the labour the labour market. With the mechanisation and de-skilling of labour, work and handicraft had lost their intellectual component and became reduced to mere manual activity so that skill in work required

primarily physical attributes (Meyer 1981, 38). Consequently, to speak in Bourdieuian terms, the body had turned into the worker's 'physical capital' which had to be transformed into 'economic capital' through physical labour (Bourdieu 1978). As Koelsch states, 'the working man benefits in the first place from the achievements [of industrial medicine], because his labour power is often the only capital he brings into the economic struggle' (Koelsch 1963, 2).

The reconfiguration of work and the ensuing commodification of the body and its labour power rendered possible the selection of industrial workers on the basis of their mere physical attributes. Frederick W. Taylor integrated this idea of the physical selection of workers into his management strategies:

> As to the scientific selection of the men, it is a fact that in this gang of 75 pig-iron handlers only about one man in eight was physically capable of handling $47^{1}/2$ tons per day. (…) He merely happened to be a man of the type of the ox, - no rare specimen of humanity, difficult to find and therefore very highly prized. On the contrary, he was a man so stupid that he was unfitted to do most kinds of laboring work, even. The selection of the man, then, does not involve finding some extraordinary individual, but merely picking out from among very ordinary men the few who are especially suited to this type of work (Taylor, Frederick W. *The Principles of Scientific Management.* New York, 1967, 61-62; quotation taken from: Braverman 1998, 75).

It became the task of the industrial physicians to conduct and supervise the 'scientific selection' of suitable workers according to their physical characteristics. [10] Koelsch identifies several 'corporeal types' with varying aptness for certain occupations: He differentiates mainly between 'weaklings' with a poor physical condition, workers of 'a sturdy or stocky build' with a good physical condition but a tendency towards obesity in mature years, and 'athletic' workers being tall, slim and extraordinarily muscular (as Koelsch treats the male worker as the model worker and women as a distinct and special category of labourers, he

[10] The selection of apt workers for industry was not the sole domain of industrial doctors, though. At the beginning of the 20th century, psychologists like Hugo Münsterberg and Walter Dill Scott advanced the new discipline of industrial psychology. They developed methods of psychological testing for the selection of workers which remained in wide use especially in the US and Germany until the end of the 1920s when the inaptitude of these tests to assess reliably the abilities of the workers in real-life work situations led to criticisms of the testing methods and dissatisfaction with industrial psychology (Braverman 1998, 98-99).

makes no such a differentiation with regard to the female body). These bodily characteristics are then matched to certain occupational branches. Whereas 'weaklings' are especially suitable for filigree work requiring nimble fingers and little strength such as tailoring or hairdressing, 'sturdy' and 'athletic' workers are thought to be especially suited for heavy industrial labour (Koelsch 1963, 21-22, 28).

A distinct tool which emerges in the context of industrial medicine is the physical examination of workers. Associated with the implementation of new diagnostic techniques and precise methods, with the rise of industrial productivity and the promotion of national health and public hygiene, medical examinations yielded great prestige at the time of their introduction into industry. Industrial doctors praised the examination as the 'keystone of medical supervision in industry' and as a 'method par excellence' to improve the health of the working class and to increase the stability of the work force by reducing labour turnover and absences from work, thereby guaranteeing the success of industrial practice (Nugent 1983, 578, 583). Model tests such as developed by Selby, Clark, Raymond Cutler and the US Conference Board of Physicians in Industry during the 1920s focussed on immediate threats to industrial production: contagion, accidents and workmen's compensation coasts. Consequently, the proposed examination procedures included primarily the investigation of sensory deficiencies, heart and lung diseases, hernias, venereal diseases and foot ailments (ibid, 589).

The physical examination in industry was primarily a diagnostic, non-therapeutic tool which had various aims. As outlined above, it served the selection of the fittest workers for industrial labour by choosing those applicants whose bodily characteristics were thought to be most in line with the tasks required of them. Furthermore, when conducted periodically the medical examination also functioned as a tool for the medical supervision of the workers through the detection of infectious and chronic diseases (ibid, 585). However, physical

examinations had an additional disciplinary effect on the work force through the prevention and correction of deviant and undesired behaviour. Commenting on the work of the Ford Company's Medical Department in the area of health and its effects on lateness, absenteeism and efficiency, Henry Ford states:

> Doctors are in a better position to exercise a sort of watchfulness over the men than lawyers and superintendents, and our method is to have them to straighten out men who show evidences of not keeping up to their standard (*New York Times*, April 1914, sec. 4, p. 3; quoted after Meyer 1981, 115).

Workers themselves were very sensible of and anxious with regard to the power inequality inherent in the physical examinations which allowed corporations access into the 'inner realms' of the workers' bodies, while the workers themselves were denied such information as well as the information about the hazardous nature of their work environment (Nugent 1983, 593). Organised labour in the US reacted with outrage, hostility and suspicion against the introduction of physical examinations. The examination was perceived as an intrusion into the workers' private life and control over their work. Furthermore, the examination was feared as a barrier to work. Workers were anxious that they might be rejected despite experience and willingness to work due to insufficient health conditions or unwanted body features such as shortness in height. Finally, the examination appeared to unionists as a powerful weapon in the hands of the management to monitor the behaviour and profile of the work force as it might provide seemingly legitimate justifications for the rejection and firing of troublesome unionists and labour activists (ibid, 590-91).

Seeing the various aims and effects of the industrial medical examination, it becomes apparent that both disciplinary and bio-political power mechanisms merged in its implementation. As a practical tool of industrial medicine, the physical examination was positioned at the intersection of public health concerns with the vitality of the population and the creation of disciplined individual workers who were capable of adopting to the prescribed

work patterns of industrial labour and willing to so without disrupting the organised and planned work process.

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The transition to industrial modes of production entailed profound changes in the relationship between the body, labour and public health politics. While modern industry went hand in hand with the formation of an able-bodied, disciplined and normed workforce, developments in the field of public health made it possible to regulate the newly discovered economic value of the population's health and to medically select and control the industrial workforce. However, public health measures were not only directed at the sphere of work. They also constituted a significant means to monitor the mobility of population groups across state boundaries. In the next chapter, I will focus on this international dimension of public health by discussing the implementation of public health measures at the borders of nation states in the form of medial immigrant examinations.

4 Monitoring the 'Foreign Body': Medical Immigrant Inspections at the Border

In the last chapter, I concentrated on the sphere of work as a major field of concern for the implementation of public health measures. The medical control of transnational population movements constitutes another significant area of public health intervention. Migration, border management and public health politics are intimately interwoven in a complex way. In this chapter, I will first characterise and unravel this inter-relationship. Second, I will discuss in detail cases of state-enforced medical inspections of immigrants which were employed by major migration countries such as the US, Australia and Canada in the period from the late 19th to early 20th century. As these cases outline the context against which my own case takes shape, such a discussion can yield fruitful insights with respect to the various dynamics and power mechanisms inherent to the medical examination procedures at the German recruitment offices. Especially, my focus of analysis will be on the question of how disease categories overlapped in multi-fold ways with concepts of race, class, disability and gender/sexuality to generate different exclusion and inclusion patterns in these medical immigrant inspections.

4.1. Health Politics, Migration and the Management of Boundaries

As pointed out in the previous chapter, public health politics during the 19th century took on an increasingly bio-political character as their focus shifted from the regulation of geographically defined spaces and the circulation of matter or people across such spaces to the regulation of individual human bodies and inter-personal practices. So far, I have discussed the development of modern public health regimes only within the framework of the modern state seeking to control and ameliorate the health of its national population. However, a significant international dimension of public health politics exists which consists in the government and administration of 'life' and 'population' not within but across and between

states. Extending Foucault's analyses of health politics and state formation to a level beyond the nation state, Alison Bashford has coined the term 'international bio-politics' to describe this international regulation of public health across the boundaries of multiple sovereign states (Bashford 2004, 138).

The contemporary international order of states is to a great extent the result of such international bio-politics due to a close affinity between state government, border formation and health politics. As Bashford has argued, boundaries of rule often constitute lines of hygiene and vice versa (ibid, 1). Patrick Zylberman makes a similar argument stating that health boundaries are often not the secondary but the primary boundaries of modern states (Zylberman 2006, 22). He differentiates between a conceptualisation of the border in juristic terms, which defines the border administratively as a zone of contact between states, and a conceptualisation of the border in terms of health politics. In the second case, the border comes to be understood rather as a line of demarcation than a zone of contact. It fulfils the role of a 'strategic keystone' and 'watchtower of health' to prevent the importation of objects or humans endangering the nation's health (ibid, 23).

The fear of disease 'coming from outside' to invade the nation body is closely connected to the fear of 'foreigners'. Since the rise of germ theory and the spread of new sanitary and hygienic measures at the end of the 19th century, the body of the migrant has undergone a significant process of pathologisation in public health discourses which has resulted in a scientifically legitimised naturalisation of the link between disease and 'foreign' bodies. Consequently, immigration regulations have often taken the form of health regulations (Bashford 2004, 150). The assumed affinity between migrants - or 'aliens'- and disease is not coincidental in character. As Alan Ingram and Richard Coker have underlined, both disease and migration pose a challenge to the supposedly clear-cut boundaries of nation states and 'national populations' because both phenomena cut across the categories of 'us' versus 'them'

and 'here' versus 'there' (Coker and Ingram 2006, 161). In other words, both migration and disease threaten to violate the lines of demarcation along which difference is constructed. It is by reinforcing the borders of the community against disease and the assumed bearers of disease that the distinction between what counts as different is constructed and maintained. As Alan Sears states: 'The activity of 'keeping disease out' has the political effect of constructing the category of 'others' as a threat to health, 'The Health' of 'The Public'' (Sears 1992, 66).

Furthermore, a close relation between notions of dirt or uncleanliness and notions of 'non-belonging' exists. Mary Douglas has illustrated how 'dirt' as a symbolic category designates essentially 'matter-out-of-place' (Douglas 1984, 36). As such, dirt poses a threat to order and established boundaries; it signals disorder and danger (ibid, 2). Consequently, the management of dirt and the maintenance of cleanliness are directly linked to the management and control of boundaries. Transferring Douglas' analyses of dirt, cleanliness and order to the case of migration, it becomes clear that the fear of migrants transmitting diseases through uncleanliness and lack of hygiene as commonly stated in anti-immigrant and nativist discourses [11] does not unproblematically mirror a given reality. Rather, it expresses fears concerning the boundaries between interior and exterior, between what counts as native or belonging and what as foreign or 'out-of-place', and the desire to maintain and control these boundaries. Underlining the mutual relation between hygiene, government and boundaries, Alison Bashford makes a similar argument in characterising hygiene as a 'means of signification' through which borders are maintained, threats identified and internal weaknesses managed (Bashford 2004, 5).

Douglas has furthermore pointed out how the perceived need to control social boundaries finds response in a heightened control of bodily boundaries (Douglas 1984, 116). Consequently, the rise of new public health measures in the 19th century focussing on the

[11] For a thorough and detailed analysis of the stigmatisation of immigrant population groups as unclean and as carriers of disease in nativist American discourses, see Kraut 1995.

body of the individual and emphasising personal hygiene must be seen in relation to a heightened sense of the vulnerability of boundaries, be they national borders or the outer boundaries of bodies, in an age of rapidly growing mobility and globalisation. The medical examination of immigrants satisfied this two-fold desire to secure both national borders against the import of disease and the body of the national population against the invasion of foreign germs carried into the country through migrants crossing the border.

Gaining popularity with the rise of germ theory, the medical immigrant examination belonged to a new set of public health strategies which replaced or complemented earlier quarantine measures as the main form of medical border control. With the introduction of these new measures, immigrants became the first non-military group to be subjected to state-enforced medical inspection (Yew 1980, 490-491). The aim of these new medical examinations was to assess with the help of modern science the physical, psychological and moral fitness of future-citizens for their new countries of residence. Without doubt, Ellis Island is the most famous example of immigrants waiting in line to undergo a medical examination before given permission to settle in their new home country. However, Ellis Island is by no means the only case of medico-legal border control.

By the turn of the 19th/20th century, the implementation of medical immigrant inspections had spread not only along the entire border lines of the US but also to all other major immigration countries of the time such as Canada, New Zealand and Australia. Often, medical controls at the ports of departure preceded the examinations on arrival. US health officials demanded especially strict medical controls along the migration routes from the German-Russian borders to the US. Eerily foreshadowing later procedures during the holocaust, migrants from the Eastern German frontier were transported in segregated carriages or sealed waggons to border control stations in Germany where they underwent

rigorous health checks including collective stripping, compulsory disinfection and showers before they were shipped to the Unites States (Weindling 2000, 59-69).

Although the immigrant medical examinations as conducted at immigration stations like Ellis Island lost their significance with changes in immigration legislation and migration patterns from the mid-1920s onwards, many structural aspects of these examinations have survived in immigrant examination procedures into the post-WW-II era. Consequently, an analysis of these medical examinations dating from the great era of migration in the 19th and early 20th century can deliver fruitful insights for my own case at hand. However, it will be neither feasible nor helpful to systematically trace the emergence, development and subsequent decline of these medical examinations in all of the great immigration countries. Instead, through a critical and combinatory reading of major studies in the field, I will focus on the intersection of notions of health and disease with varying concepts of bodily difference which led to the creation of both inclusionary and exclusionary dynamics at the border.

As Minna Stern and Howard Markel state, the modern state's felt need to safeguard the national public health against contagious diseases, degenerative genetic traits and chronic conditions such as disability has been one of the most powerful rationales for restricting immigration (Markel ve Stern 1999, 1314). Obviously, the medical inspection of immigrants has served multiple aims. It constituted a 'spectacle of difference' in which fear of otherness was projected on the migrant's body through concepts of race, class, disability (Dolmage 2011, 29) and also gender/sexuality. The intersection of these various concepts in the context of the medical immigrant inspection is complex as the following discussion will show.

4.2. Disease, Race and Class in Medical Immigrant Inspections

Earlier studies on migration and public health contextualised the medical inspections of immigrants at the US ports and borders at the turn of the 19th/20th century mainly with

regard to the two most powerful intellectual discourses of the time: nativism and eugenics. Thus, these studies tended to interpret the medical examinations primarily as an instrument for the exclusion of racially and biologically undesired migrants under the cover of the neutral language of science. In her article on Ellis Island inspections (1980), Elizabeth Yew concentrates on how medicine, based on its growing scientific influence and authority in the public, was applied at the border to screen out 'immigrant diseases' thought to originate outside of the US, thereby contributing to the naturalisation of assumed racial differences and hierarchies (Yew 1980, 494). Similar to Yew, Alan Kraut focusses in *Silent Travellers* (1995) on medicine as a gate-keeper for both the exclusion of infected individuals and the protection of the white Anglo-Saxon Protestant civilisation against 'inferior breeds' (Kraut 1995, 4-5). He analyses how in the context of the rise of germ theory certain ethnic groups became associated with particular diseases and how the medical examinations at Ellis Island functioned primarily as a tool to keep out immigrants deemed undesirable on the basis of health concerns which became often intermingled with racial and eugenic fears.

In *Science at the Border* (2003)*,* Amy Fairchild makes a more differentiated analysis of how disease and race overlapped with notions of class to produce both inclusionary and exclusionary patterns at the US borders. As Fairchild illustrates, the inspection procedures at the US East Coast did not primarily aim at exclusion but at the incorporation and disciplinarisation of a newly incoming workforce. The medical processing of immigrants 'along the line' served as a rationalised initiation procedure inculcating the industrial values of discipline, productivity and efficiency on the immigrants to create industrial citizens for the nation (Fairchild 2003, 7, 48, 51). Consequently, the physicians of the PHS (Public Health Service) along the East Coast were less on the look-out for contagious diseases than for diseases or conditions compromising the suitability of the migrants for industrial labour and rendering them likely to become 'a public charge' such as eye diseases, heart conditions,

hernias, 'deformities' of the limbs or spine, poor vision or simply old age (Fairchild 2003, 130, Fairchild 2006, 338-339). In short, at the East Coast economic concerns and class expectations intersected with disease in such a way as to have an inclusionary effect for the majority of the migrants. However, the fact that only steerage passengers underwent the line examination at Ellis Island whereas 1st and 2nd class passengers were inspected on board in a far less intrusive way suggests that the link between disease and class had a further dimension: clearly, low social status was seen as an indicator for disease and vice versa (Fairchild 2003, 125). Furthermore, as those travelling in steerage to become the new working class of the US were usually immigrants not from Northern and Western, but Eastern and Southern Europe, this association of low social class with disease carried an implicit racial distinction (ibid, 123). Commenting on the medical inspections at Ellis Island, disability and immigration scholar Roxana Galusca states in close analogy to Fairchild:

> The belief that a person's social status and health were closely interrelated led to the conflation of social constructions of health, race and class, so that an immigrant's racial and class provenience carried automatic medical implications (Galusca 2009, 148).

However, even though Southern and Eastern European migrants might have been regarded as 'second-class' Europeans whose arrival in the US did indeed give rise to nativist and eugenic concerns, they were still included into the nation as industrial citizens as long as they fulfilled the necessary health conditions. As Fairchild argues, 'the colour line was drawn around and not through Europe' (Fairchild 2003, 189).

Whereas the language of class meant inclusion into the industrial labour force, the language of race signified exclusion from industrial and civic participation (ibid, 130). In contrast to the East Coast, the examinations along the US West Coast and the Mexican Border served mainly exclusionary aims in preventing the entry of Asian and Mexican immigrants who were deemed unfit to become industrial citizens because of their racial identity (ibid, 134). Just as the inspection procedures were more rigorous than those at the East Coast, the

diseases primarily searched for and certified by the PHS officers varied from those in the East. Put differently, in accordance with expectations of race and class, the PHS found those diseases it was looking for. Consequently, the varying patterns of disease rates along the borders are indicative of cultural prejudices which conflated 'race' with 'disease'. Asian immigrants, who mainly entered the US via Angel Island in the West where stool examinations were obligatory for steerage and 2nd class passengers, were certified most with parasitic diseases (ibid, 138-39). Underlying this association of Asian immigrants with parasitic diseases was the nativist fear of the Asian 'coolie' labourer who 'sapped the strength' of the nation by entering parasite-like the national labour market displacing native workers (ibid, 181, 220). A similar conflation of social apprehensions with disease concepts occurred along the Mexican border where in the wake of the Mexican Revolution in 1911 concerns of spreading disorder through entering migrants and troublesome labourers dominated local US politics. [12] Unsurprisingly, the certification rate for venereal diseases, which according to health discourses of the time carried implications of disorder and lack of civilisation, was especially high along the Mexican border (ibid, 173). As in the case of Asian immigrants, the prioritisation of certain disease categories over others mirrored social and political anxieties of societal upheaval.

In *Imperial Hygiene* (2004), Alison Bashford describes a similar pattern of race, class and disease concepts overlapping in immigrant selection procedures at the Australian borders in such a way as to produce both inclusionary and exclusionary mechanisms. She analyses the dominant role of 'invasion' narratives in Australian public health politics at the turn of the 19th to 20th century. Imagined as a 'virgin island-nation', Australia had to be protected against the invasion of both 'non-white' foreigners and diseases to keep the nation pure; 'pure' meaning simultaneously 'white' and 'clean' (Bashford 2004, 116, 132, 162). Such a mingling

[12] For a detailed account of changing inspection procedures at the Mexican border after the revolution and outbreaks of epidemics along the Mexican border, see Markel and Stern 1999, 1323ii.

of racial and hygienic discourses, which presented racial 'purity' as a public health strategy, informed Australia's double strategy of exclusion and selective inclusion vis-à-vis foreigners and immigrants. On the basis of the 1901 Immigration Restriction Act and Pacific Island Labourers Act, non-Europeans, especially migrants from Asia who were deemed foreign to Australian territory and the body politic of the nation, were barred from entry (ibid, 137, 139). On the other hand, immigrants from Britain and Europe had to undergo a process of selective inclusion in the form of medical screening at the border which was guided by eugenic principles. Ever more refined medical measures including clinical examinations, mental health tests, compulsory vaccination, genito-urinary examinations and later on also X-rays of the lung were to testify whether the arrivals from Europe were physically and mentally fit to form part of the young nation and the national labour force (ibid, 139, 152).

The overlapping of race, class and disease in the medical immigrant inspections was complex. Borders are places where otherness is constructed and managed (Convery, Welshman and Bashford 2006, 109) and medical immigrant examinations contributed to this construction and management of otherness through the production and maintenance of social and racial hierarchies. As the cases reviewed above have illustrated, the certification of diseases at the border defied the assumed neutrality of medico-scientific language. Racial, eugenic and economic concerns shaped what diseases were searched for and consequently detected to exclude those from entry who were thought unsuitable for citizenship on the basis of race and health grounds and to include those who seemed likely to become fit and disciplined members of industrial society and the nation body.

4.3. Disability and 'Fictive Ability' in Medical Immigrant Inspections

The construction of race and class differences in the medical examination of immigrants is closely linked to disability as a further marker of difference. Douglas Baynton

has pointed out how disability has commonly served as a justification for the maintenance of inequalities. He argues that the common imagination of disability as an indicator of inferiority and dependency in public health and migration discourses has usually been taken as self-evident and consequently met little critical reflection by most scholars of migration, nationalism and public health (Baynton 2001, 33-34, 41). However, once disability is taken as an independent factor in the creation of social hierarchies, it emerges in the context of the medical immigrant examination with regard to three main concerns: the fear of dependents and public charges posing a burden on the state, the fear of racial degeneration and the desire to build an able nation body.

As the previous discussion on race, class and disease has clarified, the medical examinations at the borders of nation states did not only aim at excluding the carriers of contagious diseases, but also at preventing the entry of those deemed likely to become a 'public charge'. The intersection between economic state concerns and disability becomes apparent when looking at the exclusion criteria of the PHS in the US between 1903 and 1930: among those certified by the PHS with conditions 'affecting the ability to earn a living' were immigrants with physical 'deformities', 'marked defective and muscular development' or 'eyesight' conditions, to name just a few examples (Fairchild 2003, 34-35). Underlying such a categorisation was the general assumption that persons with disabilities are necessarily dependents and can never be social contributors (Baynton 2006, 394). Obviously, able-bodiedness was a pre-condition for entry because the future immigrants had to fulfil the role of productive citizens. The screening for physical fitness at the border as illustrated by Fairchild and Bashford was not unique to the US or Australia. Alan Sears has argued that the medical immigrant inspections, which were introduced at the Canadian borders in 1902 to complement quarantine measures, served the selection of immigrants according to their

usefulness for the nation. Such 'usefulness' necessitated the 'overall physical, mental and moral well-being' of the immigrant (Sears 1990, 96-97).

However, mere physical ability and 'usefulness' was not sufficient in itself to become a citizen of the nation when certain desired 'racial characteristics' were missing. Natalia Molina underlines that seasonal workers for agriculture from Mexico were welcome labourers in the US during the early 20th century because of their assumed extraordinary physical fitness which according to Mexican immigration advocates and land owners in the US rendered them 'naturally' suitable for hard work and manual labour. However, although their 'docile' and 'subordinated' character was supposed to make them ideally suitable for low-skill work, their 'natural migratory and unsettled nature' as well as their perceived racial identity rendered them culturally and racially unsuitable to become US citizens (Molina 2006, 24, 27).

The question of race and (dis-)ability is directly linked to the medical examination's second concern vis-à-vis disability: the fear of racial degeneration. Like members of 'disfavoured races', 'mental and physical defectives' were commonly seen as carriers of potentially hereditary defective conditions (Baynton 2006, 395). Consequently, the implementation of medical examinations for immigrants in countries such as the US, Canada or Australia the turn of the 19th/20th century was in part guided by the eugenic concern to prevent racial degeneration through the 'timely' detection of 'abnormality' at the border. The PHS's grouping of 'idiots', 'imbeciles', 'insane persons' or 'feeble-minded persons' under Class A 'loathsome and dangerous contagious diseases' (Fairchild 2003, 34) is telling of the pathologising stance of the health officials who regarded disability as both a deviance from the desired norm and as potentially 'communicable' over generations.

Such a perception of disability mirrors the pathologising approach to race in the medical examinations. Both disability and race signalled an undesired form of bodily difference necessitating exclusion. It is this internal similarity between race and disability as two

exclusionary markers of difference which allowed for a frequent conflation of the two concepts in the health discourses which undergirded the medical immigrant examinations and stigmatised the 'alien' as 'defective' and the 'defective' as 'alien' (Dolmage 2011, 49). In contrast, the model subject according to which the future immigrant was measured was imagined as neither raced nor disabled (Molina 2006, 23).

The desire to build an able-bodied nation was directly based on this ideal of the model subject and practically realised through the consequent effort to bar all those from entry who did not conform to this model. In analogy with Étienne Balibar's concept of 'fictive ethnicity', Roxana Galusca has coined the term 'fictive ability' to indicate how the myth of the nation is not only founded on an imagined collective ethnic identity but also on the imagination of a collectively able-bodied national community (Galusca 2009, 138-139). As a state ideology, fictive ability emerges from the assumption that the population constitutes one coherent social body and that consequently only a nation made up of able-bodied citizens can be a strong and powerful nation. Such a conceptualisation of the nation as principally able-bodied finds its ideological counterpart in the depiction of those who do not meet the ideal of health, ability and fitness as 'internal enemies' of the nation (Bashford 2004, 145, 155). The medical examination of immigrants pursued the explicit aim to prevent the formation of such 'internal enemies' within the nation body. In other words, immigrants who could not conform to the prescription of ability were not only rejected because of economic and racial fears but also because they visibly violated a fundamental founding myth of the modern nation state: the imagination of the national community as collectively able-bodied.

4.4. Gender and Sexuality in Medical Immigrant Inspections

The discussion of major studies concerning the state-enforced medical inspection of immigrants at the nation's borders so far has illustrated that conceptualisations of class, race,

disability and disease closely intertwined in the medical screening and selective incorporation of future citizens. However, the studies reviewed above largely neglect the question of how categories of sexuality and gender both influenced the selection procedure and were in turn shaped and constructed themselves in the very examination procedures. This gap in the existing literature is addressed by Eithne Luibhéid's study *Entry Denied* (2002). In this work, she analyses how female sexuality was regulated and constructed in accordance with dominant sexual and gender norms by the US immigration controls in the 19th and 20th centuries.

As Luibhéid argues, the US immigration control apparatus constituted a 'key site for the production and reproduction of sexual categories, identities and norms' as well as for the control and regulation of female sexuality (Luibhéid 2002, x-xi). The immigration controls at the US borders, including the medical examination, were directed at the enforcement and maintenance of a heterosexual and patriarchal order of society through the construction of preferred categories for entry such as 'mothers, wives' and the exclusion of undesired categories such as 'immoral, prostitute, lesbian' (ibid, xi). The selective acceptance of female immigrants along the lines of these categories allowed for the protection of the nuclear family with its prescribed gender roles of the husband as bread-winner and the wife as economically dependent and responsible for domestic labour. By casting women thus as dependents of men, immigration control procedures channelled female sexuality towards reproduction and marriage (ibid, 3).

This imagining of women as naturally dependent on men has been practically reinforced and acted out through the very procedures of immigrant selection. The inclusion of women into the nation often depended on the economic and social status of their male relatives. Consequently, the questioning procedures by the US Immigration Service focussed not so much on the individual histories of female migrants but rather on the histories of their

fathers, husbands or other male family members (ibid, 44). In a similar way, Sears observes that immigration officials at the Canadian borders paid primarily attention to the economic potential of male adults in order to gauge the desirability of a whole family, including its female members (Sears 1990, 97).

The protection of heterosexual norms and the nuclear patriarchal family was based on the exclusion of those who threatened to violate these dominant norms. As guardians of morality, immigration and health officials had to prevent the entry of all those endangering the moral codes of the nation. Unmarried pregnant women were rejected in most cases both on the grounds of their likeliness to become a public charge and their questionable morality (ibid, 5). Such exclusionary criteria demonstrate how pregnant women were imagined as quasi-disabled because of their assumed dependency and inability to contribute economically to the nation (Baynton 2006, 403, Galusca 2009, 152).

Moral concerns leading to the exclusion of certain migrants often overlapped with health concerns as the medicalisation of those deemed sexually deviant reveals. People with 'abnormal sexual instincts' (an exclusion criterion in US immigration law dating from 1917 which foreshadowed the officially stated exclusion of homosexual migrants by the 1952 Act) and 'sexually abnormal appetites' were considered just as excludable as women who were suspected of prostitution (Luibhéid 2002, 9, 15). The motive to exclude prostitutes was explicitly racialist in character because it mainly targeted Chinese women. The mere co-incidence of being Chinese and female was sufficient to trigger suspicion among the US Immigration Service officials to launch a charge of prostitution. Scientific discourses of the time suggested that prostitutes' bodies were marked by distinct characteristics so that a woman's identity as a prostitute could be read from her outward appearance. Consequently, Immigration Service and PHS officials sought to identify potential prostitutes on the basis of their semblance, clothing and physical characteristics. In the early 20th century, eugenicists

even claimed that prostitutes could be detected by scrutinising their facial expressions because they allegedly suffered from feeble-mindedness (ibid, 47-50). Such a seamless linkage between race, female sexuality and disability was realised through the parallel imagination of subjugated racialised, female and disabled bodies as 'pure bodies, unredeemed by mind or spirit' which consequently required special regulation and discipline (Garland Thomson 2006, 261).

The incentive to prevent prostitution had distinct medical dimensions as well. As Luibhéid points out, prostitution was regarded as the nexus through which germs and disease, especially venereal diseases, could spread among white men (ibid, 37). The linking of venereal disease to the body of 'non-white' migrants was not unique to the US case. Bashford has illustrated how in Australian health discourses the spread of infectious diseases and ill-health was seen to be the result of illegitimate sexual intermingling of races. According to these discourses, infectious and venereal diseases were brought into the country through Asian migrants and then further spread through illegitimate sexual contacts (Bashford 2004, 105, 107ii).

The selection and screening of immigrants along the lines of desired and undesired sexual categories was closely linked to the project of nation building. Eugenic fears of racial degeneration of the national stock have fed the demonising of child-bearing by minority women and contributed to the strict regulation of entry for non-European immigrants (Luibhéid 2002, 56ii). Such fears exemplify the link between female sexuality and national identity. Founded on the ideal of the nuclear patriarchal family, the nation state required 'healthy mothers' and 'pure wives' (Galusca 2009, 152). Being appropriated by the state, female bodies were screened at the border as to what degree they could fulfil these criteria (ibid). Consequently, the medical examination at the border did not only pursue the aim of

producing productive, able-bodied and non-raced citizens but also of maintaining a hetero-sexual and patriarchal order which supported the myth of the nation.

Undoubtedly, a major short-coming of Luibhéid's nevertheless very informative work is her exclusive focus on the regulation and control of female sexuality whereas male sexual norms remain unquestioned. Such a perspective implicitly reinforces the heterosexual, patriarchal construction of female sexuality as the problem in need of regulation and special attention while male sexuality is cast as the unproblematic norm. Consequently, the question of how immigrant control apparatuses contributed to the construction process of male migrant identities constitutes so far an unfortunate gap in the research literature.

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As the cases reviewed above illustrate, the medical inspection of immigrants in the liminal space of border zones were a common and wide-spread tool for the regulation and control of migration at the turn of the 19th/20th century. As a scientifically sanctioned practice, these inspections constituted not just a preventive public health measure against the spread of disease. Rather, they must be seen as a distinct form of government over the life of mobile population groups. Being non-neutral and power-laden in character, these examinations sought to balance two conflicting interests: the desire to include suitable productive citizens into the imagined national community and the impulse to exclude those deemed to pose a threat to the nation due to economic, racial, eugenic or moral reasons. This impulse to exclude was fed by various social, political and economic anxieties which in the course of the examination were played out on the body of the immigrant, both through the very structures of the examination process itself and the discourses sustaining the examination which naturalised the link between 'foreigners' and 'disease'.

The studies reviewed and discussed in this chapter focused overwhelmingly on permanent immigration processes which were state-controlled but not state-initiated. In

contrast, the field of state-organised and –initiated temporary labour migration is largely understudied in the literature on migration and public health. In the following chapters, I will contribute to filling this gap by first outlining the context of Federal Germany's recruitment of labour migrants from Southern and South Eastern Europe, especially Turkey, and second by analysing in detail the medical examination of labour migrant applicants from Turkey in the context of recruitment which constituted a medical selection process combining aspects of the physical examination of industrial workers and medical immigrant inspections.

5 'Pre-Modern and Essentially Foreign': Federal Germany's Recruitment of 'Guest Worker' Labour Migrants and Their Representation in Contemporary German Modernisation and Health Discourses

Whereas mass emigration to the US had been the largest European migration movement before WW I, Federal Germany's state-controlled recruitment of migrant labour from Southern and South Eastern Europe after WW II initiated one of the most significant European migration movements of the second half of the 20th century. The recruitment of 'foreign' labour constituted no novelty for the German state. Already before WW I, Polish seasonal labourers had worked in agriculture in the German border regions. Forced labour of war prisoners during both World Wars and of concentration camp prisoners during World War II formed an integral part of the German war economy and the systematic extermination of persecuted population groups under National Socialism (Herbert 2001, 337-338). When the recruitment of 'foreign' labour recommenced in Federal Germany only ten years after WW II with the signing of a labour recruitment agreement with Italy in 1955, neither in government circles nor in the public a critical reflection on the recent history of employment of non-native workers took place. A 'fiction of historylessness' and the idea of a completely new beginning prevailed with regard to the post-war recruitment which rendered such a silence possible (ibid, 206, 339; Pagenstecher 1994, 30). Celebrated by representatives of the Federal German economy and government as a form of development aid and as a symbol for international cooperation, the post-war labour recruitment was even presented as a proof of the advanced democratic level Federal Germany had reached (Pagenstecher 1994, 35, Hunn 2005, 57-58). Any reflection on possible continuities in German history with regard to the employment of non-German workers was rendered impossible by such an interpretation of the recruitment process.

In this chapter, I will outline the context of Federal Germany's recruitment of labour from Turkey concentrating on those elements which were of significance for the

implementation of the medical examinations in the German recruitment offices. My contextualisation will focus on two levels. First, I will trace developments on a structural-institutional level, especially the structural elements of Germany's recruitment of 'guest worker' labour migrants and its major phases, the macro-political and macro-economic reasons for the signing of the German-Turkish recruitment agreement, the different pathways for migrants to Germany and the legal situation of the recruited migrants in Germany. Second, to avoid a perspective centred exclusively on the state and its institutions, I will pay attention to the discursive level as a second site of meaning production which sustained the structural organisation of the recruitment process. Recruitment procedures were shaped by varying and sometimes conflicting dynamics in many different areas of the Federal Republic such as the economy, labour politics, interior and exterior politics, the health sector or public media. Discourses in these varying fields evolved around a broad array of topics such as the economic costs and benefits of migrant labour, the economic and social integration of the 'guest workers' and its infrastructural consequences or the import of labour migrants as a menace to the national population be it through political extremism among migrant workers (after all, the Iron Curtain ran right through Germany), the import of 'foreign' diseases or, a fear taking shape from the 1970s onwards, permanent settlement causing *Überfremdung* (the 'swamping of the nation' by foreigners). [13] With regard to my thesis topic, I will concentrate exclusively on two contemporary discursive themes unfolding in the realms of politics, labour, medical science and the public: first, modernisation discourses stressing the cultural and economic backwardness of the labour migrants and their integration into industrial production as a performed 'time leap', and second, the construction of the labour migrant as

[13] For discussions on the economic benefits and disadvantages of labour migrants, see Sabel 1966 and Balke 1966; for discussions on economic and social integration, see Hunn 2005, 212ii, 277ii; concerning the problem of political extremism among labour migrants, see Schönwälder 1999, 134ii; with regard to the fear of health threats, see Yano 2001; for questions of *Überfremdung*, see Pagenstecher 1994, 45ii; Herbert 2001, 45ii.

both a member of a risk group with a high affinity for disease and as a potential risk to the health of the national population.

Usually, the discourses discussed in this chapter did not differentiate between the various national or ethnic groups among the labour migrants. Instead, these discourses grouped in a generalising, undifferentiated way all labour migrants under the label of 'foreign workers' or 'Southerners' who were thought to be united by a common 'Mediterranean' culture and life style. Consequently, when discussing these discourses, I do not refer specifically to the discursive representations of labour migrants from Turkey, but necessarily, following the rhetoric of the time, to the representations of labour migrants in the Federal Republic in general.

5.1. Entering the Federal Republic: Federal Germany's Post-War Recruitment of Migrant Labour and the Signing of the German-Turkish Recruitment Agreement

Federal Germany's decision to recruit migrant labour was decidedly economic in character. In the 1950s, the German labour market faced a growing labour shortage due to demographic shifts, rapid economic growth and changes in the organisation of labour such as earlier retirement age or the shortening of the working day (Pagenstecher 1994, 33). Representatives of government and the economy considered the recruitment of 'foreign employees', as they were officially called, the most convenient way to satisfy the national demand for labour. [14] Labour migrants promised to be of great economic advantage due to their mobility, flexibility (rendering them a suitable 'reserve army') and cheapness for industry because they were most likely not to claim social services once reaching old age

[14] Alternatives to the recruitment of migrant labour were discussed in policy circles, though. However, the mobilisation of the non-working population, especially women, was opposed on the grounds that it might harm family policies. For increased rationalisation procedures to compensate for the labour shortage economic capital was lacking and unions adamantly opposed the lengthening of the working-day. Consequently, during the years of economic boom the recruitment of labour power abroad came to be seen as the only viable means to satisfy the national economy's labour demand (Pagenstecher 1994, 33, Herbert 2001, 204).

(ibid, 34). The first labour recruitment agreement was signed with Italy in 1955. However, workers from Italy alone soon proved insufficient to quench the need for labour and the first agreement was soon followed by further bilateral agreements with Greece and Spain (1960), Turkey (1961), Portugal (1964) and Yugoslavia (1968). Minor agreements for smaller contingents of workers were also signed with Morocco (1963) and Tunisia (1965).

As arranged by the bilateral agreements, the recruitment from all of these countries was guided by five main principles: recruitment was state-controlled and organised by the Federal Employment Service (*Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung, BAVAV*; from 1969 onwards *Bundesanstalt für Arbeit, BfA*); the primacy of native workers was to be guaranteed and migrant labourers were only to be recruited when no native workers for a job position could be found; recruited labourers were to be treated equally with German labourers under labour and collective bargaining law (a point unions had insisted on to prevent competition); a system of rotation should be encouraged by issuing only one-year labour contracts (which could be renewed after a year) to prevent permanent settlement, and finally, a strict surveillance system was to be implemented by the foreigners' registration offices and employment offices (ibid, 28-29). [15]

Throughout the 1960s (with the exception of the recession years 1966/67) increasing numbers of labour migrants entered the Federal Republic for work. By 1964, the number of migrant labourers employed in Germany had reached the one million mark and by 1971 this number had more than doubled to 2.24 million labour migrants (Bundesanstalt, *Erfahrungsbericht 1971*, 3). With the growing presence of migrants, the euphoria over the positive effects of foreign labour recruitment, which had dominated national economic, public and political discourses during the boom years, steadily flagged. At the beginning of the

[15] For a detailed analysis of the systematic state surveillance of labour migrants and immigrants from Turkey in the Federal Republic from the 1960s to the present, see Topal 2006.

1970s, the enthusiastic evaluation of migrant labour gave increasingly way to a heightened awareness of the social and economic long-term consequences of a migration movement which began to take more and more the shape of permanent settlement (Bendix 1990, 68-69). Hence, the recruitment stop decreed in November 1973 by the Federal Minister of Labour and Social Affairs, Walter Arendt, did not only constitute a reaction to the oil boycott and looming economic crisis on a global scale. This officially stated rationale obscured to what great extend the recruitment stop was effectively the result of a growing uneasiness about the social changes brought about by mass migration to a country which adamantly maintained to be no immigration country until the late 1990s.

The recruitment agreement between Federal Germany and Turkey was signed on 30th October 1961 with effect as of 1st September 1961, retroactively (Bundesanstalt, *Amtliche Nachrichten* 12, 588). [16] Turkey had taken the initiative in arranging for the agreement to come into being. Due to rapid population growth as well as the increasing industrialisation and mechanisation of agriculture causing large scale rural exodus, Turkey was experiencing a phase of socio-economic upheaval and high unemployment. As migratory pressure was constantly rising in the face of economic crisis, the Turkish government was greatly interested in signing an agreement with the Federal Republic to ease unemployment, prevent social unrest and reduce foreign debts through money transfers of labour migrants (Hunn 2005, 33-34, 69-70). Apparently, the export of workers provided a convenient means to the Turkish government to ease social tensions and promote economic development.

The German attitude towards an official agreement was initially ambivalent. Whereas the industry and employers were definitely interested in additional labour power from Turkey, the federal government remained at first rather reserved out of fear that once Turkey had been

[16] A revised version of the recruitment agreement was passed in 1964 which abolished the economically impractical obligation for Turkish labour migrants to return after a maximum stay of two years, a regulation the Turkish side had initially insisted on, Bundesanstalt, *Amtliche Nachrichten* 13, 1.

offered such an agreement, a refusal to accept similar agreement requests launched by several non-European countries might cause diplomatic tensions (ibid, 44-47; Jamin 1998a, 69-70). [17] However, as a reaction to such hesitations on the German side, the Turkish embassy explicitly pointed out in December 1960 that it would interpret a refusal to sign an agreement as an outright political affront. As Turkey constituted an important NATO-partner, such an affront was unthinkable on part of Federal Germany and an agreement was prepared on the basis of a diplomatic exchange of notes in 1961 (Hunn 2005, 48, 53; Jamin 1998a, 71). Thus, the realisation of the agreement was not only guided by economic interests on both sides but also by diplomatic and foreign policy concerns on part of Federal Germany.

Even though Federal Germany had entered hesitatingly into the agreement regarding Turkey initially only as a minor 'reserve country', Turkey quickly developed into one of the major recruitment countries for the German labour market. In 1964 alone, 55,000 workers were recruited from Turkey, the majority of officially recruited labour migrants in that year, by 1967 already 130,000 migrants from Turkey had entered Germany and by January 1972, Turkish citizens had become the largest national group of labour migrants living in the Federal Republic (Hunn 2005, 67-68; Herbert 2001, 224).

The most convenient way for labour migrants from Turkey to enter Germany consisted in the state-supervised recruitment process via the Federal Employment Service and its German recruitment offices in Turkey. As defined by the bilateral agreement, those recruited via the German recruitment offices in Turkey were already offered a labour contract before their departure to Germany. Furthermore, they were guaranteed lodging by the employer (although for rent), insurance and equal income and work conditions with their German colleagues. Also, transport to Germany was paid for by the Federal Employment Service and a legitimation card (*Legitimationskarte*) was issued replacing both entry visa and work permit

[17] All page number references for Jamin's article refer to the German, not the Turkish version of the text.

which rendered bureaucratic hindrances at the German consulate and employment offices unnecessary. [18] Until 1972, a so-called 'Second Way' to Germany existed in the form of individual entry with visa. Migrants arriving via the 'Second Way' were not recruited by the recruitment offices. They entered the country privately with a pre-arranged labour contract and a work permit. [19] Finally, the entry with a tourist visa constituted an unofficial 'Third Way'. Migrants choosing this rather risky way had to find labour after their arrival in Germany in order to get a work and residence permit (Dunkel and Stramaglia-Faggion 2000, 61). As neither the Turkish nor the German state authorities favoured the Second and Third Way because these pathways offered less room for state control, the percentage rate of workers from Turkey recruited via the Federal Employment Service's recruitment offices remained very high throughout the recruitment years; it oscillated on average between 75% and 85% during the recruitment years and climaxed especially in years of great economic demand and large recruitment numbers (Bundesanstalt, *Erfahrungsbericht 1972/73*, 114).

Until the policy change of March 1971, officially recruited labour migrants entered Germany with a one-year labour contract which allowed them to work in the named work place for one year irrespectively of the labour market situation; [20] after one year, the migrants had to apply to the employment authorities to renew their work permit or to change the work place (Paine 1974, 69-70). The longer the workers stayed, the more rights they were entitled to. [21] However, the official equality of German workers and labour migrants under labour and

[18] See German-Turkish recruitment agreement, 31 Oct. 1961, and the attached standard model of the labour contract, Bundesanstalt, *Amtliche Nachrichten* 12, 588-592.

[19] From 1965 onwards, the Second Way was closed to male unqualified workers from all recruitment countries and remained open only for female and qualified male workers until it was completely closed in 1972, Mattes 2005, 67; Hunn 2005, 83.

[20] From 1971 onwards, the work permit was no longer bound to a specific work place and was usually offered for two years, in special cases for even up to five years, Paine 1974, 70.

[21] Since the early 1960s, five years of uninterrupted employment or eight years of residence automatically conveyed the right to stay and work for up to three years in whatever job the migrant workers chose, no matter how high the employment rate on the labour market was at the time; after ten years of residence, the

collective bargaining law as defined by the recruitment agreement was often structurally undermined in reality. Labour migrants were preferably recruited for unskilled, physically hard and in terms of health hazardous labour (Hunn 2005, 118). Workers from Turkey found mainly employment in construction, manufacturing industry (especially metalworking in case of men and textile industry in case of women) and mining (ibid, 214; Paine 1974, 90-91; Bundesanstalt, *Erfahrungsbericht 1964*, 9). Poor working conditions such as assembly line production, piece-work wage rates and shift work were typical for migrant labour. Due to the often more dangerous character of the jobs offered to migrant workers, the accident rate among them was also higher than among German workers (Herbert 2001, 213). Leading the claims of 'development aid' ad absurdum, few labour migrants received formal training while being in Germany. By 1972, only 3% of all unskilled migrant workers had moved to skilled positions (Hunn 2005, 217). Lower qualifications also meant lower salary grades. The structural inequalities inherent in migrant labour resulted in the confinement of migrant labourers to an 'underclass' status which in turn allowed for upward mobility among the German working class (Herbert 2001, 213; Hunn 2005, 215).

5.2. 'Lacking Modernity and Discipline': The Construction of the Labour Migrant as Essentially Backward and Non-Modern in Contemporary German Modernisation Discourses

The perception of the labour migrants from South and South Eastern Europe in the West German public was dominated by the image of the rural, pre-modern 'guest workers' who come first into contact with modernity and civilisation in the Federal Republic. This perception deliberately ignored the migrants' varying social backgrounds and omitted from consciousness those life histories which did not fit in with the notion of the 'backward

work permit was finally issued without limitation, Paine 1974, 70; Dunkel and Stramaglia-Faggion 2000, 50. These regulations enabled many migrant workers to stay in Germany after the recruitmen stop in 1973.

Southerner' who undergoes a time-lapse process of civilisation and modernisation only after entering the Federal Republic.

In contrast to the wide-spread stereotypical notion of the rural and 'backward' guest worker, the majority of labour migrants from Turkey came from the richer, more industrialised and urbanised Western and North Central areas of Turkey, whereas migrants from the poorer rural areas of South East and East Central Anatolia remained underrepresented throughout the years of recruitment (Paine 1974, 72). Initially, Turkey had been intended for the recruitment of mainly skilled workers (Bundesanstalt, *Erfahrungsbericht 1961*, 13). Consequently, the pioneer migrants from Turkey during the initial years of recruitment were of a relative elite status when compared with the general population of Turkey. Being mainly from the middle and upper ranks of the peasantry and urban labour force, they were comparatively better educated, more skilled, financially better off and less unemployed vis-à-vis the indigenous population (Paine 1974, 123). Although the profile of the migrants recruited from Turkey changed over the 1960s as increasing numbers of unskilled migrants from rural areas entered Germany for labour, the rate of skilled workers among Turkish migrants, and especially among female labour migrants from Turkey remained high throughout recruitment in comparison with the other recruitment countries (ibid, 71, 75; Hunn 2005, 71, 78).

Ignoring the varied social backgrounds of the labour migrants, the notion of the rural, tradition-bound 'Southerner' making first contact with modernisation and industrialisation in the Federal Republic constituted a pervasive discursive theme in the German public and economic spheres as well as within state institutions. This dominant attribution of 'backwardness' to the labour migrant fed into a modernisation discourse which created a distinct social hierarchy through an essentialising 'othering' of the migrants. The close

linkage between labour migration and questions of modernity versus backwardness is not unique to the German case. According to labour historian Stephen Meyer, the management of labour in the US at the turn of 19th/20th centuries included various strategies to adjust the migrant workers, who usually joined the ranks of low-skilled workers in American factories, to the social and cultural norms of industrialised America (Meyer 1981, 68). One such strategy was the provision of lessons on timeliness, cleanliness, self-discipline and other 'virtues' of middle-class America to inculcate on the migrant workers an industrial work ethos (ibid, 150, 158). In contrast, the 'cultural and social baggage' of these migrants was perceived by their employers as a hindrance to their adaptation to industrial norms (ibid, 70).

A different perspective on the link between migration, labour and modernisation is offered by the historian Deborah Cohen. In her dissertation on the Bracero Program (a program for state-organised Mexican labour migration to the US between 1942 and 1964), she illustrates how not only the recruiting country, but also the country sending labour migrants abroad may contribute to the maintenance of modernisation discourses. The Mexican government understood the Bracero Program as a development strategy, as a means to 'move Mexico along on the chartered path to modernity' (Cohen 2001, 242). Equating the industrial worker with the modern worker, Mexican state discourses depicted ruralness as an indicator of backwardness and the urban factory as the site of modern work per se (ibid, 187, 194-195).

A close reading of contemporary statements concerning the integration of labour migrants into German society and work life reveals a similar imagination of labour migration as a time-lapse-experience of modernisation. In a 1964 report on the situation of labour migrants in Germany, Valentin Siebrecht, president of the Bavarian Employment Office from 1957 to 1972, makes a generalising characterisation of 'foreign workers' which nicely summarises the main elements of this modernisation discourse:

> The performance of adaptation requested from the Southerners is enormous. Most of the time, the German population is not even aware of it. The Southerners do not only have to cope with the change of climate, get accustomed to different food, get along at their work place and in their leisure time without proper language skills; foremost they have to perform a leap over centuries of historical development, a transition from a usually rural society determined by tradition and the bonds of the family and the clan to the unfamiliar rhythm of the world of industrial production. They come from their villages and small towns with small-scale and still socially intact family relations, with obsolete traditions and a religiously determined order of life into the pulsing turmoil of large cities and industrial districts, into mass production and mass movement. They exchange their family and village community for the anonymity of barracks and dormitories; they operate machines which enforce upon them a new work and life rhythm, they have no siesta, but the despised long week-ends full of boredom and unnecessary spending of money (…). [22]

The above quoted statement is illuminating in many ways. Irrespective of her or his specific social and national identity, the labour migrant, stereotypically characterised as 'Southerner', is thought to perform a time leap from the archaic and timeless context of her or his place of origin to the highly modernised world of German society. A linear understanding of progress lies beneath this association of the Mediterranean countries with the temporal past of the Federal Republic. Thus, the geographical distance separating the migrant's home country from Germany is at the same time understood as a temporal distance which the migrant has to bridge over by 'catching up' on the pathway led out by member states of the industrialised West. This time leap metaphor is sustained by the idea of two diametrically opposed worlds which clash once the migrants arrive in Germany. The rural, traditional and static home community of the 'Southerners', hold together by traditions, organic family solidarity and religion, is contrasted with the industrial, modern and dynamic West German society which is governed by anonymity and processes of mass production to which the migrants must adapt.

The following nearly identical statements illustrate the contemporary pervasiveness of this discursive motive of the 'backward Southerner' who performs a time leap of

[22] Dr. Valentin Siebrecht, 'Die ausländischen Arbeitnehmer. Situation, Probleme und Aufgaben (The Foreign Workers. Situation, Problems, Responsibilities)', München 1964, 8-9, DOMiD-Archiv AL 001.

modernisation and adaptation. In an article on his experiences with the employment of labour migrants from Greece, H. Weinzierl, a company doctor in a factory for electroceramics in the German town Lauf, characterises the migration experience of the labour migrants working in the factory as follows:

> The guest workers come to us because they know they will find work here as well as a dream-like salary compared to what they are used to. Only this incentive can lure these partly primitive people out of the seclusion of their homeland and their family-centred life world into the adventure of a world completely unknown to them. (…) They come from a largely underdeveloped agricultural country into our highly industrialised, mechanised and automatised economy, (…) they effectively jump half a century of modern economic development. They come from their primitive village community, from the familiar environment of their patriarchally ruled family into our modern economic age (Weinzierl 1962, 28).

We find the same motive of the labour migrant's time leap between a rural and 'underdeveloped', even 'primitive', life world and the modern, industrialised high-tech world of Federal Germany all over again in a statement by Erich Hoeschel, the director of the Federal Employment Service's medical service which was responsible for the implementation and organisation of the medical examinations at the recruitment offices abroad:

> Employment in Germany means for many [of the foreign workers] a step over great time periods of different development stages, a step into a highly civilised industrial world shaped by technological development (Hoeschel 1973, 28).

The dominant notion of the essential 'otherness' and 'backwardness' of the labour migrants which these civilisation and modernisation discourses convey finds its counterpart in the idea that the labour migrants must undergo a process of disciplinarisation and adaptation to industrial production methods. Only through such an internalisation of the principles of industrial production can the recruited workers overcome their lack of modernity and civilisation. Necessarily, a 'new work and life rhythm' is imposed upon the recruited workers once they become integrated into industrial production (see the above quoted statement by Valentin Siebrecht). In an article on the history of migrant labour in Germany, Hans Stirn stresses the migrant labourers' lack of work discipline necessary for industrial production. He

argues that the lax and pre-modern work conditions in the Mediterranean area render the workers' adaptation to the organising principles of a German factory difficult (Stirn 1964, 65). Echoing Weber's theory of the connection between Protestantism and capitalist work ethics, he states that

> In their history, these peoples [of the Mediterranean] have never overcome the notion of 'labour as the punishment of man', they have never passed through the phase of inculcation of work discipline (*Arbeitszucht*) which we underwent under the influence of Protestantism, and of self-discipline (*Selbstzucht*) which we inherited from the Prussian kings and the former Prussian administration system (ibid, 65).

According to him, the 'foreign workers' are full of admiration for the work discipline in German factories while simultaneously disliking it for the constraints it exerts on them (ibid, 68). However, as long as these migrant workers do not change their 'attitude to work discipline' no 'efficient industrial production' can emerge in the Mediterranean area (ibid, 69).

The notion that labour migrants undergo a compulsory process of disciplinarisation once they leave the slower and more libertine work and life rhythm of their home countries behind to enter into the highly rationalised society of industrial Germany was widespread. Siebrecht, for instance, argued on a 1966 meeting of the Confederation of German Employers' Association in Bad Godesberg that the Southern European workers who used to be accustomed to a 'free life style' in their home countries have to 'integrate into the rigid principles of order' they find in Germany and the 'highly rationalised work processes' in German factories (*Magnet Bundesrepublik* 1966, 27-28).

The significance attributed to discipline as an industrial value is also made evident by contemporary evaluations of the Turkish labour migrants' potential to become industrial workers. In the report of his business trip to Turkey in October 1961, Eduard Keintzel, a member of the Ruhr mining company, comments in a highly generalising and racialising way on the inclination of 'the Turks' to obey strict rules and to respond positively to authoritarian

leadership and discipline. [23] Similarly, the Federal Foreign Office reports in 1964 that German companies praise the discipline, integrative capabilities, physical performance and undemanding nature of the Turkish workers (Hunn 2005, 104). These accounts not only emphasise the importance of discipline as a positive industrial value. In a racialising way, they map a certain aptitude for manual, low-skill labour onto the imagined collective body of Turkey's population, thereby degrading the labour migrants from Turkey to mere responsive work machines 'naturally' suited for industrial production.

The discursive themes outlined above stress the essential 'otherness' of the labour migrants in Germany due to their assumed social and cultural 'backwardness'. The quoted statements each formed part of a broader modernisation discourse which was constantly reproduced within the realms of the state, the economy and the general public. Equating the labour migrant with a child in need of socialisation, this modernisation discourse underlined the need of the labour migrants for modernisation and civilisation which primarily had to be achieved through the internalisation of industrial values, especially industrial work discipline. Thus, these discourses 'ennobled' the recruitment and employment of labour migrants into a civilising mission on part of the German state and economy.

5.3. Precarious 'Foreign' Bodies: The Representation of the Labour Migrant in Contemporary German Health Discourses

The modernisation discourse stressing the backwardness and ruralness of the labour migrants in Germany was closely related to common health discourses of the time which depicted the recruited migrants both as a specific health risk group and as a potential threat to

[23] Dr. Keintzel, 'Bericht über Erkundung der Anwerbemöglichkeiten von türkischen Bergleuten für den deutschen Bergbau in der Türkei, Dienstreise vom 14.-29. Oktober 1961 (Report about the Investigation of Opportunities for the Recruitment of Turkish Miners for the German Mining Sector, Business Trip from 14 to 29 Oct. 1961),' BARrch, B 119/3071.

the national population. The imagination of the labour migrant as non-modern and uncivilised and the close association of the migrant's body with disease and health problems mutually depended on and reinforced each other.

A pathologising understanding of both the migration process and the migrant's transition to industrial production sustained the conceptualisation of the labour migrants as a risk group easily prone to disease. The experience of foreignness and non-belonging, that is the separation from family, home and familiar cultural context as well as the social and cultural isolation in Germany, were commonly cited causes for psychological strains, depression and home sickness among the labour migrants. At the 1966 meeting of the Confederation of the German Employers' Association in Bad Godesberg, Albert Stehlin, president of the German Caritas during the 1960s, characterised the workers' experience of migration as an essentially traumatic process because of the enormous differences between their own life worlds and the German society which the migrants were forced to overcome.

> What happens is a leap from one type of social life into a totally different one. The foreign worker comes (…) from a totally different world, (…) everything is so different that the change nearly inevitably causes a trauma, which often enough is never wholly overcome (Stehlin 1966, 27).

In his presentation paper for a meeting of the Federal Committee for Foreign Workers in 1969, Volker Mathies, a company doctor of the Henkelwerke in Düsseldorf, argues that 'during (…) the phase of transition, psychological strains emerge because of the loss of village and family community, the transition from village environment to large cities.' [24]

Change of environment, especially the confrontation with different food and climate, as well as the transition to a new life rhythm were thought to result in both psychological problems and physiological health problems among the migrants. Charles Zwingmann, a

[24] Dr. Volker Mathies, 'Die Gesundheitsprobleme ausländischer Arbeitnehmer, Vortrag auf einer Sitzung der Landesarbeitsgemeinschaft für ausländische Arbeitnehmer am 16.6.69 (The Health Problems of Foreign Workers, Presentation at a Meeting of the Federal Committee for Foreign Workers on 16 June 1969)', BArch, B 119/3013, 4.

psychologist specialised in the phenomenon of home sickness among migrant workers, states in an article from 1964 that climate change from the 'bright and warm' climate of the South to the cold and wet weather in Germany contributed to 'nostalgic reactions' among labour migrants (Zwingmann 1964, 72). Similarly, Mathies argues in his presentation paper that unfamiliar food, new daily rhythms differing from the daily order in the migrants' home countries, and climate change could lead to depressions, fatigue, sleeping disorders and autonomic dysfunctions. [25]

Most significantly, the initial lack of industrial experience and the very process of industrial transition itself were seen as triggers of health problems. In an article from 1964 on medical experiences with labour migrants in German factories, the industrial physician Wilhelm Nesswetha comments on this issue as follows:

> For the majority of foreign workers, employment in Germany entails an initial contact with industrial conditions which usually (…) differ fundamentally from previous forms of occupation. The thoroughly organised and rationalised production process poses physiological as well as psychological challenges to the organism which are often still unfamiliar to the individual-biographical range of experiences (Nesswetha 1964, 82).

He regards psychophysical disorders as essentially intrinsic to the labour migrants' industrial adaptation process:

> The average foreign worker because he usually has no or only minimal industrial experience first needs to acquire a sufficient fundament of reactions, techniques and attitudes through training which can hardly be achieved without passing through a range of functional disorders and psychophysiological impairments (ibid, 94).

Similarly, Mathies contends that the 'unfamiliar work rhythm' of industrial production, especially 'concentrated and regulated work' as well as piece-rate and shift conditions, cause multiple physiological and psychological disorders. [26] Furthermore, as Hanns-Martin Schleyer, president of the Confederation of German Employers' Association and the Federation of German Industries, argued at the 1966 meeting of German Employers'

[25] Ibid, 5-6.
[26] Ibid, 6.

Association in Bad Godesberg, lack of industrial experience in combination with improper language skills led to higher accident rates among migrant workers compared to the national work force (Schleyer 1966, 40-41).

This concern with the labour migrants' health situation reveals how the migrants' labour power was seen as an economic investment which poor health could endanger. Mathies is quite explicit about this point in his paper. First stating that labour migrants were primarily recruited for manual labour so that disease necessarily leads to a restriction of their work capabilities, he comes to the following conclusion: 'I personally believe that every improvement in preserving the foreign workers' health will simultaneously be of advantage to us Germans.' [27]

The pervasive discourse which depicted the labour migrant as exposed to heightened health risks arising out of the experience of migration and industrial transition is not just remarkable because of its generalising, stereotypical imagination of both the migrants' life worlds in their home countries and their migratory experiences. What is striking is how this discourse pathologises and naturalises essential notions of otherness, non-belonging and backwardness by turning them into inevitable causes for disease. The labour migrant emerges from this discourse as fundamentally foreign and 'out of place' in Germany while disease serves as a scientific proof of this foreignness. Unsurprisingly, this focus on the foreignness of the labour migrants goes hand in hand with a heightened anxiety over the security of the Federal Republic's health boundaries. Just as company doctors and health professionals took great interest in the question of whether labour migrants had a particular affinity for certain diseases due to their special social and economic situation, public health authorities and the government in Federal Germany were concerned with the question of potential public health threats emanating from the labour migrants once they had entered German territory.

[27] Ibid, 13, 17.

With recruitment of labour migrants increasing greatly from the beginning of the 1960s onwards, fear spread among the federal government, especially within the ministerial departments responsible for health and interior affairs, that the newcomers from abroad might import not only their labour power but also disease. In an article from 1967 on health problems among labour migrants P. Rosenberger, a member of the Federal Health Council's committees for epidemic control, hygiene and health preservation, neatly summarises this anxiety:

> Apparently, many of these people [the labour migrants] come from countries with 'health – and civilisation standards' which cannot be compared to ours. The fear of the German population, medical professionals and health authorities is justified that because of these circumstances a massive import of epidemics and diseases may occur (Rosenberger 1967, 196; quotation marks in original text).

Equating health with civilisation, this quotation makes apparent how the lack of civilisation attributed to the labour migrants rendered them likely in the eyes of health professionals to bring disease over the borders into German territory.

This fear of disease import was mainly directed at those migrants who entered the Federal Republic via the Second or Third Way without undergoing a prior medical examination in their home countries at the German recruitment offices (Yano 2001, 68). To install a system of health surveillance, the Federal Ministry of the Interior in coordination with the Federal Minister of Health passed a new regulation on 30 March 1962 which made the issuing of a residence permit to labour migrants who had not been recruited via the Federal Employment Service dependent on a health certificate (ibid, 72). Previously, no standardised regulation had existed at the federal level with federal states deciding individually on whether a health certificate was obligatory for a residence permit or not. [28] According to the 1962 regulation, the medical examination, which in the following came to be

[28] The first state to introduce in 1961 a health certificate requirement for labour migrants from Spain, Italy, Greece and Turkey not recruited via the Federal Employment Service was North Rhine-Westphalia, Yano 2001, 72.

conducted by state health officials at public health offices after the migrants had entered federal territory, [29] had to cover the following aspects: a clinical inspection, an x-ray examination of the respiratory organs and a serological sample test to detect syphilis. Additional tests, such as for other venereal diseases, typhus or parasitic diseases, were left to the federal states' own discretion (ibid, 72). This restrictive approach to migration was further manifested by the Federal Republic's first foreigner law. Passed in 1965, it stated that a residence permit could be refused in case its issuing interfered with 'state concerns', a deliberately vague term which easily encompassed health policy concerns (Schönwälder 1999, 127).

In contrast to the medical examinations at the recruitment offices, the foremost aim of the examination in Germany was to prevent the import of infectious diseases; it was not directed at an evaluation of the migrants' work suitability (ibid, 72). Anton Sabel, the president of the Federal Employment Service, acidly criticised this lacking evaluation of work capabilities at the 1966 meeting of the German Employers' Association in Bad Godesberg to stress the advantages of recruitment via the Federal Employment Service: 'A hunchback could not get past our recruitment commissions, but of course he would be acceptable to the local public health office because he is not contagious', (*Magnet Bundesrepublik* 1966, 55).

The implementation of stricter health regulations was guided by the fear that labour migrants might import foreign, non-endemic diseases or cause a new eruption of infectious diseases such as TB which had only recently been contained in the Federal Republic after WW II. [30] Scientific medical articles of the time discussed which endemic as well as non-

[29] The question of who was to implement the examination when as well as the question of whether different regulations had to be applied to labour migrants from non-recruitment countries remained much disputed issues at the ministerial level after 1962, see Yano 2001, 72, 77ii.

[30] At a meeting of the Federal Health Council's committees for epidemic control, hygiene and health preservation in May 1966, the medical director Prof. Dr. Hein urged for strict health surveillance of labour migrants to prevent the 'cultıvation of a new contingent of TB-infected persons within the FRG' after great efforts had

European diseases might be spread by migrants and meetings were hold by the Federal Health Council's committees for epidemic control, hygiene and health preservation to consult about the extent to which the health status of the labour migrants constituted a potential public health threat necessitating stricter or additional legal health regulations. [31] Economic concerns also played a role with respect to this rising anxiety about diseased labour migrants entering Germany. In an article published in a major German medical journal, O.P. Michaelis, senior medical officer of the public health office in Schwabing/Bavaria, urges for strict standardised health regulations with regard to the issuing of residence permits. He emphasises the 'severe consequences' of too lax health rejection criteria because an undetected case of active TB might cause high public costs once a residence permit was granted (Michaelis 1967, 197).

The specific targeting of incoming labour migrants as potential health threats was further pushed by the public media. For instance, a newspaper article from 1966 with the telling tile 'Lice-Infected Luggage. The Guest Workers as the Problem Children of Public Health Authorities' warns against security holes in the national health boundaries. Taking it for granted that labour migrants constitute a significant health threat, the author of the article argues that the medical examinations conducted by the Federal Employment Service in the recruitment countries should not induce heightened feelings of safety among the German population because the luggage of the migrants remains unchecked, cheating constitutes a

successfully been done to contain the disease within the borders of the Federal Republic, 'Die Tuberkulose bei Gastarbeitern vom klinischen Standpunkt aus gesehen, Referat von Medizinaldirektor Prof. Dr. Hein, Tönsheide, gehalten auf der Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und –fürsorge des Bundesgesundheitsrates in Bad Godesberg am 6. Mai 1966 (The Tuberculosis among Guest Workers from a Clinical Perspective, Presentation by Medical Director Prof. Dr. Hein, Tönsheide, at the meeting of the Federal Health Council's committees for epidemic control, hygiene and health preservation in Bad Godesberg on 6 May 1966),' BArch, B 119/22369.

[31] On contemporary discussions about diseases among labour migrants, see for instance *Euromed* 1964; Beckenkamp and Schon 1965; Preuss 1966; Arens 1967; Rosenberger 1967; Rieth 1972 or Neumann 1973.

common procedure to get past the Employment Service's health controls and children who come via family reunification enter without any health checks at all (Püllmann 1966). [32]

As Yano points out, the tightening of health restrictions for migrants entering via the Second and Third Way at the beginning of the 1960s was not based on any representative statistic data implying heightened infection rates or specific dangerous health conditions among the labour migrants from South and South Eastern Europe; decisive for the implementation of obligatory health controls were rather vague fears and threat scenarios caused by a heightened mobility across the national borders (Yano 2001, 69-70, 80-82). Large-scale empirical material on the actual health condition of labour migrants in Germany became only available from the mid-1960s onwards with increasing numbers of migrants working in Germany over longer periods of time. However, the results of empirical research ran counter to what threat discourses suggested.

In 1965, the Federal Ministry of Health published a report of the 1963 results of the medical examinations within the Federal Republic for the obtainment of residence permit. According to the report, only 1% of those examined were certified with excludable disease conditions (ibid, 80-81). Also, a survey by the German Liaison Office for Intergovernmental Social Security Agreements of the Federal Association of Local Health Insurance Companies (*Deutsche Verbindungsstelle für zwischenstaatliche Sozialversicherungsabkommen beim Bundesverband der Ortskrankenkas-sen*) yielded a lower sickness absence rate among labour migrants in comparison to the national work force (ibid, 81).

Surveys about specific disease rates among the labour migrants led to similar results contradicting public and ministerial fears of imported health threats. Presenting the results of

[32] The article eerily mirrors the racial hygienic argumentation logic of the early 20th century which often equated ethnic undesirables with lice and bacilli, just as the article's plea for quarantine measures such as luggage inspection and disinfection is reminiscent of earlier health controls at the Eastern borders of Germany at the turn of the 19th/20th centuries which included delousing, bodily disinfection and luggage inspection measures, see Weindling 2000, 3, 6ii, 59ii.

the Federal Health Council's plenary meeting on 29 June 1965 in the medical journal *Arbeitsmedizin*, P. Rosenberger argued against a special health threat emanating from the labour migrants. According to the findings of the Federal Health Council, no parasitic infections were significantly imported and spread by the incoming workers, and neither were venereal, skin and intestinal diseases. [33] Consequently, on 17 February 1967, the Federal Health Council voted that the health condition of the migrant workers was not significantly different from the one of the indigenous population so that no serious health threats arose out of the presence of 'foreign workers' for the German population (Rosenberger 1967, 196-199).

The fear of non-endemic, 'foreign' diseases being imported by the labour migrants also turned out to be unfounded, to the great surprise of those who had expected otherwise. In its annual 1965 report on the employment of 'foreign workers', the Federal Employment Service states that typical diseases of the Mediterranean (such as trachoma, malaria or oriental sore) were 'surprisingly rarely' observed in the context of the medical selection examinations conducted at the Employment Service's recruitment offices abroad (Bundesanstalt, *Erfahrungsbericht 1965*, 29). The author of a report on a conference for internal medicine in 1966 comments on a presentation about typically Mediterranean diseases among 'guest workers' in a similarly astonished way: 'First and foremost remarkable was the finding that a serious endangering of the indigenous population through the spread of 'foreign diseases' has not been observed so far and is not to be feared in the future', (Preuss 1966, 1070).

In contrast to 'foreign' diseases untypical for Germany, TB was identified as a significant health problem among the labour migrants. Analysing statistical material of the Stuttgart public health office, G. Neumann, medical director of the same office's tuberculosis department, pointed out the constantly higher TB incidence rate among non-natives in

[33] For the spread of non-endemic parasites intermediate hosts were missing in Germany due to different climatic conditions. For the feared spread of venereal and skin diseases by labour migrants no empirical proof existed, Rosenberger 1967, 197-198.

Stuttgart compared to the German population between 1968 and 1972 (Neumann 1973, 36). Hans-Joachim Schmoll from the Institute for Epidemiology and Social Medicine in Hannover even stated a 200 to 250% higher TB infection rate among labour migrants than among the national population (Schmoll 1973, 2280). The findings of company doctors added to this perception of a special TB risk among the migrant workers. According to a survey by the Association of German Company Doctors (*Verband Deutscher Werksärzte*) from November 1964, the TB incidence rate among labour migrants from Italy and Turkey lay far above the one of the German work force (with a 600% higher rate among Turkish workers and a 200% higher rate among Italian workers). [34]

Significantly, a representative survey by the Association of German Pension Insurance Institutions (*Verband Deutscher Rentenversicherungsträger*) from 1964 yielded that 7.5% of the newcomers fell ill with TB during the first five months after arrival whereas roughly 75% became infected after a one-year or longer stay in the Federal Republic. [35] Obviously, TB among labour migrants was less a problem of 'import' than a question of infection or exacerbation after arrival. This heightened affinity for TB infections among the labour migrants living in Germany was commonly explained by rather vague references to changes of climate, food, working and living conditions which the migration situation of the workers entailed; a racialising and depoliticising argumentation I will discuss in more detail in chapter 7.

[34] Ausführungen von Dr. A. Solbach, Werksarzt der Ford-Werke AG, Köln auf der Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und –fürsorge des Bundesgesundheitsrates in Bad Godesberg am 6. Mai 1966 (Commentary by Dr. A. Solbach, Company Doctor of the Ford-Werke AG, Cologne, at the Meeting of the Federal Health Council's Committees for Epidemic Control, Hygiene and Health Preservation in Bad Godesberg on 6 May 1966), BArch, B 149/22369.

[35] 'Die Tuberkulose bei Gastarbeitern vom klinischen Standpunkt aus gesehen, Referat von Medizinaldirektor Prof. Dr. Hein, Tönsheide, gehalten auf der Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und –fürsorge des Bundesgesundheitsrates in Bad Godesberg am 6. Mai 1966 (The Tuberculosis among Guest Workers from a Clinical Perspective, Presentation by Medical Director Prof. Dr. Hein, Tönsheide, at the Meeting of the Federal Health Council's Committees for Epidemic Control, Hygiene and Health Preservation in Bad Godesberg on 6 May 1966),' BArch, B 119/22369.

Although no empirical evidence could be found that labour migrants threatened the general health of the German population through large-scale import of diseases, this lack of 'empirical proof' did not lead to a critical reflection among health authorities on the strict health surveillance imposed on incoming migrants. Rather, the absence of an eruption of infectious diseases was self-evidently seen as a proof for the efficiency of the medical immigrant examinations both abroad at the recruitment offices as well as inside the country. [36] This deliberate interpretation of the empirical situation fed into a discourse which legitimised the stricter health control of non-native population groups by naturally attributing them a disease affinity higher than the one of national German population.

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Federal Germany's recruitment of migrant labour was not a mere institutional process guided by structural economic needs and political considerations on the level of the state. Rather, the recruitment was accompanied and shaped by multiple discourses unfolding in the overlapping realms of the public, the state and the economy. This chapter focused especially on two such discursive formations which undergirded the process of recruitment and the public perception of 'guest workers' in German society.

A common modernisation discourse of the time depicted the incoming labour migrants as essentially pre-modern, non-industrial and backward due to their attributed cultural and social otherness. This discursive theme stressed the migrants' need for discipline and

[36] Dr. Schuhmacher, a member of the Federal Health Council's committees for epidemic control, hygiene and health preservation, states: 'We have come to the conclusion that the existent regulations by the recruitment commissions abroad as well as the examinations of foreign guest workers at the local public health offices have proven sufficient to prevent the import of infectious diseases. This also holds true for contagious TB.' Niederschrift über die Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und -fürsorge des Bundesgesundheitsrates am 2. Dezember 1966 in Bad Godesberg (Protocol of the Meeting of the Federal Health Council's Committees for Epidemic Control, Hygiene and Health Preservation in Bad Godesberg on 2 Dec. 1966), BArch, B 149/22369. Unaware of the Federal Employment Service's statements on the extremely low incidences of 'Mediterranean diseases' among labour migrant applicants, G. Sedlaczek, a physician for internal medicine, argues that the medical examinations conducted at the recruitment offices abroad have prevented the eruption of 'specific diseases non-endemic to Middle-Europe', see Sedlaczek 1973, 32.

adaptation to industrial production processes as the only legitimate way of modernisation. The ascribed otherness of the migrant workers was further enhanced by medical discourses which described the migration process in essentially pathological terms. These discourses further contributed to the naturalisation of the migrants' assumed non-belonging, their being literarily 'out-of-place' in German society by declaring the 'foreignness' of the migrants as an inevitable cause for health problems.

It was this often stressed foreignness of the labour migrants which gave in turn rise to health concerns in the public realm as well as among the ministerial and health authorities. Although no empirical evidence for significant disease 'import' by labour migrants existed and statistics rather indicated major problems of TB infection among labour migrants who had stayed over a longer period in the Federal Republic, additional health surveillance measures were implemented during the early 1960s to control those labour migrants who were not officially recruited and medically selected at the recruitment offices abroad. Numerous newspaper articles, scientific articles in medical journals as well as health committee meetings discussing the health status of labour migrants are expressions of a heightened feeling of anxiety about the security of the state's health boundaries in the face of the greatest migration movement to the Federal Republic after WW II.

The modernisation and health discourses surrounding the recruitment of migrant workers from Turkey (and other recruitment countries) form part of the context within which the medical examinations at the recruitment offices in Turkey took shape. In the following chapter, I will focus in detail on the organisation of this medical selection process and the role of the recruitment offices as the site where these examinations were implemented.

6 The Organisation of Recruitment and the German Recruitment Offices in Turkey (1961-1973)

6.1. The Recruitment Process's Organisational Structure

From 1961 to 1973, 638,800 people from Turkey were sent to Germany via the federal Employment Service's recruitment offices (Bundesanstalt, *Erfahrungsbericht 1972/73*, 42). The organisation of a state-regulated labour migration of more than half a million people required an enormous organisational bureaucracy. In coordination, the Turkish Employment Service (*Türk İş ve İşçi Bulma Kurumu*) and the Federal Employment Service were responsible for the practical realisation and organisation of labour recruitment from Turkey. [37] The Turkish Employment Service had been founded in 1946 and by 1966 its local offices had been established in all provinces of the country (Eryılmaz 1998a, 101). [38] The Federal Employment Service had come into existence in 1952 as a continuation of the Imperial Institute for Labour Exchange and Unemployment Insurance before WW II (Pagenstecher 1994, 32). Despite its tripartite character (the Federal Employment Service is administratively, politically and legally subordinate to the Labour Ministry while both the Confederation of Employers and the Trade Union Federation are permanently represented in the Federal Employment Service's directorship), the Federal Employment Service was greatly prejudiced towards private and employer interests (Bendix 1990, 12, 75, 175). In its 1965 annual report on recruitment and employment of 'foreign employees', the Federal Employment Service frankly states that the realisation of labour recruitment from Mediterranean countries was foremost guided by economic interests, that is the compensation of the national economy's lack of domestic labour (Bundesanstalt, *Erfahrungsbericht 1965*, 9).

[37] Article 1., Turkish-German Agreement, Bundesanstalt, *Amtliche Nachrichten* 12 , 588.
[38] All page number references for this article refer to the German, not the Turkish version of the text.

The German recruitment office in Istanbul, which had been established in July 1961 while the drawing up of the recruitment agreement was still under way, functioned as a link between the Federal and the Turkish Employment Services (Bundesanstalt, *Erfahrungsbericht 1961*, 17). [39] As an extended arm of the Federal Employment Service in Turkey, it realised the selection of suitable labour migrant applicants in coordination with the Turkish Employment Service directly in the recruitment country. The recruitment office in Istanbul constituted the main gateway to Germany for potential labour migrants throughout recruitment between 1961 and 1973. However, a minor branch office was opened in Ankara in 1963 due to the rising applicant numbers which far exceeded the initially intentioned recruitment scope, but this second office was closed down in 1967 in the context of the economic recession in Germany and not reopened again during the following years (Bundesanstalt, *Erfahrungsbericht 1963*, 12 and ibid, *Erfahrungbericht 1967*, 24).

The recruitment process was centrally organised, that is every applicant had to pass through one of the recruitment offices either in Istanbul or Ankara before being sent to Germany (place of residence was decisive in whether the applicants were sent to the office in Istanbul or Ankara). [40] The recruitment was organised in chain-like order (for the following paragraph see Mattes 2005, 63-64, Eryılmaz 1998a, 106-107, 109-110). A German employer who intended to hire workers from Turkey sent a recruitment order to his or her local

[39] As Hunn points out, the early establishment of the recruitment office in Istanbul before the passing of a fully drawn-up bilateral agreement was an indicator of the provisional character the recruitment office was first meant to have and the minor role which the Federal Employment Service had initially attributed to Turkey as a recruitment country. The deliberate choice to name it 'German recruitment office' and not 'German Commission' as in the other recruitment countries Italy, Spain and Greece also alludes to the only small scope of workers which the Federal Employment Service had initially intended to recruit from Turkey, Hunn 2005, 53-54.

[40] All applicants from the European part of Turkey and the West Anatolian provinces up to Zonguldak and Antalya were sent to the Istanbul office; all other applicants from the provinces east of Zonguldak and Antalya were summoned to the office in Ankara before it was closed down in 1967, DVT, annual report 1966, BArch, B 119/3017. The principle of central recruitment was abandoned only under special circumstances as in the case of natural catastrophes or in cases of large orders for certain branches like mining or textile industry for which workers were usually recruited from the same area, DVT, annual report 1968, BArch, B 119/3018 and DVT, annual report 1970, BArch, B 119/3016.

employment office with detailed information concerning the amount, nationality, sex, age, occupational experience and health requirements of the workers needed. Two types of recruitment order existed: anonymous recruitment and recruitment by name in which case the employer recruited directly a certain person, usually a family member of a worker already employed. [41] In addition, the employer had to pay a fixed recruitment fee (150 DM per worker from Turkey until recruitment fees were increased in 1972 and 1973) covering costs for the workers' transport and catering during the journey to Germany. The local employment office checked whether the order violated the 'primacy of natives' rule and whether work and income conditions as well as provided lodging fulfilled the criteria defined by the recruitment agreement. If no objections were found, the recruitment order was then sent on to the recruitment office in Istanbul. The recruitment office transmitted the details of the order to the Turkish Employment Service's foreign department which in turn organised the sending of pre-registered contingents of applicants to the German recruitment offices. [42]

For the individual aspirants the procedure of application was full of obstacles to overcome: Turkish citizens interested in going to Germany as labour migrants first had to apply to their local office of the Turkish Employment Service. For registration, they had to give information concerning their occupation and occupational experience and hand in existent employment certificates and school reports. The official who carried out the registration furthermore had to pay attention that the applicants showed no obvious signs of

[41] In the case of Turkey, recruitment by name was restricted to immediate family members as requested by the Turkish government, *Magnet Bundesrepublik* 1966, 62. See also, Leitsätze für die Vermittlung ausländischer Arbeitnehmer aus der Türkei, Namentliches Auswahlverfahren (Principles for the Placement of Foreign Workers from Turkey, Selection Process for Recruitment by Name),' BArch, B 119/4145.

[42] The Turkish Employment Service's selection of applicant contingents to be sent to the German recruitment offices was guided by the principle of temporal order of application (those who had applied first were selected first) and by the applicant's place of origin (recruitment order from all regions of the country was proportional to the size of their populations), DVT, annual report 1970, BArch, B 119/3016. The selection principles of temporal order and place of origin were not applied to female candidates whose applications were forwarded straight away to the recruitment offices because of the high demand for female labour on the German labour market, Erdem and Mattes 2003, 173.

disability and did not exceed the required age limits (Eryılmaz 1998a, 103). [43] Female applicants younger than 18 years of age had to testify the consent of their parents to go and work in Germany just as married women had to bring a declaration of consent from their husbands (Eryılmaz 1998b, 134-136). [44] Male applicants first had to complete their military service before they were allowed to leave the country as labour migrants. [45] Furthermore, the Turkish Employment Service excluded all those applicants who had criminal records, showed an 'indecent way of clothing', were illiterate, drug addicts or deemed necessary for the development of the national industry (ibid, 105). Female applicants who had to care for too many small children were also to be excluded. [46]

After registration, applicants had to wait until a suitable job position in Germany became vacant before they were summoned via the Turkish Employment Service to the German recruitment office. This waiting period between initial registration and final selection at the German recruitment office lengthened steadily over the years. As demand for female and qualified workers remained constantly high, this was especially the case for unqualified male workers. [47] An effective way to jump the queue of waiting applicants was recruitment by name as it shortened the waiting period drastically. [48] Once summoned to the German

[43] Until 1966, age limits for registration were as follows: 45 for qualified workers, 45 for women, 35 for miners and 40 for unqualified workers. In 1966, they were changed to 40 for qualified workers and 30 for unqualified workers due to increasing waiting periods between registration and call for presentation at the recruitment office, Eryılmaz 1998a, 103.

[44] All page number references for this article refer to the German, not the Turkish version of the text.

[45] Auszugsweise Abschrift aus den Richtlinien der türkischen Arbeitsvermittlung für Auslandsvermittlungen vom 15.1.1964 (Extract from the Principles of the Turkish Employment Service for International Exchange from 15 Jan. 1964), attachment to a letter from Meier, DVT, to president of the BAVAV, Istanbul, 31 March 1964, BArch, B 119/3072.

[46] In 1965, the director of the German recruitment office asked the local offices of the Turkish Employment Service to send no longer female applicants with more than three children aged younger than ten, DVT, annual report 1965, BArch, B 119/3020. In 1966, this criterion was changed to four children aged younger than ten, DVT, annual report 1966, BArch, B 119/3017.

[47] By 1968 the waiting period for unqualified male workers was already 4 years; by 1971 it had amounted to 6 or 7 years, DVT, annual report 1968, BArch, B 119/3018; DVT, annual report 1971, DOMiD-Archiv, AR 162.

[48] Contradicting the stereotypical image of the male pioneer migrant, this tactic was used by many married couples. First the women, who because of the constant shortage of female labour were usually quickly recruited, went on their own to Germany and then organised for their husbands to be either recruited by name

recruitment office, the applicants had to undergo the final selection process consisting of the medical examination and – in case they applied as qualified workers – a vocational test. Only after passing these examinations, a labour contract was signed with the applicant. [49] The applicant had finally passed the last obstacle and the journey to Germany usually started only a few days later in the form of organised group transports by train or plane (Hoeschel 1973, 29, Bundesanstalt, *Erfahrungsbericht 1961*, 10, 18).

6.2. The German Recruitment Offices in Istanbul and Ankara

The recruitment office in Istanbul consisted of three main departments responsible for managing the complex task of recruiting workers from Turkey and placing them in suitable, vacant job positions in the German labour market: the administration, the job placement section and the medical service. The branch office in Ankara was similarly structured, consisting of a job placement section and the medical service. The staff members of the placement section assessed the vocational qualifications and preferences of the candidates and conducted the vocational tests for candidates applying as qualified workers. The medical service was responsible for the realisation of the medical examination. A thorough examination procedure consisting of a serological laboratory check of blood and urine samples, an x-ray examination of the lungs and a clinical group examination was to determine the applicants' medical suitability for the occupation which the placement section staff had chosen. The recruitment offices' staff consisted of German employees sent by the Federal Employment Service, who were primarily appointed to decision-making positions and consequently in charge of the proceedings at the office, and locally hired, mainly Turkish

via the same employer or to enter Germany via family reunification, Hunn 2005, 82; Erdem and Mattes 2003, 172.

[49] Article 6., Turkish-German Agreement, Bundesanstalt, *Amtliche Nachrichten* 12 , 589.

employees who were assigned to assistant jobs and translation work. [50] The clear-cut hierarchy between the German and the local staff also found expression in different salary sizes. [51]

The recruitment offices' organisational structure and the staff numbers were kept flexible so as to make the offices adaptable to fluctuations on the German labour market. Over the 12 years of its existence, the Istanbul recruitment office underwent a transformation from a minor office to a vast bureaucratic organisation. From 1961 until spring 1963, the recruitment office in Istanbul had a rather provisional character. Initially accommodated in a few rooms provided by the foreign department of the Turkish Employment Service in the city district Tophane, the office soon moved to a different location in the district Şişli where it remained located from 1962 to March 1963. [52] Significantly, the office space provided by the Turkish Employment Service during these initial years was too small to carry out the medical examinations within the office. Instead throughout 1961 and 1962, they had to be conducted externally in the Nişantaşı and Samatya Hospitals by the recruitment office's physicians (Bundesanstalt, *Erfahrungsbericht 1961*, 15 and ibid Erfahrungsbericht *1962*, 18). [53] It was not before spring 1963 when the recruitment office moved back to an enlarged office space in the Turkish Employment Service's foreign department building that the clinical examination of applicants could be fully realised within the office space. [54]

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[50] DVT, annual report 1966, BArch, B 119/3017; DVT, annual report 1969, BArch, B 119/3013.

[51] Interview with Bernd O., former doctor at recruitment office's radiology department from 1972-1973 (names of all interview partners changed).

[52] The recruitment office moved to Şişli in the first half of 1962, Bundesvereinigung der Deutschen Arbeitgeberverbände, Informationen aus dem Bereich der Arbeitsvermittlung und Arbeitslosenversicherung (Confederation of German Employers' Associations, Information from the Area of Job Placement and Unemployment Insurance), Cologne, 16 May 1962, BArch, B 119/3024. In March 1963, it moved back to Tophane, letter from Dr. Donath, DVT, to head physician, BAVAV, Istanbul, 3 April 1963.

[53] Also, Besprechungspunkte für Besprechung unter Generaldirektor Gökçedağ im Nov. 1961 in Istanb., Auswahluntersuchungen von türkischen Arbeitnehmern (Major Points for Discussion for the Meeting with General Director Gökçedağ in Nov. 1961 in Istanbul), BArch, B 119/4080; letter from Dr. König, DVT, to president of the BAVAV, Istanbul, 27 June 1962, BArch, B 119/4080.

[54] The enlargened office space in Tophane now included two examination rooms, a waiting and a changing room, Auszug aus Bericht d. Dt. Vst. Türkei (Extract from a Report of the German Recruitment Office in Turkey), 11

Recruitment increased steadily over the next years. In September 1963, the branch office in Ankara was opened to ease the work load of the main office in Istanbul. [55] Furthermore, due to the continuing rise in recruitment numbers (whereas in 1963 23,436 workers had been recruited, this number had mounted to 45,553 in 1965; Bundesanstalt, *Erfahrungsbericht 1963*, 12 and ibid *Erfahrungsbericht 1965*, 20), a second larger expansion of the Istanbul office took place in 1965 when 19 new rooms were added to the office space which now stretched over two floors of the Turkish Employment Service's foreign department building. [56] The expansion allowed for the recruitment office's own laboratory for serological tests to open and take up work in summer 1965 so that applicants no longer had to be sent to external institutions for their serological tests (Bundesanstalt, *Erfahrungsbericht 1965*, 30).

Still, with the exception of the recession years 1966/67 when staff and space were reduced to a minimum scale and the office in Ankara was permanently closed down in February 1967, [57] the spatial expansion could not keep up with the continually rising scope of recruitment. In May 1969, a separate building close to the recruitment office was rented for the medical service because the examination facilities had become insufficient for the constantly required employment of 13 physicians. [58] However, the limits of this added space were soon once more reached and in 1970, the recruitment office finally moved into a modern multi-floor apartment house in the district Mecidiyeköy which included a laboratory and a radiology department for the medical service as well as special rooms with machinery for

March 1963, BArch, B 119/4080. Only the clinical examination was conducted in the recruitment office, laboratory tests of blood and urine samples continued to be carried out externally until 1965 when the recruitment office opened its own laboratory and radiographs were even produced externally until November 1970 when the office's own radiology department was completed, Bundesanstalt, *Erfahrungsbericht 1965*, 30 and ibid *Erfahrungsbericht 1970*, 39.

[55] Letter from H. Meier, DVT, to president of the BAVAV, Istanbul, 15 Oct. 1963, BArch, B 119/3072.

[56] DVT, annual report 1965, BArch, B 119/3020.

[57] DVT, annual report 1967, BArch, B 119/3014.

[58] DVT, annual report 1969, BArch, B 119/3013.

vocational tests. [59] With the relocation of the recruitment office to Mecidiyeköy, all stages of the selection process at the recruitment office from vocational tests over laboratory tests and x-raying to the clinical examination had finally become united under a single roof and within one large bureaucratic procedure. The recruitment office remained in Mecidiyeköy until December 1975, although all recruitment processes were already stopped in November 1973. [60] As the office steadily expanded, the staff also grew significantly in number. Whereas in 1961 an annual average of only 9 persons was employed in the recruitment office, this number had increased to 68 by 1966 and 179 by 1973 (Bundesanstalt, *Erfahrungsbericht* 1961, 9 and ibid Erfahrungsbericht *1972/73*, 41). [61]

The selection process at the recruitment office consisted of various stages and lasted for several days. [62] First, the applicants underwent the job placement procedure in groups of 10 to 12 people. Their identity was controlled to prevent fraud and a reading test conducted to exclude illiterates. Afterwards, the placement staff interviewed the applicants to assess their occupational experiences and preferences. Those applying as qualified workers underwent an additional work skill assessment test for the verification of their qualifications. [63] Once the

[59] In June 1970, the recruitment office moved to Mecidiyeköy and the integrated radiology department took up work in November of the same year, DVT, annual report 1970, BArch, B 119/3016.

[60] This maintenance of the recruitment office past the recruitment stop was partly guided by the assumption that recruitment might be once more recommenced and partly by diplomatic concerns vis-a-vis the Turkish government, German Embassy in Istanbul to Federal Foreign Office in Bonn, Besetzung der Auslandsdienststellen der Bundesanstalt für Arbeit (Staffing of the Federal Employment Service's Foreign Offices), Istanbul-Tarabya, 25 July 1975, BArch, B 149/125833; German consul general in Istanbul to Federal Foreign Office in Bonn, 'Suspendierung' (Schließung) der Tätigkeit der Verbindungsstelle der Bundesanstalt für Arbeit in Istanbul ('Suspension' (Closure) of the Federal Employment Service's Recruitment Office's Activities in Istanbul), Istanbul, 26 Jan. 1976, BArch, B 149/125833.

[61] Also, DVT, annual report 1966, BArch, B 119/3017.

[62] The following description of the selection process is based on DVT, annual report 1969, BArch, B 119/3013; DVT, annual report 1970, BArch, B 119/3016; see also, Eryılmaz 1998a, 113ii.

[63] These vocational tests consisted of specific occupation related questions and work samples which were often conducted externally in work shops or on construction sites. However, once the recruitment office moved to the new location in Mecidiyeköy, a wide range of work samples could be practically realised with the work tools and machines available at the recruitment office. In fact, from 1970 onwards the recruitment office in Istanbul possessed the most elaborated work tool collection of all German recruitment offices abroad, DVT, annual report 1968, BArch, B 119/3018; DVT, annual report 1969, BArch, B 119/3013; Niederschrift über die Dienstbesprechung mit den Vermittlungsleitern der Auslandsdienststellen in der Verwaltungsschule Aalen vom 12.-13. Juli 1972 (Protocol of the Internal Meeting of the Foreign Offices' Placement Sections' Directors in

placement interview was over, the applicants were forwarded to the medical service where their suitability for the now envisaged occupation was to be medically evaluated. [64] Those who finally passed the medical examination were offered a labour contract, provided with a legitimation card and registered for group transport.

Rejection had severe consequences for the applicants' migration plans. Those qualified applicants who failed the vocational work skill tests had to restart their application from the very beginning, including a new waiting period because failure meant that they lost their place on the waiting list. They could not be placed as unqualified workers because the Turkish Employment Service prohibited such a procedure to prevent unqualified workers from reducing their waiting period simply by registering as much demanded skilled workers. [65] Those who were rejected in the medical selection also faced severe consequences. Only applicants with minor health problems deemed quickly curable or 'fixable', such as a head cold, dental problems or cystitis, had the chance to be re-examined within a few days. All those definitely rejected were registered as 'Z1-cases' in a special index card system which ensured that these applicants, in case they entered Germany via the Second or Third Way after rejection at the recruitment office, were once more examined for the registered health problem by the local employment office's medical service before being issued a labour permit. [66]

Aalen, 12 and 13 July 1972), BArch, B 119/4692. Sometimes, firm representatives were present at the job placement procedures to directly select their work candidates, DVT, annual report 1966, BArch, B 119/3017; DVT, annual report 1968, BArch, B 119/3018.

[64] From 1971 onwards, this order of procedure was slighly changed. As the medical rejection rate had nearly doubled in 1970 and mounted to 20%, the placement interview before the medical selection only aimed at a rough branch assignment whereas the finer choice of placement occurred after the medical selection. This newly adopted procedure was meant to prevent unnecessary job assignments for candidates later rejected in the medical examination, DVT, annual report 1971, DOMiD-Archiv AR 126.

[65] Leitsätze für die Vermittlung ausländischer Arbeitskräfte aus der Türkei, Allgemeine Auswahlkriterien (Principles for the Placement of Foreign Workers from Turkey, General Principles of Selection), BArch, B 119/4145; DVT, annual report 1971, DOMiD-Archiv AR 162.

[66] These examinations were conducted *in addition* to the obligatory medical examinations conducted by public health officers which migrants entering via the Second or Third Way had to undergo to obtain a residence permit. Whereas these examinations for the residence permit checked only for epidemiological health problems, the additional examination of Z1-candidates focused on occupational health questions before the issuing of a labour permit, RdErl. 265/63.1.3 'Durchführung des Ausländergenehmigungsverfahren; hier:

6.3. The Organisational Structure of the Medical Examination and the Medical Staff at the Recruitment Offices

The medical examination constituted a selection mechanism. Erich Hoeschel, who as the director of the Federal Employment Service's medical service had the supervision over the medical selection examinations in all of the German recruitment offices abroad, summarised the goals of the examination as follows:

> The aim of the medical examination is to ascertain the applicant's suitability for the envisaged occupation in Germany and to screen the general state of health in order to exclude especially infectious diseases (tuberculosis, syphilis etc.), but also chronic diseases and ailments (Hoeschel 1973, 28).

As this statement reveals, the medical examination had to combine aspects of both industrial medicine and public health immigration control to assess both the work suitability of the applicants from a medical perspective and to check their general health condition, especially under epidemiological aspects. The multiple aims of the medical selection process were shaped by various concerns with regard to the national economy, social service system and public health. As Hoeschel states:

> Of course, the Federal Employment Service's medical examination of foreign workers in the various recruitment countries primarily takes place to assess the work suitability. However, in the broadest sense of the meaning, the Federal Employment Service also assumes responsibility, which it cannot evade, towards the German social service. Concerning epidemiological regulations, a similar situation exists with regard to the general public because the foreign workers do not undergo a further medical examination according to federal regulations once they have entered Germany due to the fact that they have already been medically examined at the German recruitment offices. [67]

The medical examination consisted of three main parts: an analysis of a chest radiograph to check especially for TB, a serological test of blood and urine samples to check for infectious and chronic diseases and a clinical group examination to assess the applicants' general physical constitution. With the gradual expansion of the recruitment office over the

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Gesundheitliche Voraussetzungen' (Implementation of the Authorisation Process for Foreigners, concerning: Health Preconditions), Nuremberg, 20 June 1963, BArch, B 119/3350.

[67] Note, ÄD BAVAV, Ref. Dr. Hoeschel, Betr. Anwerbung und Vermittlung türkischer Arbeitnehmer (Concerning the Recruitment and Placement of Turkish Workers), Nuremberg, 2 March 1964, BArch, B 119/4080.

years, the control over the medical examination procedures moved increasingly into the hands of the office's medical staff. Initially, only the clinical examination had been firmly placed under 'German' control, although it had to be conducted externally at local hospitals during the first years both in Istanbul and Ankara until sufficient space in the offices was provided. [68] As the recruitment office in Istanbul opened its own laboratory not before mid-1965 and its own radiology department only in November 1970 after moving to the new recruitment office in Mecidiyeköy, laboratory and x-ray tests came only gradually under the supervision of the German recruitment staff. Beforehand, local hospitals, private institutes and the Society for the Fight against Tuberculosis had been contracted to implement these examinations; however, their task was reduced to the practical realisation of the tests whereas the medical recruitment staff remained responsible for the evaluation of the test results. [69]

The Federal Employment Service emphasised the necessity of the final medical evaluation to remain under firm German supervision. On a meeting of all recruitment offices' head physicians in 1960, Hoeschel firmly underlined this obligatory German control:

> The final selection must be in German hands. (…) The German doctor knows the work conditions in Germany; sometimes he even has first-hand knowledge of the envisaged or similar work places. After all, we check for suitability for specific occupations. (…) By conducting the final examination, the German doctor assumes responsibility for this suitability; he thus relieves the foreign doctor. He assumes responsibility towards the German factory and the German social service. [70]

Apparently, recruiting migrant workers was considered a risky endeavour for the German employers as well as the national social service and the responsibility to prevent any unwanted consequences was thought to be best entrusted to 'German hands'.

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[68] In the case of the office in Ankara, the examinations were initially conducted at the local Şifa Polyclinic, letter from H. Meier, DVT, to president of the BAVAV, Istanbul, 15 Oct. 1963, BArch, B 119/3072.

[69] The Society for the Fight against Tuberculosis was contracted in August 1965 for x-raying the applicants who underwent the examination at the recruitment office in Istanbul. With regard to the recruitment office in Ankara, the Society was charged both with the production of radiographs (from November 1965 onwards) and laboratory tests (from February 1966 onwards), DVT, annual report 1965, BArch, B 119/3020, and ibid annual report 1966, BArch, B 119/3017.

[70] Dienstbesprechung mit den Leitern der ärztlichen Dienststellen bei den Deutschen Kommissionen im Ausland am 6. und 7. 12.1960 in der Hauptstelle (Internal Meeting of the Head Physicians of the Medical Departments of the German Commissions Abroad on 6 and 7 Dec. 1960 at the Central Office), BArch, B 119/5057 (1).

Initially, as in most other German recruitment countries of the time, applicants were first medically examined at their place of residence by local Turkish physicians before they were sent to the recruitment office. The medical staff of the recruitment office in Istanbul then evaluated the applicants' health certificates issued by the Turkish physicians and selected only those applicants for personal presentation at the recruitment offices who according to their certificates seemed medically suitable (Bundesanstalt, *Erfahrungsbericht 1962*, 18). However, with the growing expansion of the recruitment offices, this medical pre-selection lost increasingly its significance. From August 1965 onwards, the recruitment offices' medical staff took no longer notice of the pre-selection results which the Federal Employment Service apparently did not consider to be a great loss (Bundesanstalt, *Erfahrungsbericht 1965*, 30). [71] As the Federal Employment Service's 1965 annual report states,

> As according to the experiences so far no significant advantage has been recognisable, the evaluation of the medical certificates issued by Turkish physicians in Anatolia has been given up from 1 August 1965 onwards so that from now on every Turkish applicant is directly summoned to the final medical selection in Istanbul or Ankara (ibid).

Similarly underlining the primary importance of the examination at the recruitment office, Hoeschel repeatedly emphasised that the pre-selection constituted only a 'crude selection' (*Grobauswahl* or *Grobsichtung*) in contrast to the 'meticulous selection' (*Feinauswahl*) at the recruitment offices (Höschel 1966, 143). [72] In March 1966, the Turkish Employment Service finally ordered the medical pre-selections by Turkish physicians to be abandoned. [73]

The gradual expansion of the recruitment office in Istanbul did not only enhance the control of the office's medical staff over the examination procedures, it also led to a growing rationalisation of the medical selection process which was shortened from three to two days

[71] Also, letter from Kemal Gökçedağ to Anton Sabel, Ankara, 6 May 1965, BArch B 119/4081.

[72] Also, note, ÄD BAVAV, Ref. Dr. Hoeschel, Nuremberg, 26 Nov. 1962, BArch, B 119/4080.

[73] Directorate-General of the Turkish Employment Service, Naki Tezel and Mukbil Birerçin, to T. Marquard, DVT, Ankara, 21 March 1966, BArch, B 119/3073. However, this order has apparently not been applied consequently. In 1968, local employment offices in several Turkish provinces reintroduced pre-examinations for candidates; however, the examination results were not taken note of by the recruitment office's medical staff, DVT, annual report 1968, BArch B 119/3018.

once the recruitment office's radiology department took up its work. [74] Still, being stretched over more than one day, the medical examination constituted the most time-consuming element of the whole recruitment process, an implicit indicator of its central role within recruitment. Significantly, the laboratory and x-ray tests had to be completed first so that the physician conducting the clinical examination could pass a final judgement with regard to the applicant's overall suitability. [75]

The physicians at the recruitment offices had to evaluate the suitability of the applicants on the basis of a list of general exclusion criteria which was issued by the medical service of the Federal Employment Service and compulsory for all German recruitment offices at the time. To be excluded were roughly three main categories of people: those with insufficient work capability, with infectious diseases and those considered to be a public charge. In detail, criteria for exclusion were the following: applicants with diseases and 'health disorders' preventing their suitability for the envisaged occupation; diseases/health disorders which negatively influence their socialising with other people (especially 'disgusting dermatological diseases', 'deformations', 'severe physical impairments' and 'mental diseases'); chronic diseases requiring constant medical treatment; all forms of TB, including latent forms of the disease, and other infectious diseases, especially venereal diseases and 'typically Mediterranean diseases' (leprosies, malaria, trachoma); all diseases likely to worsen under climate change and change of nutrition rendering the applicants either incapable of working or requiring constant medical treatment; reduced hearing and sight performance (categorical

[74] DVT, annual report 1968, BArch, B 119/3018; DVT, annual report 1970, BArch, B 119/3016.

[75] DVT, annual report 1965, BArch, B 119/3020; DVT, annual report 1970, BArch, B 119/3016. This order of procedure was reversed in Ankara in October 1966. By first conducting the clinical examination, the recruitment staff hoped to save additional costs because laboratory and x-ray tests would no longer be necessary for those candidates disqualified in the clinical examination, DVT, annual report 1966, BArch, B 119/3017. However, this reversed procedure was severely criticised by a member of the Federal Employment Service's medical service who in accordance with Hoeschel maintained that radiographs should be taken before the clinical examination so as to evaluate problematic lung results in the context of the clinical examination, letter from Dr. Reichel to Dr. Jantzen, Nuremberg, 20 April 1967, BArch B 119/4081.

rejection of one-eyed candidates) and carious or periodontal teeth. [76] As will become clear in more detail in the following chapter, these criteria reflect the social role envisaged for the recruited 'guest workers': they had to be industrious and able-bodied to contribute to the national wealth without becoming a burden on national social services and without posing a threat to the public health of the recruiting nation.

The medical rejection rate at the Turkish recruitment offices was usually above the average of the total rejection rates in all recruitment centres abroad. [77] Until 1970, it oscillated between 7-13%, after 1970 it jumped to 20% and remained similarly high with 18% (1972) and 17% (1973) until the recruitment stop. For miners, an occupation requiring strictest health standards, the rejection rate was even higher. [78] This oscillation of the rejection rate was dependent on multiple factors which can only partially be reconstructed. Apparently, the rejection rate bore a certain relation to the development of labour demand on the German labour market because the rejection rate often rose in years of great demand for migrant labour and high applicant numbers while dropping in years of lower demand and lower applicant numbers. [79] Also, changes within the examination procedure and staff changes might have had a profound influence on rejection rates. [80]

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[76] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058; Grundsätze über Art und Umfang der gesundheitlichen Auswahl von türkischen Arbeitnehmern, die sich aufgrund der Vereinbarung vom … um eine Tätigkeit in der Bundesrepublik bewerben (General Criteria Concerning the Method and Scope of the Medical Selection of Turkish Workers who on the Basis of the Agreement as from … Apply for an Occupation in the Federal Republic), BArch, B 119/ 22372.

[77] For the rejection rates in Turkey and the average rejection rates, see Bundesanstalt, *Erfahrungsbericht 1961*, 15; ibid *Erfahrungsbericht 1962*, 18; ibid *Erfahrungsbericht 1963*, 18; ibid *Erfahrungsbericht 1964*, 29; ibid *Erfahrungsbericht 1965*, 24; ibid *Erfahrungsbericht 1966*, 37; ibid *Erfahrungsbericht 1967*, 30; ibid *Erfahrungsbericht 1968*, 36, 38; ibid *Erfahrungsbericht 1969*, 36, 38; ibid *Erfahrungsbericht 1970*, 36, 39; ibid *Erfahrungsbericht 1971*, 47, 49; ibid *Erfahrungsbericht 1972/73*, 63, 64.

[78] For instance, in 1965 the rejection rate for miners was 26.54% (total rejection rate Turkey: 11.8%), in 1966 the miners' rejection rate was 25% (12.7%) and in 1969 16% (8.3%); DVT, annual report 1965, BArch, B 119/3020; DVT, annual report 1966, BArch, B 119/3017; DVT, annual report 1969, BArch, B 119/3013.

[79] For the development of German market's labour demand, see Bundesanstalt, *Erfahrungsbericht 1961*, 3, 7; ibid *Erfahrungsbericht 1962*, 5; ibid *Erfahrungsbericht 1963*, 3; ibid *Erfahrungsbericht 1964*, 4-5; ibid

The medical staff consisted of mainly male German physicians sent by the Federal Employment Service and predominantly female local Turkish employees working as assistants and translators. To a lesser extent, Turkish physicians were also employed in the recruitment offices in Istanbul and Ankara from 1964 onwards to ease the workload of the German physicians or to cover up for them in case of sickness or holiday leave (Bundesanstalt, *Erfahrungsbericht 1964*, 30). [81] However, apparently the German physicians' trust towards their Turkish colleagues was limited. In the 1970 annual report of the recruitment office, it is stated that the Turkish physicians employed by the recruitment office required 'strict and constant guidance concerning the examination procedures and the observance of the selection criteria'. [82]

With the exception of the recession years 1966/1967, the medical staff greatly increased over the years. Whereas both in Istanbul and Ankara directly after the opening of the offices only one physician respectively had been employed, by 1966 four to five doctors were constantly employed in Istanbul and two physicians in Ankara, among them one Turkish physician working in Istanbul and one in Ankara. [83] By 1969, a permanent staffing of 13 physicians was constantly on duty in the recruitment office including a head physician, ten examining physicians, a radiologist and a substitute to cover up for absences. [84] During the final years with rising female recruitment numbers, female German physicians were also

Erfahrungsbericht 1965, 4; ibid *1966*, 3-4; ibid *1967*, 3-4; ibid *1968*, 3; ibid *1969*, 3-4; ibid *1970*, 3; ibid *1971*, 3-4; ibid *Erfahrungsbericht 1972/73*, 3, 5.

[80] The opening of the recruitment office's own laboratory in 1965 resulted in higher rejection rates for pathological serological test results, just as the extreme jump of the rejection rate from 1970 to 1971 coincided with the opening of the recruitment office's radiology department and a shortening of the period for follow-up examinations for minor health problems from seven to three days; DVT, annual report 1965, BArch, B 119/3020; DVT, annual report 1971, DOMiD-Archiv AR 162. The sudden drop of the rejection rate in 1967 from 12.7% to 7.3% coincided both with economic recession and a change of the examining physician, DVT, annual report 1967, BArch, B 119/3014.

[81] The first Turkish physician to be employed at the recruitment office in Istanbul in 1964 was a former military doctor, letter from Dr. Reichel to Dr. Hoeschel, Istanbul, 2 May 1964, BArch, B 119/4080.

[82] DVT, annual report 1970, BArch, B 119/3016.

[83] DVT, annual report 1966, BArch, B 119/3017.

[84] DVT, annual report 1969, BArch, B 119/3013.

employed to conduct the main share of examinations of female applicants. [85] Also, from 1970 onwards, company doctors of the Ruhrkohle mining company were regularly sent from Germany to the recruitment office to oversee the examinations of their own mining candidates. [86]

Over the years, not only the staff size but also the staff profile changed significantly. Throughout most of the recruitment years, the medical personnel consisted of public health officers of the Federal Employment Service with training in industrial medicine and public health. However, during the 1970s due to increasing demand for medical personnel, the Federal Employment Service increasingly took to contracting young doctors who had just left university and not yet begun a specialist training. Being appointed for short one- or two-year periods, these young physicians, who came to represent the majority of the physicians during the 1970s, usually had no training in the field of industrial medicine, [87] a striking incidence with respect to the strong emphasis which the Federal Employment Service put on the occupational aspect of the medical examination. [88]

The parallel employment of on the one hand the Federal Employment Service's own fully trained and experienced public health officers and on the other hand young physicians who had only just graduated from university resulted in the formation of a medical team

[85] The employment of female physicians is mentioned by former physicians who were employed in the recruitment office during the 1970s. Interviews with Emil P. and Anton E., two former examining physicians who were employed at the recruitment office in Istanbul in 1973. The last director of the recruitment office in Istanbul from 1970 to 1975, also mentions a female Turkish gynaecologist conducting physical examinations of female applicants, interview by Cord Pagenstecher with Mader and von Harrasowski.

[86] DVT, annual report 1970, BArch, B 119/3016.

[87] DVT, annual report 1971, DOMiD-Archiv AR 162. Among those physicians contracted for short periods were also several refugees from the GDR who often had not yet established an occupational foundation in the Federal Republic and consequently went abroad for one or two years to financially bridge over their new beginning in West Germany, interview by Mathilde Jamin with a former female placement staff member of the recruitment office in Istanbul.

[88] In the Federal Employment Service's 1972/73 annual report on the recruitment and employment of 'foreign employees', it is stated that the 'medical selection of foreign workers has been conducted according to the criteria which have proven themselves over the years. Central to the medical selection is the applicants' aptitude in terms of their health status *for the envisaged occupation* on federal territory' (emphasis added), Bundesanstalt, *Annual report 1972/73*, 62.

which was greatly heterogeneous in character. A representative of the Federal Employment Service, who had the supervision over all German recruitment offices abroad from 1968 onwards, indicates that this heterogeneity of the medical team sometimes led to conflicts because the young physicians 'lacked a close affiliation' with the Employment Service in contrast to the Employment Service's own employees. [89] Similarly, Emil P., who worked as an examining physician in the recruitment office in 1973 shortly after his graduation from university and the completion of his internship as an assistant physician, reflects on the differences among the staff members by stating that 'two different worlds, two different world views' clashed in the medical team. [90]

This notion of 'differing world views' creating tensions within the medical staff can only be fully understood in the context of the generation change in the medical profession which took place in Federal Germany around the late 1960s and early 1970s. After WW II, the public health service in Federal Germany greatly lost significance and prestige vis-à-vis privately practicing physicians. Especially in financial terms a career as a public health officer was unattractive in comparison to a career as a private practitioner (Lindner 2004, 69-70). Emil P. recounts accordingly that during his university years in the late 1960s the public health service was a highly unpopular career option among university students because of the low salary sizes and loss of independence in comparison to the work of private practitioners. Jokingly, he remembers how public health positions were regarded as an option for 'losers only' among the medical students of his time. [91]

This unattractiveness of the public health service was furthermore related to the ideological generation conflict of the late 1960s. In the immediate post-WW II era, no critical reflection on the problematic role of public health institutions under National Socialism had

[89] Interview by Mathilde Jamin and Aytaç Eryılmaz with last director of recruitment office in Istanbul, former member of recruitment office's placement staff and a representative of the Federal Employment Service.
[90] Interview with Emil P.
[91] Interview with Emil P.

occurred. Leading public health representatives of the Federal Republic maintained the opinion that the public health service had lost none of its legitimacy and credibility during the Third Reich (ibid, 43 - 44, 63). In contrast, those young physicians at the recruitment office who were influenced by the ’68 movement and leftist politics came to associate especially the older-generation public health officers with reactionary policies and the problematic heritage of the German past. Emil P. points out how he and his young fellow colleagues at the office perceived the recruitment office’s head physician, who was a public health officer of the Federal Employment Service in near retirement age at the time, as a reactionary ‘hard liner’ with even fascist tendencies:

> I think he was fascist, well ‘fascist’ might be exaggerated, but he was reactionary, at least this is how we perceived him, that’s more correct; but we were all young and rather leftist, to us he was, to put it kindly, very conservative, but I’d rather say reactionary and a disguised Nazi, that’s more how we perceived him. [92]

No doubt, such perceptions and accusations must be carefully evaluated. Although this perception of the head physician in question was not only voiced by Emil P., [93] it is not the primary task of this thesis to analyse whether ‘disguised Nazis’ had indeed found their way into the recruitment office. What is remarkable about the quotation is the deeply felt generational and ideological difference within the medical team by one of its members. [94]

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[92] Interview with Emil P.

[93] A Turkish assistant working in the recruitment office’s medical service during the 1960s and 1970s makes a similar judgement about the public health officer in question, interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office’s medical service. The physician was even summoned to the state authorities in Ankara because of this accusation of a Nazi-past and consequently stripped off his residence permit in 1974. The last director of the recruitment office, however, firmly denied the accurateness of these accusations claiming them to be mere acts of defamation, interview by Mathilde Jamin and Aytaç Eryılmaz with last director of recruitment office in Istanbul, former member of recruitment office’s placement staff and a representative of the Federal Employment Service.

[94] However, the assumption of a certain affiliation of staff members with the era of National Socialism is not without foundation either. The careers of many public health officers during the Third Reich are marked by continuity in the post-WW II-era (Lindner 2004, 45-47). Also, the older-generation public health officers at the recruitment office are likely to have commenced or completed their medical training during the 1930s and 1940s. An existent connection to the Nazi-era is also implied by a certain familiarity with Nazi terminology on part of one examining physician at the recruitment office in Istanbul, who also held the position of the medical service’s head physician in 1970: In his report on a business trip to the recruitment office in Istanbul, a Siemens company doctor quotes how this public health officer characterises his medical team at the recruitment office as consisting of young inexperienced physicians of the type ‘Hitler Youth’ and more mature, experienced public

The question remains with what personal motivations and self-identifications the physicians took up their work at the recruitment offices. In the case of the older-generation public health officers, these self-understandings and motivations are very difficult to gauge because no first-hand oral memories exist and little can be gained in this aspect from the official documents of the time. However, the question can be more satisfyingly answered for at least some of the young physicians entering the medical team in the final years of recruitment. It was not a heightened responsibility with respect to the economic development of the nation or the protection of the national population's health what made the physicians whom I interviewed and who often did not feel attracted to a public health career join in the medical selection of labour migrants from Turkey. Rather, for them the incentive to work at the recruitment office primarily arose out of the promise of adventure, work experience abroad and the 'exoticism' of Istanbul and Turkey. As for the medical job itself, they perceived it as the unpleasant, but necessary 'price to pay'. Emil P. describes his occupational activities at the recruitment office as 'unattractive' because he had never intended to pursue a career as public or industrial health officer; for him the job itself 'was a means to an end to get out and go abroad'. [95] Similarly, Anton E., another former young member of the medical team who worked as an examining physician in the recruitment office in 1973 after the completion of his internship as an assistant physician, reveals that his motivation to work at the recruitment office stemmed from his desire to see and experience Istanbul: 'I found Istanbul exotic, the job less interesting, such a job would not have interested me at all.' [96] He also describes himself as being without 'emotional attachment' to the institution of the Federal

health officers of the type 'Volkssturm', Bericht des Dr. Schmidt über ein Gespräch mit der deutschen Verbindungsstelle in der Türkei (Dir. Henke) und Besuch in der ärztlichen Dienststelle des Bundesarbeitsamtes in Istanbul, Dr. Jansen (Dr. Schmidt's Report about a Conversation with the German Recruitment Office in Turkey (Director Henke) and a Visit to the Medical Service of the Federal Employment Service in Istanbul, Dr. Jansen), 3 Aug. 1970, SAA 10590.

[95] Interview with Emil P.

[96] Interview with Anton E.

Employment Service: 'I was not the advocate of the Federal Employment Service, I was under contractual obligation towards them but this played no role for me on-the-spot.' [97] In accordance with the statements of these two physicians, Bernd O., another former young member of the medical service who supervised the radiology department between 1972 and 1973, cites 'curiosity and adventurism' as the incentives for working at the recruitment office. As for the job itself, he experienced it as rather 'unsatisfying' in terms of its medical challenges. [98]

Such private interests as expressed by the former members of the medical selection team stand in stark contrast to the proud self-understanding of PHS officers at Ellis Island at the turn of the 19th/20th centuries who saw themselves as guardians against the nation's enemies in the form of 'disease and debility' (Kraut 1995, 57). Undoubtedly, the motivations of the physicians whom I interviewed cannot be treated as representative for all staff members. Emil P. indicates how especially the older-generation public health officers of the recruitment team saw it as their job to select only 'the best human work material' for the German economy, [99] an evaluation which sheds light on a possibly different self-understanding with regard to occupation and responsibility towards the nation. However, such reflections must remain hypothetical in want of first-hand personal narratives on part of the former public health officers themselves.

The physicians at the recruitment office and their assistants had to work under difficult work conditions. The increasing mass character of the examination meant that during the final years more than 600 people a day underwent the examination, so that a single physician had to examine 65 or more people per day (Bundesanstalt, *Erfahrungsbericht 1972/73*, 64). [100] Shift work, introduced in 1968 to manage the examinations of the rising numbers of

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[97] Ibid.
[98] Interview with Bernd O.
[99] Interview with Emil P.
[100] Also, DVT, annual report 1969, BArch, B 119/3013.

applicants, and continuous irregularities with water and electricity supply further added to these difficulties. [101] The physicians whom I interviewed also stressed the emotional strains of their work: Emil P. characterised his job at the recruitment office as 'emotionally burdensome', especially when it came to rejecting applicants who sometimes had waited for years for the appointment at the recruitment office and who had also become highly indebted to pay for the application procedure. Anton E. even states that he earnestly thought about quitting his job at the recruitment office shortly after arrival because he felt uneasy and unhappy about the rejections he had to make. [102]

For the young physicians who entered the recruitment office without training in public health and industrial medicine, no special introductory courses were provided, they usually had to cope with the situation in the form of 'learning by doing' as the only introduction consisted in accompanying an experienced physician for a few days to see how he proceeded in the examination. [103] However, Anton E. at least regarded the examination as a rather dull and low-demanding job and consequently did not consider this lack of prior experience as a problem:

> You know, what happens in such an examination in an employment office's medical service is an examination on the lowest possible level (…), an advanced university student of medicine could have done that, you didn't need immense experience for that, you didn't need a specialist for that. [104]

The list of criteria issued by the Federal Employment Service's medical service and existent work experience were the only guidelines for the physicians. Whereas for the evaluation of blood and urine samples norm values existed, the evaluation of the lung radiographs and the physical condition of the applicant depended largely on the personal evaluation of the physician. However, the discretionary powers physicians yielded in the

[101] DVT, annual report 1966, BArch, B 119/3017; DVT, annual report 1968, BArch, B 119/3018; DVT, annual report 1970, BArch, B 119/3016.
[102] Interviews with Emil P. and Anton E.
[103] Interviews with Emil P. and Anton E.
[104] Interview with Anton E.

context of the examination must be relativised with regard to the local conditions in which the examination took place. The physicians depended to a great extent on the mediation of their Turkish assistants who were young female graduates from the German School or St. George's Austrian High School in Istanbul and fluent in German. Although the physicians were responsible for the final evaluation, these assistants took part in the examination in multifold ways. They managed the applicants' files, conducted the pre-examinations (measuring weight, height and checking sight performance), prepared the applicants for the physician's examination by telling them to undress and get in a row and by keeping them disciplined throughout the examination (sometimes scolding and shouting at the applicants) and they acted as translators to ensure contact between the physicians and the applicants. [105] The memories of Emil P. even suggest that the assistants were not only responsible for managerial tasks, but also took actively part in judging the applicants' suitability for work in Germany.

> I learned most from her [meaning his assistant], this initial week in which I accompanied the physician has proven less fruitful for me compared to what she could tell me about the proceedings (…), she was very experienced, I think she could have done the whole examination without me, she didn't have the medical background, of course, but she knew what it was all about, she knew about the procedure, but also things like 'look doctor, this applicant and his desired occupation, that does not fit, what can we do about it?', she also participated in these kind of things, she also knew all the files, she knew exactly who was going to be recruited for what kind of job. [106]

Similarly, one assistant narrates how she as an experienced member of the medical service kept quarrelling with a physician newly arrived from Germany, who according to her opinion excluded many applicants by applying too strict criteria so that she finally felt compelled to complain about the said physician to the head physician. [107] Consequently, when analysing the immanent power relations of the medical examination, it is crucial to keep in mind that expertise was not the exclusive domain of the physicians who were foreigners

[105] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service; Interview with Emil P.

[106] Interview with Emil P.

[107] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service.

themselves in the country of recruitment and consequently needed the mediation and management on part of their local assistants.

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A vast organisational bureaucracy spanning Turkey and Federal Germany operated to realise the recruitment of migrant workers from Turkey for the German labour market. As this chapter has shown, the application procedure was far from easy for those interested in working in the Federal Republic. They had to overcome multiple hindrances and pass various selection stages among which the medical examination at the recruitment offices took a prominent place. The Federal Employment Service considered the examination an essential part of the recruitment procedure which necessarily had to rest under German control and supervision.

The significance of the medical examination is furthermore underlined by the great degree to which the outcome of the examination determined the fate of the applicants. It is this centrality of the examination to the whole recruitment apparatus which underscores the significance attributed to the labour migrant's body. In the following chapter, I will turn in detail to the question of the body by analysing the multifold conceptualisations of the labour migrant's body emerging in the context of the medical examination and the various power dynamics these conceptualisations entailed.

7 Logics of Inclusion, Exclusion and Risk Management: The Body of the Labour Migrant in the Medical Examination

7.1. Logic of Inclusion: the Labour Migrant's Body as an Industrious Machine

The assessment of the applicants' work aptitude to select suitable workers for the German economy was the primary aim of the examination. [108] As Hoeschel states,

> The determination of work suitability stands in the centre of the selection examination by the German physician. For that reason, the examination is specifically conducted with regard to the envisaged occupation (Höschel 1966, 143).

Although company doctors and local physicians in Germany often complained about too lax medical selection measures at the German recruitment offices abroad and kept asking for stricter and more nuanced examination procedures, [109] the medical examination was primarily not an exclusionary tool. It mostly worked as an instrument of inclusion to satisfy the economy's need for labour. A physician of the Federal Employment Service's medical service underscores this economically motivated inclusionary aim as follows,

> It would be going too far to exclude all possible health defects on the basis of certain idealistic criteria. The aim of delivering capable foreign workers to the German economy surely could not be achieved that way. [110]

If in the course of the examination applicants turned out to simply lack the physical suitability for the occupation for which they had initially been chosen by the recruitment office's placement section staff, rejections were not to take place. Rather, a renewed

[108] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058; Ref. Dr. Reichel to Labour Minister Baden-Württemberg, Nuremberg, 22 Sep. 1966, BArch, B 119/5058.

[109] Letter by Dr. Med. F. Germann to chairmen of AOK, IKK, BKK Zahnradfabrik Schwäbisch Gmünd, Schwäbisch Gmünd, 11 July 1966, BArch, B 119/5058; in his letter, Dr Germann complains about recurring incidences of spinal diseases among labour migrants and consequently urges for a stricter medical selection at the recruitment offices. Also, letter by Dr. Remler to Dr. Damm, Neu-Isenburg, 30 March 1969, BArch, B 119/5058; in his letter, Dr. Remler argues for the necessity of stricter eye examinations at the recruitment offices; see also Seidel 1966, 147.

[110] ÄD BAVAV to the president of the Regional Employment Office North Rhine-Westphalia, Nuremberg, 11 March 1965, BArch, B 119/5057 (2).

placement was to be achieved in accordance with the applicant's abilities. Hoeschel decidedly emphasises this regulation,

> If the specific suitability for the envisaged occupation is not existent, a rejection on health grounds does not necessarily occur; rather, a rejection takes only place if on the basis of general health reasons (according to the agreement with the sending country) suitability must be negated. [111]

This regulation of renewed placement in case of lacking work suitability for a specific occupation was also practically applied. Emil P. remembers how he and his colleagues tried to avoid rejections by asking the placement team for a revision of an applicant's planned occupation.

> In case there was a weakling of only 40kg who had been selected for mining or steelworks, we could say, 'well, that's not possible because he does not fulfil the physical pre-conditions, but in general he is healthy, he can go to Germany, however, he has to be assigned to a new job position, let's say hotel industry or dish washer or whatever', then this person would be send back to the placement section and it was their job to find something suitable. [112]

This practice of assigning new jobs to applicants deemed 'generally healthy' but unsuitable for a certain occupation was especially wide-spread for mining applicants, for instance in 1965, 20% and in 1966 even 41% of the rejected mining applicants were placed in another job position. [113] The explicit focus of the examination on work aptitude and suitable job placement underlines the examination's inclusionary logic. Being part of a recruitment process of foreign labour, the medical examination functioned primarily as an instrument for the production and incorporation of an importable able-bodied and industrious labour force, not as tool for immigration restriction.

It remains to be questioned, however, whether the clinical examination really fulfilled this aim of specifically selecting applicants according to the particular occupation they were supposed to carry out in Germany, as was claimed by representatives of the German

[111] Note, ÄD BAVAV, Ref. Hoeschel, Nuremberg, 29 Nov. 1962, BArch, B 119/3350.
[112] Interview with Emil P.
[113] DVT, annual report 1965, BArch B 119/3020; DVT, annual report 1966, BArch, B 119/3017.

Employment Service. The mass character of the examination, the often rather crude exclusion criteria (as in the case of operation or accident scars) combined with many physicians' lack of training in industrial medicine cast a doubtful light on this claim. Instead of specific occupational suitability, it was rather the general physical aptness of the applicants for industrial labour which the examination was designed to test for. This assessment of the candidates' general industrial fitness was primarily realised in the context of the clinical examination which was directed at the detection of physical disability and bodily anomaly among the applicants.

Reflecting the industrial requirement of able, normed and productive bodies, the whole structural organisation of the clinical examination was undergirded by a conceptualisation of the body as an industrious machine. Conducted in gender-segregated groups of 10 to 20 persons, the clinical examination had the character of a mass screening procedure. The applicants had to stand in a row, usually stripped naked to their underwear (women were often allowed to keep their bras on), sometimes with numbers written on their chests. [114] The logic of the clinical examination required the applicant's body to be broken down into its constitutive elements so that the physician could check one after the other for 'defects' and 'functional disorders' just like the various parts of a machine. The compulsory guidelines for the examination issued by the Federal Employment Service required of the physicians to systematically examine the functionality of the musculoskeletal system, the cardiovascular system, the respiration system, the sight and hearing performance and 'all other organ systems'. [115] This mechanical understanding of the body which informed the clinical examination is mirrored in Emil P.'s memories:

[114] Interviews with Emil P., Anton E., and the former labour migrants Ayla L., Ender A., Ülkü E.; see also Eryılmaz 1998a, 114-115.

[115] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria

> You had to check one organ system after the other, you went around auscultating everyone's heart, then you went around auscultating the lungs, then you looked into everybody's mouth, then into everyone's underpants, then you laid them down on the couch to look at the abdomen, you palpated to check for any enlargements of the organs or indurations or scars, if there were scars you asked 'why is there a scar, what has been operated', then you checked the skeletal system, the back, the legs etc. [116]

Anton E. describes a similar procedure

> A group of ten people always came into the examination room, they stood there stripped to the waist, dressed in their underpants; (…) like in a military medical screening procedure the people were auscultated for heart murmurs and cardiac defects or problems of the lung, they were measured, the assistant did that, their weight was registered, height was registered (…), sight performance was tested with and without glasses, of course, the throat was inspected, their ears were examined, many people's teeth were in an extremely bad state which had to be recorded, and then the people were put one after the other on the couch and their abdominal organs palpated; of course, in the context of the whole examination you had already noticed whether they had any skin diseases. [117]

The 'checklist' of organs to be examined was similar for men and women. However, differences existed with regard to the primary and secondary sexual organs. Whereas men had to undergo a quick check of their penis and testicles by the physician shortly looking into their underpants, women often had their breasts palpated for tumours. [118] Violating the applicants' feelings of privacy and intimacy, such group examinations of sexual organs were a sensitive issue, especially as many female applicants were examined by male physicians and male applicants underwent the examination while the female medical assistants often remained in the same room, simply turning their backs to the applicants. [119]

Some physicians also made the applicants perform gymnastic and coordination exercises such as standing on a single leg, touching the nose with closed eyes, bending the

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for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058.

[116] Interview with Emil P.

[117] Interview with Anton E.

[118] Interviews with Emil P., Anton E., and the former labour migrant Aliya K., see also Eryılmaz 1198a, 114-115.

[119] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service; interviews with Emil P., Anton E. The narratives of former applicants suggest that the detailed procedure of the examination varied over time. Some of the applicants I interviewed recounted being stripped to their underwear; whereas others pointed out that they were only bare-chested. Also, not all of the applicants to whom I talked remembered gymnastic exercises or numbers written on their chest.

knees or bending the back to touch the ground in order to detect irregularities and 'disorders' of movement, posture and the nervous system. [120] Commenting on these exercises, Anton E. states,

> They had to do knee bends; you know, when somebody is standing in front of you, you would never guess whether somebody has a restricted bending capability of the knees and of course they had to demonstrate flexing and stretching of the arm, that's also part of a physical examination; of course the body was closely looked at with all of your senses, you also had to check whether he has all ten fingers, whether he can clench his fist, whether he can stretch all ten fingers, whether he has a deficient bending capability. [121]

The quotation above as well as Anton E.'s former comparison of the clinical examination with 'military medical screening' procedures both make apparent how the evaluation of organic functionality and physical capabilities was inseparable from the attempt to detect those deemed physically disabled and deviant. A former labour migrant applicant's listing of rejection criteria neatly illustrates how work suitability and physical ability went hand in hand:

> For them [the recruitment office's staff] to reject you, you had to have missing fingers, an amputated arm, you had to be unable to work because of an organ defect; if you were blind, if you had lost a finger or an arm or whatever, they didn't want you. [122]

As the migrant workers were mainly recruited for manual, industrial labour, the medical selection was guided by the requirements of rationalised industrial production which necessitated that all forms of physical impairment and bodily deviance interfering with these requirements were excluded. In other words, the industrial imperatives of compulsory able-bodiedness and bodily normalcy pervaded the clinical examination leading to the rejection of all those applicants who violated these imperatives, thus physically homogenising those who were included. Limited sight performance, partial blindness, restricted flexibility of the major joints, stiff fingers, a 'reduced physical constitution', 'externally visible deformities of the

[120] Interview with Emil P.
[121] Interview with Anton E.
[122] Interview with the former labour migrant Arif E.

spine', operation scars, especially from abdominal operations, obesity, underweight and a short stature all severely restricted an applicants' likeability to count as 'suitable' for work in Germany. [123] The exclusion of candidates with such unwanted properties effectively meant the inclusion of those who fitted the ideal image of physically fit and industrious work machines.

The notion of bodily normalcy, which informed the clinical examination procedure, easily overlapped with concepts of race. Echoing racialist imaginations of what counts as a 'normal body', members of the Federal Employment Service often complained about the shorter stature of the 'Mediterranean', or specifically Turkish migrant workers which rendered suitable job placements for recruitment orders difficult. The federal employment office for Southern Bavaria remarked on the Istanbul recruitment office's problem to find suitable migrant workers for job positions requiring a minimum height of 170cm for men and 160cm for women as the 'population in Turkey is of an average shorter stature than the German one' (Mattes 2005, 77-78). Similarly, Hoeschel states that,

> Specific information [concerning the job requirements] is important because the population of the Mediterranean area is characterised by constitutional differences compared to the Central European, which, as in the case of shorter body and limbs proportions, can have disadvantageous effects on the work process. Difficulties once arose with the assignment of female Greeks to the textile industry; with their short stature and correspondingly short limbs they were unable to operate the existent machines (Hoeschel 1966, 143).

These argumentations are striking in how they cast imaginations of racial difference as a form of bodily deviance disadvantageous to industrial production. Race and disability become conflated as the migrant worker is compared with the neither raced nor disabled model 'Central European'.

Such discourses equating disability and racial difference make apparent the necessity to contextualise and historicise what is defined as 'bodily impairment'. The forms of bodily

[123] DVT, annual report 1971, DOMiD Archiv, AR 162.

impairment discussed above which disqualified the applicants from work in Germany should not be treated as unproblematic givens. In other words, the medical examination was not just a procedure of sifting out the obviously impaired from the able-bodied to exclude the former and include the latter. Rather, the clinical examination must be seen as the very momentum in which the definitions of bodily impairment and able-bodiedness were recast in accordance with the necessities of migrant labour in Germany.

Shelley Tremain criticises theoretical approaches differentiating between socially produced disability and biologically determined impairment which treat bodily impairment and in turn able-bodiedness as unquestioned natural givens. Combining disability theory with a Foucauldian framework of analysis, she regards impairment as not being external to processes of social construction. Rather ‘impaired subjectivies’ constitute a specific effect of knowledge-power-relations. Subjects are produced who 'have' impairments because this identity meets certain requirements of political, economic and social arrangements in a given socio-historical context (Tremain 2006, 185-186, 192). Tremain’s theoretical approach proves insightful for the case at hand. Patterns of inclusion and rejection in the clinical examination show how the production of the industrious, ‘able-bodied’ labour migrant necessitated in turn the definition of those, who were rejected because they did not fit the requirements, as ‘impaired’. An empirical case may illustrate how the process of applying as a labour migrant applicant turned individuals into impaired subjects.

The case of the former applicant R. S. is preserved in the archives because she objected to her initial rejection in the medical examination due to near blindness of the left eye. In 1964, she wrote a letter to Anton Sabel, the president of the Federal Employment Service, stating that she had been rejected by the recruitment staff because of an eye problem although she had been working without difficulties as a seamstress for ten years in Turkey. Arguing

that she was convinced of being able to do the same job in Germany, she asked for her case to be re-evaluated. [124] Upon that letter, she was indeed re-examined at the recruitment office in Ankara and the physician revised the initial evaluation by judging her capable of doing needle work as long as it was not 'too fine', because she had grown perfectly accustomed to the left eye's restricted sight performance over the years. However, the placement staff refused to accept her application arguing that no employer in Germany would hire her with such an eye condition. [125] A written reply simply informed R.S. that she could not be accepted because her eye sight was insufficient to practice the profession of a seamstress in Germany. [126]

The case above illustrates how an applicant's identity as being 'impaired' should not be treated as an unproblematic given. After working successfully for several years in her profession, R.S. rather became 'impaired' with regard to the specific labour requirements in Germany once she applied as a labour migrant. Furthermore, her designation as an impaired subject was contested within the recruitment staff and her final rejection did not occur because of her actual sight capabilities but because of the placement staff's assumption that nobody would ever employ her.

An applicant's likeliness to be rejected as 'impaired' was furthermore dependent on labour market demands in Germany. In case an employer wanted to recruit a specific migrant worker by name, less strict examination criteria were applied so that the applicant would be sent to Germany even if his or her bodily ability had been judged 'restricted'. However, such a relaxation of examination criteria only extended to questions of able-bodiedness; chronic or

[124] Letter from R.S. to Anton Sabel, 14 June 1964, BArch, B 119/4080.
[125] Letter from Dr. Reichel to president of the BAVAV, Istanbul, 10 Oct. 1964, BArch, B 119/4080.
[126] Letter from Dr. Reichel to R.S., Istanbul, 29 Sep. 1964.

infectious diseases posing a risk to the national social service and the health of the population still remained exclusionary factors for recruitments by name. [127]

The less qualified an applicant was, the more her or his body had to be 'impeccable', because the body constituted the unqualified worker's exclusive resource whereas qualified workers could offer their additional technical knowledge. The official guidelines for the recruitment of labour from Turkey explicitly state that a qualified candidate's vocational aptitude should be evaluated on the basis of work certificates and demonstrated practical abilities. In contrast, an unqualified applicant should be judged according to the placement staff's 'general impression of mental and physical ability'. [128] Just like applicants recruited by name, qualified applicants desperately needed on the German labour market were more likely to be accepted even if their physical ability had been judged to be 'restricted'. For instance, Hoeschel repeatedly argued that earlier abdominal operations categorically disqualified general applicants from recruitment whereas exceptions might be made for qualified or specialised workers difficult to recruit for the German economy. [129]

Empirical cases confirm that medical inclusion and exclusion patterns depended on the labour market's demands. The fact that the above related case of R.S.'s rejection was re-evaluated at all (albeit without success for the applicant) when several thousands of applicants were rejected each year, might have been due to her being a female qualified worker and therefore a member of an occupational category greatly needed on the German labour market. Another illuminating example is provided by the case of the former applicant Y.K. who

[127] DVT, annual report 1971, DOMiD Archiv, AR 162; letter from T. Marquard to president of the BAVAV, Istanbul, 23 May 1966, BArch, B 119/4081.

[128] Leitsätze für die Vermittlung ausländischer Arbeitnehmer aus der Türkei, Allgemeine Auswahlkriterien (Principles for the Placement of Foreign Workers from Turkey, General Principles of Selection), BArch, B 119/4145

[129] Letter from Dr. Hoeschel to Dr. Jantzen, Nuremberg, 26 April 1968, BArch, B 119/4082; Dienstbesprechung mit den Leitern der ärztlichen Dienststellen bei den Deutschen Kommissionen im Ausland am 6. und 7. 12.1960 in der Hauptstelle (Internal Meeting of the Head Physicians of the Medical Departments of the German Commissions Abroad on 6 and 7 Dec. 1960 at the Central Office), BArch, B 119/5057 (1).

underwent the examination in 1962. According to his medical certificate, the right hand had a missing phalanx which 'severely hinders the functionality' of the hand. Nevertheless, as a skilled carpenter, he passed the examination and was sent to Germany. [130] Especially insightful is the case of A.K., a skilled bricklayer, whose medical certificate states that he has a 'cleft palate'. According to the certificate this was not to be treated as a reason for exclusion because 'he is otherwise sturdy and bricklayers are much in demand'. [131] Problems arose once A.K. tried to have the cleft palate operated in Germany and his health insurance company, trying to avoid costs, claimed that he should never have been deemed suitable for work in Germany because of the cleft palate. [132] An incidence which once more underlines how what counts as 'impairment' is negotiated within a field of multiple interests and conditions.

Federal Germany's recruitment of migrant labour was set against the background of a clear-cut division between male and female industrial occupations which entailed a distinct salary hierarchy because the majority of female workers were structurally restricted to low income occupations (Mattes 2005, 11). This segregation of the labour market was based on the notion of men as the primary bread winners and women as only additional wage earners whose main occupation lay in the domestic sphere (ibid, 10, 15). The model of the 'guest worker' corresponded to these gender-specific notions of occupation. It cast the migrant labourer as the typically male and mobile bread winner who works in the Federal Republic while his wife either remains in the home country to look after the family or enters Germany as the passive companion of her economically active husband via family reunification (ibid, 10, Erdem and Mattes 2003, 167). Such a definition of labour migration as an essentially male

[130] Duplicate, medical examination report for the recruitment of Turkish workers for the Federal Republic of Germany, 22 Sep. 1962, BArch, B 119/4080.

[131] Duplicate, medical examination report for the recruitment of Turkish workers for the Federal Republic of Germany, 28 March 1963, BArch, B 119/4080.

[132] AOK Pforzheim to BAVAV, Pforzheim, 8 July 1963, BArch, B 119/4080.

domain ran counter to the actual employment of female labour migrants who often also acted as pioneers in levelling the migration path for their husbands (Erdem and Mattes 2003, 172).

Despite the male-oriented language of the recruitment agreement, [133] female labour migrants had privileged access to the German labour market because their waiting periods were much shorter than those for most male applicants due to the severe labour demand in female work branches. However, such privileged access required that female migrants complied with the model of the essentially mobile labour migrant. Unlike male applicants, women who were considered to have 'many children' were disqualified from application, a regulation which underscored the primary association of women with the domestic sphere. [134] It was also this notion of the model migrant and the emphasis on mobility it entailed which rendered pregnant women quasi-disabled in the eyes of the Federal Employment Service and consequently excludable (Hoeschel 1966, 144, Mattes 2005, 115ii). [135]

Not only the preconditions for application, but the very process of recruitment itself followed certain gender conceptualisations which structured the labour market around essentialist notions of the fundamental difference between male and female bodies. According to the Federal Employment Service, women were naturally more predisposed than men for physically light and filigree work requiring dexterity and nimbleness (Bundesanstalt, *Erfahrungsbericht 1971*, 19). In his textbook Koelsch argues similarly, stating that women, whose 'delicate and fragile' bodies render them primarily suitable for reproduction and less for physical labour in contrast to men, are 'from the outset more suitable than men' for

[133] See German-Turkish recruitment agreement, 31 Oct. 1961, Bundesanstalt, *Amtliche Nachrichten* 12, 588-592, the agreement refers consequently to the labour migrant as male.
[134] See chapter 6.
[135] Also, Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058.

filigree work necessitating nimbleness (Koelsch 1963, 36, 46). Due to the assumed aptness of female workers to do fine-motor and meticulous work, which in analogy with stereotypical notions of femininity was based on the imagination of female bodies as being essentially more delicate and graceful than men's bodies, female migrant workers were primarily recruited for precision work in the electronics industry as well as for textile and food industry jobs (Mattes 2005, 75-76, Bundesanstalt, *Erfahrungsbericht 1971*, 19-20).

The various stages of the selection process at the recruitment office had to produce a workforce which corresponded to these gendered expectations of work aptness. The evaluation of female dexterity and fine-motor skills was not restricted to the clinical examination, rather the boundaries between clinical examination and work skill assessment overlapped in this respect. Just as the gaze of the physician had to evaluate the applicant's physical condition in search for impairments on the applicant's body, so was the evaluation of women's work ability judged through observation by placement staff and firm representatives: According to the 1969 annual report of the recruitment office, the evaluation of female work suitability should be based on 'outward appearance' and 'dexterity of the fingers'. [136] The memories of two former female labour migrants underline how specific attention was paid to the slimness and nimbleness of their fingers during job placement interviews. Emel L., who was recruited for Siemens in 1965, recounts how Siemens representatives during the selection process in Istanbul tested her finger and hand movements through work samples and how she was selected for meticulous assembling work due to her great dexterity and experience as a seamstress. [137] In contrast, Ümit R., who was also recruited for Siemens in 1970, narrates how she was initially rejected for precision work by Siemens

[136] DVT, annual report 1969, BArch, B 119-3013.
[137] Interview with Emel L.

representatives because of her 'rough and big hands' and instead recruited for less meticulous assembly line work at a Siemens factory. [138]

Whereas women were preferably recruited for work requiring 'female abilities' such as deftness and fine-motor skills, men were predominantly selected for the 'male domain' of physically hard labour such as mining or construction work (Mattes 2005, 75-76; Hunn 2005, 214; Paine 1974, 90-91). Consequently, the bodies of men were searched during the clinical examination and the placement interrogation for signs of strength, powerful stature and hard labour. Emil P. recounts how he used to shake the hands of male applicants during the examination to get an impression of their physical strength. [139] Similarly conceptualising the applicants' hands as testifiers of their work suitability, the placement staff checked especially the mining applicants' hands for calluses and traces of hard labour and mining experience. [140] The same method was used by the examining physicians to detect the applicants' aptness for strenuous labour. Arif E., who applied for work in Germany as a welder, relates that during his clinical examination the doctor went around examining hands to check whether these were 'callused and rough' or 'soft and smooth', thereby evaluating the applicants' work experience and likeliness to stand hard physical labour. [141]

As the examination procedures and recruitment preferences discussed above illustrate, the medical examination at the recruitment office did not only serve the creation of an able-bodied, productive labour force; rather, the able and industrious bodies emerging from the examination were gendered in character. Judith Butler's concept of 'performativity' proves especially helpful to make sense of this process of gendered body formation. Contrary to stable notions of gender and sex which interpret gender as the 'cultural inscription of

[138] Interview with Ümit R.
[139] Interview with Emil P.
[140] Interview by Aytaç Eryılmaz with former male assistant and female employee of the recruitment office in Istanbul.
[141] Interview with Arif E.

meaning' on a pregiven biological sex (Butler 2010, 10), Butler argues that sex 'has always already been gender' because our cultural understanding of the material body is gendered itself (ibid, 10-11). As Butler states, 'bodies cannot be said to have a signifiable existence prior to the mark of their gender'; they 'come into being in and through the marks of gender' (ibid, 12). More specifically, the materialisation of the body and our gendered conceptualisation of this materiality are the results of performative and repetitive acts which produce the regulatory gender norms through which we come to take the duality of sex as a biological given:

> Gender is the repeated stylisation of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being (ibid, 45).

Thus, gender creates 'the very identity it is purported to be' through endless acts of repetition (ibid, 34). It produces what is culturally and socially expected through this very act of anticipation: 'gender operates as an expectation that produces the very phenomenon it anticipates' (ibid, 45).

I take the selection process at the recruitment office to constitute a significant site for such performative creation of gendered bodies. The examination sought to detect in the applicants' bodies the very attributes of femininity and masculinity which it had priorly ascribed to them, thereby producing the gendered materiality of bodies it had anticipated. Male labour migrants fulfilled the role of strong, muscular hard-working labourers because they had been selected as such and female labour migrants fitted the image of the nimble-fingered, deft precision worker because they had been examined and recruited with regard to these requirements. Consequently, the selection procedures at the recruitment offices contributed to the production of gender norms. They reinforced existing hegemonic notions of what constitutes a genuinely male or female body, thus reproducing the gender-segregated character of the labour market.

Designed for the inclusion of able, industrious working bodies in accordance with the requirements of a gender-segregated labour market, the clinical examination exerted a normalising and disciplinary effect on the applicants' bodies. This disciplinary effect was realised through the objectifying gaze of the physician, the asymmetrical distribution of visibility which created a clear-cut hierarchy between the half-naked applicants and the examining medical staff, and the group character of the examination. [142] The applicants' visibility which exposed them to the judging gaze and touch of the doctor was often further enhanced by numbers written on their bare chests. Marking each of the applicants as a single case in a row, as an analysable and describable object, these numbers aimed at the subjection of the applicants' bodies through objectification and individualisation. In addition, the numbers contributed to what Foucault calls disciplinary power's 'principle of partitioning' (Foucault 1995, 143). Introducing a system of sorting and order, these numbers together with the groups' arrangement in a row broke down the mass of applicants into individuals each occupying her or his assigned place. Furthermore, these numbers constituted a mark of identification to prevent confusion and fraud, thereby allowing the supervision of each applicant and of the group's mobility as a whole.

Also, the motive to conduct the examination in groups was not simply the result of an efficiency calculation; it was rather the expression of a distinct strategy of disciplinary power. Establishing a normalising system of comparison, the group examination allowed the physician to detect 'bodily anomalies' more easily through direct comparison of the applicants' body features. A member of the Federal Employment Service's medical service commented on the method of group examination as follows: 'This method has proven to be

[142] The following analysis follows Foucault's description of the examination as a technique of disciplinary power, see Foucault 1995, 184ii, Dreyfus and Rabinow 1983, 158.

practical because better opportunities for comparison exist in a group to detect bodily defects (…).' [143] Emil P. further elaborates on this examination principle:

> You didn't proceed by first examining completely one applicant and then the second one, no; you always checked the whole group for one organ system and then the whole group for the next organ system etc. (…). This is a common principle of industrial medicine to compare by looking at, let's say the skeletal system or the musculature or the back of all applicants at the same time. (…) Like with the military medical examinations at the *Bundeswehr* (the Federal Armed Forces), it is intentional to have several people standing next to each other to compare them, to better see the differences than when you look at only one person. [144]

The repeatedly stated comparison with military medical examinations is not accidental. Similar to a military environment, the clinical examination aimed at creating disciplined, docile bodies by combining normalising judgement and hierarchical observation within an established system of comparison. In the clinical examination, knowledge of bodies and power exercised over bodies combined to divide those applicants deemed 'suitable' from those considered 'unsuitable'. Thus, the homogenisation of the labour migrant's body according to the model of the 'industrious machine' was not achieved through training over time, but through the strategy of division and selective inclusion.

Garland Thomson has pointed out how women and the disabled as the archetypical signifiers of the body are especially subjected to bodily disciplinarisation and surveillance (Garland Thomson 2006, 262). As the spatial and structural organisation of the clinical examination makes apparent, the labour migrant, recruited primarily for her or his pure bodily abilities, was similarly exposed to intense disciplinarisation. This disciplinary effect of the clinical examination was in line with the contemporary modernisation discourse stressing the necessity for the Mediterranean, rural labour migrant to adapt to the modern rhythms and discipline of industrial production in Germany.

[143] Ref. Dr. Reichel to Ministry of Labour Baden-Württemberg, Nuremberg, 22 Sep. 1966, BArch, B 119, 5058.
[144] Interview with Emil P.

Borrowing from Foucault, Amy Fairchild has argued that the structure and organisation of the medical immigration inspections at the great U.S. ports aimed at the immigrants' disciplinarisation through their inculcation of industrial values right at the border of the US. A major element of this inculcation process was the medical immigrant inspection's organisation according to the principle of factory-line mass processing (Fairchild 2003, 7, 15-16). A similar argument can be made for the case of the clinical examination at the recruitment offices. Staff members as well as external visitors of the recruitment office kept underlining the recruitment process's similarities with modern factory procedures. A newspaper article from 1973 comments on the serological tests at the recruitment office by stating that 'the drawing of blood in the laboratory proceeds like on the assembly line' and a Siemens company doctor visiting the recruitment office in 1970 remarks in nearly identical terms that 'the necessary blood samples are taken like on the assembly line' (Endstation Sehnsucht 1973, 19). [145] A further analogy with mechanised work processes was drawn by physicians from the Ruhrkohle mining company stationed at the recruitment office in the 1970s who, according to the recruitment office's last director, described the office's medical staff as 'working like automats' to keep up with the immense applicant numbers. [146] Perhaps the most obvious comparison between factory processes and the recruitment office's organisational structure stems from one of the Istanbul recruitment office's physicians. Complaining about much fewer staff in the medical service than in the placement section leading to slowed-down recruitment, he requests additional personnel from the Employment Service because 'at assembly line work the adjacent link must never be weaker than the

[145] Bericht des Dr. Schmidt über ein Gespräch mit der deutschen Verbindungsstelle in der Türkei (Dir. Henke) und Besuch in der ärztlichen Dienststelle des Bundesarbeitsamtes in Istanbul, Dr. Jansen (Dr. Schmidt's Report about a Conversation with the German Recruitment Office in Turkey (Director Henke) and a Visit to the Medical Service of the Federal Employment Service in Istanbul, Dr. Jansen), 3 Aug. 1970, SAA 10590.

[146] Interview by Mathilde Jamin and Aytaç Eryılmaz with last director of recruitment office in Istanbul, former member of recruitment office's placement staff and a representative of the Federal Employment Service.

preceding one'. [147] Echoing contemporary notions of progress and modernisation, a former Turkish assistant even goes so far as to depict working at the recruitment office as a process of adaptation to the modern values of efficiency and rationality. According to him, the years spent at the recruitment office first introduced the Turkish staff members to the systematics and efficiency of late 20th century bureaucracy lacking in Turkish bureaucratic institutions. [148]

In consideration of contemporary discourses which presented the labour migrant as somebody who had to undergo a process of modernisation through the internalisation of industrial work discipline and production modes, the close affinity between the recruitment process and industrial mass processing methods must not be regarded as arbitrary. Rather, this affinity points out how the selection process and especially the moment of the medical examination constituted an initiation rite for the inculcation of industrial values such as discipline, efficiency, rationality and normativity. Such inculcation was achieved both through the organisational structure of the medical examination and the purposeful construction of the applicant's body in analogy with an industrious machine during the examination. The medical examination taught the applicants that their bodies both had to represent and internalise the imperatives of industrial production if they wanted to pass on to Germany as labour migrants. Therefore, the examination marks a zone of liminality for the transformation of applicants into labour migrants; [149] it delineates the very moment in which the labour migrant was created.

[147] Letter from Dr. Jantzen to Dr. Hoeschel, Istanbul, 7 Feb. 1968, BArch, B 119/4082.
[148] Interview by Aytaç Eryılmaz with former male assistant and female employee of the recruitment office in Istanbul.
[149] The term 'liminality' was coined by Victor Turner to describe phases of transition. Following Van Gennep's division of human rituals into three successive stages, separation, margin, aggregation (1909), Turner has especially elaborated on the marginal or liminal stage as he prefers to call it. This liminal phase is characterised by a process of transition or transformation between two different conditional states in life, V. Turner 1964.

7.2. Logic of Exclusion: the Labour Migrant's Body as a Potential Carrier of Disease

The second aim of the medical examination was to assess the general health status of the labour migrants - especially under epidemiological aspects - before they entered West German territory. Although a similar medical examination was conducted in all of the countries which had signed a recruitment agreement with Germany during the 1950s and 1960s, the article Nr. 5 of the German-Turkish Recruitment Agreement varied in terms of the health regulations from previous and subsequent agreements. Due to insistence of the German Ministry for Interior Affairs, the article text was changed. It explicitly states that the medical examination should evaluate the 'health suitability for residence in Federal Germany' in addition to health suitability for work, [150] whereas the analogous formulation in the other agreement texts only requested a suitable health condition for the work offered. The only exception in this aspect was the recruitment agreement with Tunisia which also explicitly required 'health suitability' as a precondition for residence (Jamin 1998a, 72-73). Apparently, the recruitment countries' various populations were not regarded as equal with regard to potential health threats. Rather, the labour migrants from Turkey (along with those from Tunisia) were perceived as a special danger to the health of the national German population.

It is tempting to simply trace back this discriminatory focus on labour migrants from Turkey to their Islamic identity. However, as Hunn emphasises, such an anachronistic argumentation overlooks how the public perception of Islam as *the* marker of difference of Turkish migrants in Germany arose out of the social and economic situation of the 1970s and 1980s, whereas during the 1960s neither Islam nor Islamic hygienic regulations carried wide-spread pejorative connotations in the German public (Hunn 2005, 32, 46, 139). The case of the Hamburg health authority, which in 1971 requested that Muslim labour migrants be

[150] Article 5., Turkish-German Recruitment Agreement, 30 Oct. 1961, Bundesanstalt, *Amtliche Nachrichten* 12, 589.

banned from employment in the food industry because of their 'unhygienic toilet habits', remained a significant, albeit drastic, exception (ibid, 139). [151] Reacting to this request, the Federal Employment Service pointed immediately out that it did not consider such singular concerns as a reason to change its recruitment and examination patterns. [152] However, although prejudices against Islam may not have played a significant role in shaping the form of the recruitment agreement, the distinct singling out of Turkey and Tunisia with regard to health regulations indicates a heightened perception of 'foreignness' with respect to the geographically most remote, 'non-European' recruitment countries which in turn found expression in an enhanced association of the migrants from these countries with disease and health threats.

As an instrument for controlling the general health status of the labour migrant, the medical examination came to play its role as a security instrument to protect and maintain the Federal Republic's health boundaries. Whereas the assessment of work suitability was guided by the inclusionary motive to create an importable, productive labour force, the evaluation of the applicants' general health status followed an exclusionary logic as it aimed at protecting the national population and the National Health Service against the import of contagious and economically burdensome chronic diseases. The high rejection rates due to suspected diseases underline this exclusionary potential of the examination: Throughout the 1960s, pathological lung x-rays remained the main reason for rejection, usually because of suspected TB. From 1971 to 1973, pathological serological values indicating possible chronic diseases or

[151] Ref. Dr. Schumacher, Federal Ministry for Youth, Family and Health to Supreme Federal State Health Authorities, Bad Godesberg, 2 June 1971, BArch, B 119/4083.

[152] The Federal Employment Service made it clear that it would not refuse to recruit Muslim labour migrants if these were requested by firms in the food industry. Furthermore, it pointed out that it was not the aim of the medical examination to check for 'habits spreading disease', ibid.

infectious diseases such as for example diabetes, hypertonia, hepatitis or syphilis became the main reason for rejection closely followed by pathological lung x-ray results. [153]

By restricting the entrance of labour migrants deemed likely to pose a health threat to the nation or to become an economic burden, the physicians at the recruitment office assumed the role of gatekeepers who guarded and maintained the health boundaries of the Federal Republic. As Heinz Seidel, the supervisor for all recruitment offices from 1968 onwards, put it: the medical examination was a 'pre-condition for the residence permit', consequently certain 'standards for the examination' were necessary. [154] In other words, the physicians had to make sure that no labour migrant entering Germany violated the article of the recruitment agreement requesting a suitable health condition for residence. Dr. Kästner, a representative of the Federal Employment Service's medical service, especially emphasises this gate-keeping role of the medical examination in protecting the public health of the population:

> This examination [meaning the medical examination by public health authorities in Germany for labour migrants entering via the Second or Third Way] is rendered unnecessary for the foreign workers recruited by the German commissions and recruitment offices abroad for the sole reason that the Federal Employment Service has taken it upon itself to implement a medical examination by German physicians during the recruitment process. Thereby, the Federal Employment Service assumes responsibility not only towards the company for which it has to recruit foreign workers suitable for work, but also towards the health sector and the government departments concerned with public health as well as towards the German public. [155]

This perception of the physicians as guardians of the nation's health boundaries did not remain restricted to the higher institutional levels of the Federal Employment Service. Commenting on his work responsibility, Emil P. points out how he had to consider public health interests with regard to the national population, the labour market and the social service system when conducting the medical selection:

[153] Bundesanstalt, *Erfahrungsbericht 1961*, 15; ibid *Erfahrungsbericht 1962*, 18; ibid *Erfahrungsbericht 1963*, 18; ibid *Erfahrungsbericht 1964*, 29; ibid *Erfahrungsbericht 1965*, 24; ibid *Erfahrungsbericht 1966*, 37; ibid *Erfahrungsbericht 1967*, 30; ibid *Erfahrungsbericht 1968*, 36, 38; ibid *Erfahrungsbericht 1969*, 36, 38; ibid *Erfahrungsbericht 1970*, 36, 39; ibid *Erfahrungsbericht 1971*, 47, 49; ibid *Erfahrungsbericht 1972/73*, 63, 64.

[154] Quotation is taken from the documentary film 'Der Rote Teppich'.

[155] ÄD BAVAV to DVT, Nuremberg, 25 Nov 1965, BArch, B 119/4081.

> They [the applicants] were not recruited if they had severe contagious diseases, or severe diseases requiring early retirement in Germany, that was in the interest of the German people, so to speak, and you had to respect that, I mean that was our job, to choose the applicants for the sake of the protection of employees and employers in such a way as to prevent complications and conflicts of interests. [156]

In consideration of the examination's security function, it is not sufficient to characterise the medical selection solely as an instrument of disciplinary power. According to Foucault, security apparatuses constitute a crucial element of bio-political power regimes because they are exercised over a whole population (Foucault 2007, 11). Security apparatuses manage the population and its biological qualities through a regulation of circulation which aims at identifying and eliminating 'dangerous' elements of circulation while allowing the movement of 'good' elements (ibid, 18). In its desire to assess the applicants' general health status, the medical examination emerges as such a bio-political space of security which was directed at regulating, controlling and safeguarding the health of the total German population by identifying and excluding 'dangerous' diseased bodies from entering the territory of the Federal Republic while allowing the migration of 'normal' healthy bodies.

Thus, a different conceptualisation of the body becomes evident in the context of this bio-political dimension of the medical examination. The body was no longer conceptualised as a productive machine; it was now imagined as a primarily dangerous entity because of its potentiality to carry disease. Starting from this initial assumption of general danger, the task of the medical examination was to gauge what threats effectively emanated from the individual applicant's body. Indicating a line of demarcation between what counts as 'normal' or 'healthy' and what as 'pathological' and 'dangerous', norm values emerged as powerful instruments for regulating the applicants' entrance to Germany. Accepted were only those applicants whose blood and urine values lay within the 'normal' limit indicating an absence of disease and danger. This 'gate-keeping' function of norm values is illustrated by the

[156] Interview with Emil P.

difficulties which the former labour migrant Emine G. experienced during her recruitment in 1970. At the time she underwent the selection process at the recruitment office, she was still breastfeeding her son. During the medical examination, she was diagnosed with hypertonia due to breastfeeding and consequently not accepted as a labour migrant. Only after weaning the infant and making cold compresses over the span of a whole month, did her blood pressure sink to the 'normal' value so that she could pass the examination. [157]

The prominent role of norm values reveals how the evaluation of an applicant's health status was based on the concept of a 'normal body' which simultaneously signified the 'healthy body'. As such a notion of the 'normal body' is necessarily relational in character, it can never constitute an absolute truth. However, the physicians' reliance on norm values as objective indicators of health and disease led to problems in the context of the medical examination. This is best illustrated by the case of a certain laboratory test. The ESR test which measured the blood's erythrocyte sedimentation rate (ESR) was an integral part of the examination. As a decreased or increased ESR value possibly indicated certain diseases such as for example TB, auto-immune diseases or chronic kidney diseases, the ESR test was routinely implemented during the examination. Problems arose because the ESR values of a significant number of especially female applicants were constantly above the norm level although often no pathological signs of disease could be detected to explain the values. The constantly occurring high ESR values required time-consuming follow-up controls and de facto many rejections without a clear diagnosis of disease. [158] To keep such follow-up examinations and the rate of rejections in absence of clear disease causes low, a flexible handling of test results and norm values was implemented during the 1960s. A note by the Federal Employment Service's medical service from April 1966 states the ESR norm values

[157] Interview with Emine G.
[158] DVT, annual report 1970, BArch, B 119/3016.

should not be treated as 'strict limits'. In case of slightly increased values, the applicants might be accepted if no indications for pathological causes were found. [159] Shortly after this note, in October 1966 the norm values for female Turkish applicants were officially raised [160] and the recruitment office's annual report from 1970 even refers to officially raised norm values for both male and female applicants because 'experience over the years has shown that German norm concepts obviously do not apply to the local conditions on-the-spot'. [161] Such a flexible approach to ESR values also caused anxiety. In 1970, the Siemens company doctors in Berlin complained about the raised ESR norm values for labour migrants from Turkey pleading for a renewed application of the values 'normal for Germany' to prevent the recruitment of migrant workers with chronic diseases. [162] Similarly, the 1971 annual report of the recruitment office emphasised the urgency to 'solve the ESR problem' because the method of simply raising the norm values for Turkish applicants 'ignored all German norm concepts' and therefore was 'neither medically nor scientifically tenable'. [163]

The problems surrounding the ESR test are indicative of how the concept of a 'normal body' met with difficulties once practically applied in the examination. The non-conformity of the Turkish applicants' bodies to the ESR norm values did not necessarily indicate a pathological health status; consequently, applicants with deviating values were regularly accepted. As the insistence on 'German norm concepts' illustrates, such a flexible approach to the test results was not appreciated on all sides. The implicit conceptualisation of the 'normal body' as essentially German, which pervades these anxieties, sustained the notion of 'non-German' bodies as 'deviant' and consequently likely to be 'diseased', although the practical

[159] Note, Ref. Dr. Hoeschel, ÄD BAVAV, Nuremberg, 15 April 1966, BArch, B 119/4081.
[160] DVT, annual report 1966, BArch, B 119/3017.
[161] DVT, annual report 1970, BArch, B 119/3016.
[162] Regional Employment Office Berlin, annual report 1970 'Beschäftigung, Anwerbung und Vermittlung ausländischer Arbeitnehmer (Employment, Recruitment and Placement of Foreign Workers),' Berlin, 1970, BArch, B 119/3015.
[163] DVT, annual report 1971, DOMiD-Archiv, AR 162.

experience during the medical examination in fact challenged the dichotomy of the 'normal' versus the 'healthy' body.

The conceptualisation of the body as a carrier of disease found expression in a corresponding mode of examination. Whereas the evaluation of an applicant's work suitability had been based on the gaze and touch of the physician for the detection of outward signs of disability or disabling disease *on* the body, the exclusionary logic of health assessment required that markers of infectious and chronic disease now were traced *within* the body. Significantly, the pure gaze of the physician was not deemed sufficient to fulfil this task. In order to reach into the interior of the body, it had to be enhanced through laboratory technology and radiography. This relocation of the focus of the examination from an external evaluation of ability to an internal assessment of disease and contagiousness is closely related to an imagination of the body as 'dangerous' because of its capacity to contain 'hidden' diseases not manifest in the body's outer appearance.

Robert Castel has pointed out how 'dangerousness' does not only designate a 'quality immanent to the subject', but also a 'mere probability', a 'hypothesis of a more or less probable relationship between certain present symptoms and a certain act to come' (Castel 1991, 283). In the context of preventive medicine and public health, this notion of 'dangerousness as probability' finds expression in the concept of 'latency'. As Armstrong has pointed out, preventive medicine and public health politics focussing on the body as the transmitter of disease do not differentiate between the healthy and the sick because the seemingly 'normal' and 'well-being' person 'without overt signs of disease' may still be infested with latent forms of communicable diseases and constitute a danger to her- or himself as well as to the environment. Thus, the focus of medical attention shifts from the sick person seeking treatment to the mass of the seemingly healthy, nevertheless at risk as every

individual comes to be seen as a potential carrier of infectious disease (Armstrong 2012, 178, 180-181). It is this concept of latency which informed the implementation of mass screening methods in the examination such as chest x-rays and serological tests. Dangerousness because of disease lying hidden inside the body constituted a probability immanent to the body of every single applicant. Consequently, the interiors of all applicants' bodies had to be probed for signs of latent diseases to prevent any applicants with infectious and chronic diseases from entering Germany. Former staff members of the recruitment office like Bernd. O. and Anton E. decidedly emphasise this non-curative, but preventive security character of the examination:

> I knew from the beginning that this was going to be a temporary occupation at the recruitment office, because it wasn't a medically satisfying, humanistic field of work, it was rather like a military examination commission (…), it was about sorting the people, not about what you usually do in medicine, not about helping the people. [164]

> This work [at the recruitment office] was of no interest to me, because I was not interested in such a military-like job, I would rather have been interested in the medical tasks of a physician. (…) This [the medical examination] was not about *treating the sick*, it was about *examining allegedly healthy people* who wanted to enter into a work process and therefore we didn't make a diagnosis to clarify a certain disease, instead we made sure that no sick person embarked on the journey to Germany (my emphasises). [165]

This preventive shift of focus away from the 'sick' to the 'seemingly healthy' nevertheless constituting a potential health threat entailed a shift in the possession of expertise about the body. The individual applicant was no longer ascribed the knowledge about whether her or his body was sick or healthy, rather modern medical technology and screening methods expanded the medical gaze into the body revealing the outwardly healthy to be interiorly diseased. The former labour migrant Ayla A., who was recruited twice for work in Germany in 1969 and 1973 relates this personal loss of expertise about the body in the context of the examination. She narrates how she warned her travel companion on the way to the

[164] Interview with Bernd O.
[165] Interview with Anton E.

recruitment office in 1973 against being too confident about going to Germany because of the impossibility to tell in advance whether somebody would pass or not.

> Fatma, I said, don't be too confident, it's like a closed, secret match-box, you never know what will come out from our inside, don't be too sure, because it happened a lot last time, two or three people were rejected because of their blood, their blood you know, brings forth what is inside, that's why they didn't pass. [166]

Later on in the same interview she states:

> He [the physician] looks at us whether we are 'good' or 'bad'. Anyway, the disease comes instantly out of the blood, the blood becomes all bad, so many people were told to leave; they couldn't come with us because of their blood.

The quotations above underline how the individual applicant was not entitled to make a final judgement about whether she or he was healthy or not. Everyone's body might turn out diseased, betrayed by the body's own fluids. The knowledge concerning the body's actual health condition was hidden inside it and only the physician had the equipment and know-how to read these secret signs.

Although x-raying and laboratory tests were directed at the detection of various infectious and chronic diseases, the identification and exclusion of applicants with tuberculosis constituted the main concern of the physicians as the high rejection rates on grounds of x-ray results underline. The role of TB in the medical examination deserves a detailed discussion because it is related to the questions dealt with above: the notion of the body's 'dangerousness' arising out of latent disease infections, the examination's preventive focus on 'seemingly healthy' people turning out to be 'internally diseased', the applicants' loss of expertise with regard to their own bodies and the 'foreignness' of the body enhancing its propensity for disease.

The constantly high rejection rates due to TB during all years of recruitment can be traced back to the strict selection criteria which required the exclusion of 'all forms of

[166] Interview with Ayla A.

pulmonary tuberculosis even if these are apparently completely cured'. [167] The motive for such strict rejection was preventive in character. According to the official selection criteria, such a rigorous exclusion of all forms of TB, including inactive or latent TB, was necessary to 'eliminate the inestimable potential danger of a reactivation of former infections of the lung'. [168] Such a preventive exclusion logic meant in fact that applicants who outside of the context of the medical examination would have been considered as 'healthy' because they were no longer suffering from active TB had to be rejected as latently 'diseased' due to the possibility of exacerbation. Bernd O., who was responsible for the recruitment office's radiology department and the evaluation of the radiographs from 1972 to 1973, remembers well the practice of rejecting applicants who were not 'acutely ill' but diagnosed with latent TB:

> Quite strict exclusion criteria existed; if there was more than one small trace of opacity or calcification on the lung, you had to disqualify, to sort out, even though by the standards of the time endemic infections with TB in child age were still wide-spread, so that a small trace of opacity or calcification did not signify an acute illness; it could exacerbate, though. (…) But such small, old residues of a so-called primary complex of tuberculosis didn't mean that the patient was sick, we all used to have that as children when tuberculosis was still wide-spread. [169]

As Bernd O.'s statement illustrates, latency concerns and fear of exacerbation were decisive in rejecting all those applicants who had once been infected with TB but were otherwise 'healthy'.

Individual cases of applicants diagnosed with latent TB further illustrate how people who were usually considered 'healthy' by their relatives and who thought of themselves as 'healthy' were rejected as 'diseased' in the medical examination. In 1970, the labour migrant applicant E.H. who wanted to join his wife already working in Berlin was declared 'unfit' in

[167] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058.
[168] Ibid.
[169] Interview with Bernd O.

the medical examination at the recruitment office because of scars detected on his lung x-ray which indicated an inactive form of TB. [170] In a petition to the mayor of Berlin written on behalf of E.H. by an acquaintance of his, it is stated that neither E.H. nor his family could remember him ever contracting TB during childhood and that he had completed his military service without being sorted out as 'unfit'. After rejection at the recruitment office, E.H. entered Germany as a tourist but was denied a work permit by the Federal Employment Service on the ground of his prior rejection at the recruitment office in Istanbul. Instead of accepting this denial, E.H. underwent an additional x-ray screening at a TB centre in Berlin. The examining physician confirmed the existence of scars on the lung; however, he stated that these scars were no indication of a TB infection but residues of a 'widely common lung disease'. In consideration of this medical report, the Federal Employment Service revised its initial judgement and declared its former concerns against issuing a work permit as no longer valid.

This case underlines how preventive concerns especially with regard to TB were decisive in the evaluation of an applicant's health suitability. Mere suspicion of latent TB possibly turning into an active disease process after the migrant's entrance into the Federal Republic was sufficient for rejection. Of significance is especially how the applicant's family referred to absence of TB during childhood as well as to the military service as proof of physical fitness. Strikingly, the recruitment office's examination criteria with regard to public health protection were stricter than those of the National Health Service in Germany as the

[170] The case of E.H. was reconstructed from the following archival documents: Regional Employment Office Berlin, ÄD, Betr. Türkischer Staatsbürger E.H. (Concerning Turkish Citizen E.H.), Berlin, 25 Jan. 1971, BArch, B 119/4083; petition by H. R. to Klaus Schütz, Mayor of Berlin, Berlin, 9 Dec. 1970, BArch, B 119/4083; letter from H. R. to Berlin Senator of the Interior, Berlin, 27 Dec. 1970, BArch, B 119/4083; ÄD BfA, Betr. Mitwirkung bei der Anwerbung und Vermittlung von Ausländern, hier: Türke, H., E. (Concerning the Participation in the Recruitment and Placement of Foreigners, concerning: the Turk H., E.), Nuremberg, 10 March 1971, BArch, B 119/4083.

follow-up examination by a physician of a TB centre in Berlin and the revised judgement of the Federal Employment Service illustrate.

A petition written on behalf of a certain S.Ö. allows insights into another case of rejection which mirrors the experiences of E.H. [171] Like E.H., S.Ö. who underwent the medical examination in 1963 was rejected because of his lung radiograph. The x-ray picture showed traces of calcification on the lung which induced the examining physician to exclude S.Ö. as 'unfit' because of suspected inactive TB. The petition, which was written by a German acquaintance, decisively emphasises S.Ö.'s impeccable health by pointing out that his family could not remember him to have ever contracted TB and that he had completed his military service without suffering from any health problems. Furthermore, the petition states that S.Ö. underwent both a mass screening procedure and an examination by a public health officer after entering Germany as a tourist in the context of which he was twice confirmed to have no indications of lung diseases.

Similar to the experiences of E.H., this case underlines the preventive security function of the medical examination at the recruitment office requiring an equal treatment of latent and manifest diseases. My argument here is not to accuse the physicians of 'exaggeration' and rejection of 'healthy' applicants. What I want to point out is how a certain conceptualisation of the body as 'dangerous' and 'pathological' once it showed signs of a latent disease infection entailed the rejection of applicants who had never considered themselves as 'diseased'. Often these applicants were shocked by the physicians' exclusionary decision which they met with bewilderment and disbelief. The former labour migrant Barış G. remembers well his own rejection in the medical examination because of scars showing on his lung x-ray which forced him to change plans and enter Germany as a tourist:

[171] Petition by G. K., Betrifft die Probleme eines Gastarbeiters (Concerning the Problems of a Guest Worker), attachment to a letter from G. K. to Luise Joppe, administrative director of the BfA, Crailsheim, 5 March 1972, BArch, B 119/4080.

> It was absolutely unfair; a man like me who has worked in Germany and who is still alive 45 years after the examination was rejected as sick. They said I had scars on my lung from pneumonia during childhood, therefore I couldn't go, but that's nonsense, I can't even remember ever having had pneumonia as a child. [172]

The strict rejection criteria for TB were justified with reference to an argumentation in which notions of disease closely intertwined with notions of foreignness and backwardness. According to the official selection criteria of the medical examination, the imminent danger of TB reactivation among labour migrants, which required strictest rejection guidelines for all forms of TB, was triggered by the very processes of migration and sudden modernisation. As the official selection criteria state, TB reactivation among recruited workers was mainly 'due to change of climatic conditions, change of life style and nutrition, due to psychological strains as a result of the shift from the domestic environment to the environment of industrial society and due to the changed intensity of work'. [173] Dr. Kästner, a representative of the Federal Employment Service's medical service, argued in accordance with this rationale of the official selection criteria:

> This strict evaluation of radiographs is necessary, because foreign workers from Southern countries (…) are exposed to special strains resulting from an adjustment to new climatic conditions, a change of life style and nutrition, and a change of work intensity in German companies in contrast to the home country. Herein lies without doubt a danger for persons with old, even though seemingly 'cured' tuberculous infections to relapse – as experience has shown. (…) The great number of foreigners in German sanatoriums repeatedly confirms this. [174]

This discourse which linked the provably heightened affinity of the labour migrants to contract TB in Germany [175] to changes of climate, food, life style, environment and work rhythm was not restricted to the circles of the Federal Employment Service, but also reproduced by public health authorities, company doctors and the public media. On a meeting

[172] Interview with Barış G.

[173] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058.

[174] Dr. Kästner, ÄD BAVAV to the Federal Minister of Health, Nuremberg, 12 June 1963, BArch, B 149/22368.

[175] See chapter 5.

of the Federal Health Council's committees for epidemic control, hygiene and health preservation in May 1966, A. Solbach, company doctor of the Ford-Werke in Cologne, claimed that the unfamiliar environment, the change of work, food and climate were responsible for the high rate of TB infections and reactivations among labour migrants in Germany. [176] Similarly, at the same meeting the health expert Prof. Dr. Hein identified the change of climate, new working and living conditions as well as psychological strains arising out of the migration situation as causes for TB infections. [177] This explanatory argumentation was also seized on by the public media. For instance, a newspaper article from the *Kölner Rundschau* from 1965 argues that the labour migrants' adaptation to new climatic conditions and new food causes various diseases of the respiratory organs such as TB (Schröder 1965).

This seemingly scientific neutral discourse had both a racialising and de-politicising effect which becomes apparent once the seemingly harmless attributions of unfamiliarity of climate, nutrition, life mode and work rhythm are opened up for problematisation. In *Imperial Hygiene*, Alison Bashford has demonstrated how the white settlement of Australia was haunted by the fear that a 'white Australia' might not be realisable because the local climate might simply turn out be intolerable and unhealthy for the 'white man'. This fear found especially expression in Australian tropical medicine and hygiene discourses which employed the notion of 'climate unfamiliarity' as a metaphor for the racial distinctness and alienness of 'white bodies' in tropical Australia (Bashford 2004, 140). These discourses linking climate to

[176] Ausführungen von Dr. A. Solbach, Werksarzt der Ford-Werke AG, Köln auf der Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und –fürsorge des Bundesgesundheitsrates in Bad Godesberg am 6. Mai 1966 (Commentary by Dr. A. Solbach, Company Doctor of the Ford-Werke AG, Cologne, at the Meeting of the Federal Health Council's Committees for Epidemic Control, Hygiene and Health Preservation in Bad Godesberg on 6 May 1966), BArch, B 149/22369.

[177] 'Die Tuberkulose bei Gastarbeitern vom klinischen Standpunkt aus gesehen, Referat von Medizinaldirektor Prof. Dr. Hein, Tönsheide, gehalten auf der Sitzung der Ausschüsse Seuchenbekämpfung und Hygiene und Gesundheitsvor- und –fürsorge des Bundesgesundheitsrates in Bad Godesberg am 6. Mai 1966 (The Tuberculosis among Guest Workers from a Clinical Perspective, Presentation by Medical Director Prof. Dr. Hein, Tönsheide, at the Meeting of the Federal Health Council's Committees for Epidemic Control, Hygiene and Health Preservation in Bad Godesberg on 6 May 1966),' BArch, B 119/22369.

race are in line with a discursive shift in the legislative language of major immigration acts at the turn of the $19^{th}/20^{th}$ centuries from exclusionary categories based on explicit nominations of race to implicitly racialised categories of exclusion such as certain migrants' 'unsuitability' for the local climate or their 'peculiar customs and modes of life' rendering them ineligible for entering the country (ibid, 144). Bashford's arguments illustrate that conceptualisations of climate and culture should not be treated as neutral concepts; rather, they are closely intertwined with notions of race, belonging and alienness. They function as powerful metaphors drawing a strict distinction between those who are territorially, biologically and culturally belonging and those who are not.

Bashford's deliberations are helpful for problematising the argumentation that labour migrants are especially prone to contract disease because of their unfamiliarity with the local climate as well as with local life habits and work intensity. Based on an essentialist and static notion of 'Mediterranean' culture and society, this implicitly racialising discourse effectively traced the high TB infection rate among labour migrants back to their cultural otherness, their lack of familiarity with the essential ingredients of modernity and their alienness in a German environment. Thus, without making use of an overtly biologically motivated racial language, this discourse had the twofold effect of branding the labour migrant as an essentially alien and 'misplaced' element in the social and cultural fabric of the Federal Republic and of reinforcing the imagination of foreign bodies as having a greater propensity for disease than native bodies. A statement by a senior medical officer of the public health office in Schwabing/Bavaria published in the medical journal *Deutsches Ärzteblatt* in 1967 is quite telling in this aspect:

> Where do the guest workers, in case they had not been infected yet, contract their first TB infection in our country? Surely not, or only to a very minor extent, from the native population, because even in the industrial cities, where contact is closest, the contact with the native population is much less intense than the guest workers' contact among themselves. Infections at the work place are only of minor significance. (…) Without doubt, reactivations play a not

> insignificant role among [the infected]. As already pointed out, the reactivation of latent infections due to altered life conditions and the unfamiliar rude weather is three times higher among guest workers than among natives (Michaelis 1967, 198).

This statement neatly illustrates how TB was primarily thought to be spread by foreign bodies. Furthermore, it makes apparent the depoliticising dimension of the pervasive discourse which associated TB infections among labour migrants exclusively with their cultural difference and their experience of migration and dislocation while decidedly downplaying the fact that the majority of the labour migrants worked and lived under harder and in terms of health standards more precarious conditions than most of their German colleagues. Thus, 'dangerousness' and 'insecurity' became neatly attached to the body of the labour migrant while the insecure social conditions which characterised the life world of labour migrants in the Federal Republic were rendered invisible.

7.3. Logic of Risk Management: the Labour Migrant's Body as a Commodity

So far I have described the medical examination as both an inclusionary instrument of disciplinarisation for the creation of an importable labour force informed by a conceptualisation of the body as an industrious machine and as an exclusionary security tool for the protection of the nation's health boundaries based on a notion of the body as a potential carrier of latent disease. However, a third dimension of the medical examination existed which was concerned with questions of risk management. In the context of this third dimension, the body of the labour migrant became constructed as a commodity and an insurable interest.

As indicated in the previous chapters, the medical examination had two official aims: to assess both the applicant's work suitability and general health status. However, a close reading of the official selection criteria reveals an implicit third aim:

> With these objectives [meaning the assessment of work suitability and general health status], the risks for all those involved are intended to be minimised to the greatest extent: for the employee, the company, the German population, and the Federal Employment Service as the intermediary institution. [178]

In consideration of this implicitly formulated third aim, it is not sufficient to argue that the medical examination served both inclusionary disciplinary and exclusionary bio-political purposes. Rather, the inclusionary and exclusionary patterns emerging in the course of the examination were undergirded by a distinct logic of risk management. To avoid confusion, it is important to point out that the logics of risk management shaped the medical examination in multifold ways. As shown in the previous section, the examination's role as a preventive security tool to control and safeguard the nation's public health was based on a conceptualisation of 'foreign' bodies as potentially dangerous entities posing various health risks to the national population. In this context, 'risk' was understood and employed by the public health authorities and the Federal Employment Service in its commonplace, everyday meaning indicating a possible 'peril' or 'danger' (Ewald 1991, 199). In the section at hand, I am focussing on a different understanding of 'risk' taken from the language of insurance which indicates 'the actual value of a possible damage in a determined unit of time' (ibid, 205). It was this second conceptualisation of 'risk' which was at play in the contractual relationship between the Federal Employment Service and the employer defining the mutual rights and interests of these two parties. Only by focussing on this understanding of 'risk', which defines the occurrence of a certain event in a certain limit of time to constitute a specific financial value, is it possible to fully grasp how the medical examination contributed

[178] Grundsätze zur gesundheitlichen Auswahl ausländischer Arbeitnehmer bei den Deutschen Kommissionen und Verbindungsstellen der Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (General Criteria for the Medical Selection of Foreign Workers at the Federal Employment Service's German Commissions and Recruitment Offices), attachment to a letter from the Federal Employment Service's medical service to the Federal Minister of Defence, 15 Nov. 1966, BArch, B 119/5058.

to the commodification of the labour migrant's body. This statement will require further elaboration.

By recruiting an unknown employee via the Federal Employment Service as an intermediary agent to which he or she had to pay a transaction charge in the form of a fixed recruitment fee, an employer literally 'did a blind bargain'. Usually, the employer was not present at the recruitment office and consequently, he or she necessarily relied on the Federal Employment Service to choose a healthy, productive and able candidate for the work in question. However, as the labour migrant's body and the labour power it yielded constituted a financial investment for the employer, the employer wanted to be assured that the recruited worker was indeed capable of fulfilling the ascribed work tasks. In other words, the employer demanded the 'quality' of the ordered 'good' to live up to his or her expectations. The institutionalisation of the medical examination within recruitment as a means to check on and guarantee the 'quality' of the labour migrant's body makes apparent how the medical examination contributed to the commodification of the labour migrant's body by affirming its status as a 'purchasable good' and 'financial investment'. A former local employee who was working at the recruitment office during the 1970s makes a striking comparison which reveals how the medical examination fulfilled the role of a 'quality check' for the 'commodity' of the labour migrant's body. Commenting on the medical examination's strict selection criteria, she states that applicants with only the slightest indicators of health problems were rejected just as a 't-shirt with only minimal production faults' would not be allowed to pass 'production control for sale on the market'. [179]

Although the medical examination was implemented to ensure that the employer received a suitable worker in exchange for the paid recruitment fee, the situation might

[179] Interview by Aytaç Eryılmaz with former male assistant and female employee of the recruitment office in Istanbul.

nevertheless arise that the recruited labour migrant did not fulfil the ‘quality expectations’ of the employer with regard to work aptitude or health status. To protect the employer’s interests, the actual recruitment of labour migrants who turned out unsuitable after arrival was declared as a risk against which the employer was to be insured by a certain ‘right of return’. Within seven days after arrival (or four weeks in case of ‘mental diseases’), the employer had the right to report labour migrants with insufficient health condition, work inaptitude or an externally recognisable pregnancy as ‘erroneous recruitments’. [180] If the Federal Employment Service confirmed such an incidence to constitute indeed a case of ‘erroneous recruitment’, the labour migrant in question was sent back to her or his home country while the employer was either repaid the recruitment fee or provided with a new labour migrant without paying the recruitment fee for a second time. However, for the Federal Employment Service to accept the claim and to refund the recruitment fee, several conditions had to be met: the cause of complaint had to date back to the time before the migrant’s arrival and the examining physician should have theoretically been able to detect it in the context of the examination.

François Ewald has pointed out how by declaring an entity or event as an insurable interest, this entity or event assumes a financial value; it is commodified by being turned into a capital against the loss of which the insurer offers a guarantee (Ewald 1991, 204-205). Adopting Ewald’s terminology, I argue that with recruitment the labour migrant’s body and the labour power it yielded had been turned into a certain capital for the employer against the loss of which in case of the migrant’s unsuitability for employment the employer was offered a guarantee via the regulation of ‘erroneous recruitment’. In other words, the regulation of ‘erroneous recruitment’ makes apparent how the labour migrant’s body had become a

[180] BAVAV RdErl. 348/62.1, 21 Aug. 1962, BArch, B 119/3038, it states that the recruitment fee will be paid back in case the non-employability of the recruited worker becomes obvious within one after week after arrival at the work place; this span is extended to four weeks in case of ‘mental diseases’. Note, BAVAV, Ref. Dreyer, Nuremberg, Aug. 1961, BArch, B 119/3038, the document refers to BAVAV RdErl. 279/60.1, 5 Nov. 1960, which states that only an externally recognisable pregnancy constitutes a case of erroneous recruitment.

commodity through the very act of declaring it as an insurable value. In addition to its function as a tool for disciplinarisation and security regulation, the medical examination thus assumed a third role as an instrument of risk management which sought to reduce the risk probability of recruiting unemployable labour migrants to a minimum, thereby acting as a guarantor towards the purchaser of the labour migrant's physical labour power.

The existence of a regulatory system for cases of 'erroneous recruitment' exemplifies how the temporary inclusion of non-native labour migrants into the territory of the Federal Republic was solely based on the promise of productivity. Impeccable health and ability were preconditions for a labour migrant to enter and stay in Germany. A labour migrant who upon arrival did not fulfil these conditions could lose his or her right to stay in the Federal Republic in case the employer made a complaint within the prescribed time period. As indicated in chapter 4, the migrants' residence opportunities as well as social entitlements expanded the longer they stayed in Germany. However, labour migrants who did not fulfil the omnipresent societal expectation of economic productivity because they fell ill and underwent medical treatment in Germany were commonly perceived as a public burden. Such 'public charge' discourses largely overlooked the migrants' economic contributions prior to the loss of health and the social rights arising out of such contributions. Numerous complaints depicting sick migrant workers as a massive financial strain on the social service system on part of company representatives, health practitioners, health insurance companies and the public media make apparent the pervasiveness of the thought that only healthy, able-bodied and productive labour migrants deserved to reside in the Federal Republic. It suffices here to consider just a few exemplary complaints.

In a letter from 1966 addressed to the local branches of major national insurance companies, a medical specialist for surgery draws a stark distinction between deserving

German patients and undeserving labour migrants. He differentiates between German patients' cases of illness which he considers as unavoidable and 'brought about by fate' and labour migrants' cases of illness which he characterises as 'avoidable' because the migrant workers in question 'should have definitively been sorted out before being granted a residence and labour permit'. [181] Similarly, in a letter from 1969, an eye specialist complains to a colleague about numerous cases of migrant worker patients who do not fulfil their envisaged role by contributing productively to the national economy and become instead a financial burden on the state:

> Our guestworkers are supposed to work in our country. However, sometimes I have the impression that they are not guestworkers but guest patients. (…) I sometimes wonder who lets these people into our country. Are there no guidelines according to which these people are selected and medically examined before they are granted a work permit in Germany? (…) The man suffering from chorioideremia [a certain patient mentioned earlier in the letter] will soon draw monthly disability benefits for blindness, but these will not be paid by the country of origin but out of our public purse. [182]

A nearly identical argumentation can be found in a letter sent by a company representative to a deputy of the Bundestag in 1960:

> Due to labour shortage in Germany, we are in great need of foreign workers, however, in the end only healthy persons can be of avail to us; what would be gained if somebody worked for a few weeks and then spent several months in a sanatorium at the expense of the state (…)? [183]

Insurance companies joined in the 'public burden' discourse. In 1963, the insurance company IKK Baden-Baden sent a circular note to its contractual company partners which states that the 'labour shortage must not lead to the situation that guest workers only temporarily employed in Germany cure their chronic ailments at the expense of German citizens'. [184] The discourse depicting the sick labour migrant as an undue financial burden for the public purse was also sustained by public media. A newspaper article published in the *Rheinische Post* in

[181] Letter from Dr. Friedrich Germann to chairmen of AOK, IKK, BKK Schwäbisch Gemünd, Schwäbisch Gemünd, 11 July 1966, BArch, B 119/5058.

[182] Letter from Dr. Remler to Dr. Damm, Neu-Isenburg, 30 March 1969, BArch, B 119/5058.

[183] Letter from Ursula Richter to Thomas Ruf, Esslingen, 3 July 1960, BArch, B 149/22370.

[184] Federal Association of Guild Health Insurance Funds, cicular note K 218/63, Cologne, 21 Oct. 1963, BArch, B 149/22368.

1966 may serve as an example. The article first emphasises how the treatment of every single migrant worker infected with TB costs the insurance companies a sum of 15,000 to 20,000 DM and then goes on to question whether such costs 'render the recruitment of guest workers profitable in the first place'. It further states that treatment costs can be 'drastically reduced by admitting only healthy guestworkers' into the country. The article concludes by quoting company doctors from Düsseldorf who intent to witness in future the medical selection of migrant workers at the recruitment offices abroad because such a regulation would 'turn out much cheaper for the companies than the treatment of sick guest workers in Düsseldorf' (*Viele Gastarbeiter werden lungenkrank* 1966).

To make sense of these discourses stressing health and ability as necessary preconditions for legitimate residence in Germany, it will be helpful to once more refer to Roxana Galusca's concept of 'fictive ability' (Galusca 2009, 138-139). As discussed in chapter 3, Galusca makes use of this term to indicate how the sick and disabled are excluded from the nation body which is imagined as essentially able-bodied. Such an imagination of the nation is necessarily fictive because disability and disease exist in every society. Only by rendering the disabled and sick invisible, only by marginalising and excluding them (as in the case of medical immigrant examinations at the nation's borders), is it possible to maintain the myth of the nation. However, Galusca's concept cannot be directly transferred to the case of Germany's recruitment of migrant labour. The labour migrants were already excluded from the nation body in terms of their lack of citizenship. Originally, they had been meant to stay only temporarily in exchange for labour without becoming part of the nation through naturalisation. Still, the concept of 'fictive ability' proves insightful for the case at hand if it is thought in combination with Karl Polanyi's concept of 'fictitious commodities'.

The exclusion of disabled and sick labour migrants from recruitment, the employers' 'right of return' in the form of 'erroneous recruitment' and the pervasive discourse depicting sick labour migrants as illegitimate inhabitants in the country and as an economic burden all together sustain a myth different from the myth of the nation: the myth of the complete commodification of labour power and the labouring body. In *The Great Transformation*, Karl Polanyi has pointed out how the organisation of the modern market economy requires land, labour and money to be treated as commodities, as goods for sale. However, unlike real commodities which are produced for the sole aim of selling and buying on the market, land, labour and money are not initially 'produced' for such an end; they constitute 'fictitious commodities' because their inherent characteristics and qualities transcend the realm of the market exchange. The alleged commodity of labour, and of the labouring body we should add, cannot 'be detached from the rest of life'; 'it cannot be shoved about, used indiscriminately, or even left unused, without affecting the human individual who happens to be the bearer of this peculiar commodity' (Polanyi 2001, 75-76).

Polanyi's notion of labour power as a 'fictitious commodity' constitutes a fruitful addition to Galusca's concept of 'fictive ability'. Just as the imagination of the nation as able-bodied constitutes a fabrication, albeit one with serious effects as this imagination entails the denial of full citizenship rights to the disabled, so is the imagination of the migrant labour force as essentially able-bodied and healthy fictive in character, an imagination which in turn seeks to exclude the sick or disabled migrant worker and deprive him or her of social rights. This ideal of a completely able-bodied importable labour force has to be fictive because the labour migrant's body constitutes a 'fictitious commodity'; it can never be totally commodified, it cannot 'be used indiscriminately' because this body forms part of a human being who may become disabled or sick. The imagination of the medical examination as a

perfect instrument of risk management which can produce and fully guarantee for an able-bodied and productive work force is illusionary. The case of the sick or disabled labour migrant, suddenly depicted as a 'burden on the state', makes apparent the limitations of a migration process steered exclusively by economic ends. It reveals the inhumane character of a migrant recruitment process which reduced the human experience of illness and disability to mere disruptive factors in need of control and exclusion just as it deprived the migrants of their status as full persons by equating them with mere commodities and body-machines.

7.4. Compliance and Non-Compliance: Resisting the Logics of Examination

The power mechanisms inherent in the examination procedure were not exercised over passive bodies by a puppet-like medical staff steered solely by the will of an all-encompassing power-knowledge-apparatus. Such a reading of the examination procedures would turn Foucault's conceptual understanding of power into a caricature of itself. As already implicitly indicated in this chapter, various forms of resistance existed both within and outside of the examination which opened possibilities to subvert its intended functions.

As illustrated in this chapter, applicants rejected in the medical examination entered Germany via alternative ways or they wrote petition letters questioning and challenging the initial judgements of the physicians, sometimes successfully, sometimes without success. In the direct context of the examination, various attempts were undertaken to trick the medical staff which ranged from drinking ayran to 'fool' the x-ray machine and make the lungs appear 'white' and healthy to more subversive stratagems such as smuggling bought urine and blood samples into the examination, bribery or identity fraud by sending a different person under the applicant's name into the examination (Eryılmaz 1998, 108-109; *Endstation Sehnsucht*, 19;

Gür 1987, 130).[185] A large fair developed around the recruitment office where applicants could buy supposedly 'clean' blood and urine samples or get immediate 'treatment' before the examination by self-declared dentists, opticians or other 'specialists'.[186] Even professional bands formed which organised fraud in exchange for large sums of money. In 1971, one such organised band was unmasked and convicted which in collaboration with local employees at the recruitment office had regularly sent stooges to the examination, manipulated the applicants' documents or falsified test results. A German physician at the recruitment office was also involved in these incidences and consequently dismissed from his job position at the recruitment office.[187] Although it would exceed the scope of this thesis to discuss in detail these incidents of organised fraud which involved the recruitment staff, this short overview already illustrates that examination conditions on the ground were far from being invulnerable against attempted subversion.

To discuss incidences of resistance in the context of the medical examination, first a theoretical problematisation of 'resistance' with regard to the adopted concept of power will be in place to avoid a simplistic and reductionist understanding of the term. The question of how Foucault's understanding of power relates to resistance is problematic, not because he negates the existence of resistance, but because he has devoted far less attention to it than to the problem of power. His conceptualisation of power as diffuse, relational and anonymous has led to the inference on part of various theoretical thinkers that his understanding of power is essentially nihilistic in character leaving no room for resistance and meaningful individual

[185] DVT, annual report 1968, BArch, B 119/3018; DVT, annual report 1969, BArch, B 119/3013; DVT, annual report 1970, BArch, B 119/3016. Detailed information concerning fraud was also given in the interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service and the interview by Mathilde Jamin and Aytaç Eryılmaz with last director of recruitment office in Istanbul, former member of recruitment office's placement staff and a representative of the Federal Employment Service.

[186] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service and the interview by Mathilde Jamin and Aytaç Eryılmaz with last director of recruitment office in Istanbul, former member of recruitment office's placement staff and a representative of the Federal Employment Service.

[187] BAVAV, Ref. Eichner, to Federal Ministry of Labour and Social Order, Nuremberg, 6 July 1971, BArch B 119/4706; DVT, annual report 1971, DOMiD-Archiv, AR 162.

action. [188] However, such a negative reading of Foucault's work is still guided by the sovereign notion of power which Foucault intended to overcome. It is based on an understanding of power as essentially repressive and of resistance as a liberating force which is external to power. For Foucault, power clearly is not analogous to repression and domination. He stresses the productive potential of power, including the capacity to create forms of resistance, just as he emphasises that the exercise of power pre-supposes a certain degree of freedom and a potential for agency on part of the one power is exercised upon.

> In effect, what defines a relationship of power is that it is a mode of action which does not act directly and immediately on others. Instead it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or the future. A relationship of violence acts upon a body or upon things; it forces, it bends, it breaks on the wheel, it destroys or it closes the door on all possibilities. Its opposite pole can only be passivity, and if it comes up against any resistance it has no other option but to try and minimize it. On the other hand a power relationship can only be articulated on the basis of two elements which are each indispensable if it is to be a power relationship: that the 'other' (the one over whom power is exercised) be thoroughly recognised and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reactions, results and possible inventions may open up (Foucault 1983, 220).

Foucault adds further on in the same text:

> When one defines the exercise of power as a mode of action upon the actions of others, when one characterises these actions by the government of men by other men – in the broadest sense of the term – one includes an important element: freedom. Power is exercised only over free subjects and only insofar as they are free. By this we mean individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments may be realized (ibid, 221).

As these quotations make clear, the formation of power relations is contingent on the very existence of subjects who are able to respond and react to the exercise of power in multifold ways and who therefore have the potential to resist power effects. Contrary to the sovereign model of repressive power which is opposed by resistance as a liberating force external and antithetical to power, Foucault maintains a conceptualisation of power and resistance as co-formative and mutually dependent on each other. Resistance and power form two sides of the

[188] An insightful overview over such critical receptions of Foucault's concept of power by authors such as Jürgen Habermas, Nancy Fraser, Anthony Giddens or Peter Dews can be found in Kevin Jon Heller's article 'Power, Subjectification and Resistance in Foucault', Heller 1996, 78-79.

same coin, there is no resistance external to power exactly because both power and resistance are relational in character:

> Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power. The existence [of power relationships] depends on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations. These points of resistance are present everywhere in the power network. Hence there is no single locus of great Refusal (…). Instead there is a plurality of resistances, each of them a special case (…); by definition, [resistances] can only exist in the strategic field of power relations. (…) They are the odd term in relations of power; they are inscribed in the latter as an irreducible opposite. Hence they too are distributed in irregular fashion. (Foucault 1978, 95-96).

This quotation illustrates how a relational, non-institutional and diffuse notion of power necessitates an equally relational, diffuse and non-institutional concept of resistance which locates resistance no longer in a distinct organisation or institution but in multiple sites and everyday practices.

Such a non-institutional understanding of resistance lies at the heart of James Scott's concept of 'everyday forms of resistance' which refers to the ways in which subordinate and seemingly powerless groups practice resistance on a daily level, albeit without making use of any formal organisation. As these everyday forms of resistance are invisible at the level of institutionalised politics, Scott introduces the term 'infrapolitics' to describe them (Scott 1990, 183). Infrapolitics aim at an 'unobtrusive renegotiation of power relations' (ibid, 190) and avoid 'a direct symbolic confrontation with authority' (Scott 1985, xvi). As a form of individual self-help, they are not so much directed at a systematic change of power relations, but at realising 'immediate, de facto gains' (ibid, 33). Being acted out on multiple sites, they make use of disguise, anonymity and low-profile stratagems to achieve these gains at minimum risk. Although in developing his concept of 'everyday forms of resistance' Scott mainly focuses on the ways in which the peasants of a Malaysian village resist material domination on a daily level, his theoretical approach to resistance nevertheless proves insightful for the case at hand. It opens the way to identify disguised, low-profile forms of

trickery, fraud and non-compliance in the medical examination as everyday forms of resistance against the examination's subordinating power effects.

However, Scott's binary model of resistance and domination which depicts 'the subordinated' and the 'the dominant' as two self-contained opposed groups is problematic. Sherry Ortner has rightfully criticised such binary approaches to resistance. She emphasises that the line of demarcation between the oppressed and the oppressors is never stable as the exercise of power and practice of resistance are highly situational in character (Ortner 2006, 44, 46). To avoid a simplistic binary perception of how power and resistance take shape in the medical examination, the medical staff should not be identified as the 'oppressor' and the applicants as the 'oppressed'. Such an approach remains entangled in an understanding of power as something that can be 'possessed' by an individual or a group of individuals who deprive the oppressed of power. Instead, a relational understanding of power necessitates a search for resistance against and compliance with power effects on all sides. Recognising the multiple sites of resistance constitutes a necessary move towards a de-romanticisation of resistance; it does not amount to a depoliticisation of the medical examination by downplaying the humiliation it entailed for many applicants.

The former physicians I interviewed did not question or challenge the medical examination as such. This becomes apparent from how they put emphasis on the examination's necessity and effectivity with regard to recruitment. As Anton E. states,

> I think, the medical examination was indispensable, not so much because of the fear that the Federal Employment Service might have been negatively affected by so-called erroneous recruitments, (…) but rather because of the human individual, I mean, of course, it was also about epidemiological questions, it's obvious that I can't send somebody who is acutely ill on a journey without a medical examination just saying 'have a nice journey'; it's the same in a German employment office (…), when somebody applies for an occupational re-training, let's say he has a flour dust allergy and can no longer work as a baker and now wants to become an electrician, he has to undergo a test for sight performance and colour blindness at the occupational health service (…), it's obvious that these things were necessary in the procedure, obviously certain things were essentially necessary; if somebody is colour blind, I can't place him in a job position where colour vision is requested, such examinations do make sense and

> today (…) today it would surely be much, much stricter and more secure with regard to somebody having a disease or not (…), as for the necessity for these various examinations, well, they appeared reasonable to me, especially in terms of occupational medicine; we used to say, in Istanbul you can buy any health certificate on the bazar and of course the placement staff also checked whether the applicant is really as capable as he claims, I mean, that made sense as well. [189]

The above statement illustrates how Anton E. greatly stresses the necessity of the examination. Never questioning its overall function, he regards the examination as an essential tool to successfully place applicants in job positions, to prevent epidemiological danger through the entrance of applicants with diseases and to forestall fraud which in a rather Orientalist way he portrays as intrinsic to the social patterns in Turkey. Significantly, he downplays the security and risk management functions of the medical examination by laying primary stress upon the testing of work suitability, thus conveying the impression that the medical examination at the recruitment office was not much different from a routine work placement test in a German employment office. Emil P. is more cautious in evaluating the medical examination and refrains from a direct affirmation of its necessity. However, by underlining the examination's effectivity in achieving its aims, he nevertheless makes an implicitly legitimising statement which emphasises the examination's significance in the context of recruitment.

> The selection criteria were comprehensible and ok (…), I think we usually could exclude severe cases; we took care that the employer became a fairly capable worker and that the Federal Republic and the people living there were not endangered by any contagious diseases, yes, I do think that the examination criteria were such that you could get a rough idea, a very detailed picture could only have been obtained by an individual examination, but I think the procedure was sufficient to exclude what you had to exclude, meaning severe chronic diseases, severe contagious diseases and physical defects which would have rendered the worker unable to perform the envisaged occupation. [190]

As the statements above make clear, at least some of the physicians complied with or even defended the logics of the medical examination. However, such compliance does not exclude incidences of resistance on part of the same physicians. The power exercised over the

[189] Interview with Anton E.
[190] Interview with Emil P.

applicants' bodies originated in the whole setting and procedure of the medical examination, including the situational *role* or *position* of the physicians in their relation to the applicants. As the memories of the former physicians show, they could feel uneasy about their role and did not necessarily identify with it. Emil P. is quite clear about this:

> I knew that I was part of the system, actually it was not conform to my ideology to do something like this; initially, I had struggled with the decision whether I really wanted to do this (…), but in order to get abroad and because I didn't find anything else, I did it in the end, but the whole work situation was not nice, no, I didn't like, didn't like it at all. [191]

It is such a lack of identification with the task to be performed and the role to be played which opened the way for unobtrusive forms of resistance which did not challenge the overall logics of the medical examination. Such 'modifications of the system' as Emil P. calls it included his refusal to examine the female applicants for cancer through palpation of the breast:

> The undressing was horrible, especially for the women. Sometimes, they were so embarrassed they outright refused to undress, and then we had to send them back home. Often, you had to make compromises, you just couldn't conduct a thorough examination when the women were so ashamed that they tightly crossed their arms over their breasts and hardly moved at all. (…) Actually, I was supposed to palpate their breasts to check for cancer, but I didn't do it, I didn't want to, although I was supposed to do it, at some point you just had to recognise these boundaries of shame. I don't know how the other colleagues did it. [192]

Anton E. relates a different incidence of low-profile resistance. From 1971 onwards, applicants who were rejected due to minor acute illnesses could come back for a follow-up examination within three days, whereas previously during the 1960s this time span had amounted up to seven days. [193] According to Anton E., he and Emil P. regularly extended the official time span for follow-up examinations, because

> (…) some infects or dental problems simply cannot be cured in three days, but once cured there was no reason for rejection; so what we, I mean Emil P. and I, what we often did was allow the

[191] Interview with Emil P.
[192] Interview with Emil P.
[193] DVT, annual report 1971, DOMiD-Archiv, AR 162.

> patients to come back after more than three days, but that was not official, that was between us. [194]

This combination of general compliance with the logics of the examination and secret incidences of small-scale resistance or non-compliance also occurred among the medical assistants. In an interview, a former assistant of the medical service decidedly emphasises the necessity and legitimacy of the medical examination. She states that although the examination was criticised and likened to cattle markets in the press, it was absolutely necessary for the applicants to get undressed for the detection of diseases. If these were not recognised in the examination, problems would arise once the labour migrants were in Germany. According to her, there could be no doubt that it was the 'right of the Germans' to pick only the healthiest from the applicants, especially as there was every chance to be highly selective because of the great numbers of applicants. However, despite her embracement of the examination's logics, later in the same interview she relates how she once secretly, although spontaneously and without former arrangement, smuggled a friend whom she knew to be blind on one eye through the sight performance test while the physician was out of the room. [195]

Incidences of both compliance and resistance can also be found among the applicants. There can be no doubt that the medical examination was a traumatic experience for many applicants which violated their feelings of privacy and dignity as human beings. Analogies to cattle or slave markets and even concentration camps are repeatedly drawn by former migrants that underline how the applicants experienced the examination as greatly dehumanising and degrading:

> Stripped stark naked, examined by the German doctor from our penis, pardon me, to our anus. The government of the Turkish Republic has sold us like cattle on the market. We were examined very thoroughly, starting with our teeth in our mouths right through to the traces of operations on our bodies, from A to Z. They took 25 persons into a room and all 25 had to strip stark naked collectively. For the first time, I thought that just like the black slaves were sold in

[194] Interview with Anton E.

[195] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service.

> Africa, so were we put through a slave market (Erol S., recruited as a labour migrant in 1965; DOMiT 2000, 9a).

Emine G. who was recruited in 1970 relates a similar perception of the examination as a humiliating and inhumane procedure: "It was so terrible. Like in a stable. We were stripped naked and the doctor closely examined our bodies, we were treated like animals." [196] Perhaps the most drastic characterisation of the examination which I heard when conducting my interviews was made by Aliya K. who was selected for a Berlin rubber factory in 1970:

> I don't know why they did the examination. It was horrible. During the examination I had my first doubts whether it was a good idea to go to Germany. (…) They treated us like slaves on a slave market, that's how I felt. Or like in a in concentration camp, but I didn't know about these camps back then. That came to my mind later when I was already in Germany and heard about German history. The shame, being naked and inspected by the doctor and his assistants, you were dependent on the doctor, he decides, is she useful or not, can she do the job or not, is she healthy or not? Abnormal, I say, it's just not normal to be standing naked in front of strangers. [197]

It is against the backdrop of these feelings of shock, humiliation and shame that attempts at resistance, no matter whether they proved successful or not, must be understood not only as a means to enter Germany but also as strategies to maintain agency and the self-understanding as a human being in the context of an objectifying examination logic.

Although the examination was a very unpleasant and as pointed out above sometimes even traumatic experience for the applicants, it would simply be incorrect to assume that all applicants outright questioned or condemned the procedure of the examination. The final outcome of the examination, previous experiences with modern medicine or even modern military medicine, the atmosphere and exact proceedings during the examination which were dependent on the respective examining staff and the location of the recruitment office as well as the applicants' personal motivations to go to Germany, all of these were decisive in shaping the applicants' perception and experience of the examination. It was not uncommon

[196] Interview with Emine G.
[197] Interview with Aliya K.

for former migrants I interviewed or whose life stories I read in the secondary literature to stress the right of the physicians to conduct such an examination or of the employers to insist on a medical check. Ümit R., recruited in 1970 for Siemens in Berlin, argues that

> Sick persons or pregnant women would have cost the employer much money, that's why they did the examination; they didn't want sick or pregnant persons. I can understand that, I don't blame them; if I were a company chef I wouldn't want them either. [198]

Emel L., another female labour migrant who was recruited in 1965 for Siemens in Munich, comments on her experiences as follows:

> Being only in our underwear in front of the German, that was the only bad thing, apart from this we didn't experience anything bad, and that was his natural right, because you are passing the last control, that's the natural right of the physician, because he lets the people pass, he has to give permission. [199]

Like Ümit R., Ali B., who was among the first Turkish labour migrants recruited in November 1961 for construction work, justifies the examination with reference to the costs arising from the recruitment of sick labour migrants:

> During my examination, there were a nurse and two or three doctors present. I was examined from head to toe: tapped, touched, x-rayed. But that was all right. If somebody had been sick, the health insurances in Germany would have had to pay for it (quotation from Goddar and Huneke 2011, 42).

It is difficult to gauge whether the statements above form part of what James Scott calls the 'public transcript', the official front-stage discourse of power. It might well be that the interview partners purposefully refrained from a direct public criticism of the examination procedure to avoid an open challenge of existing power structures. Consequently, there is no way of satisfyingly answering the question to what extent publicly expressed compliance with the examination logics was in line with the participants' intimate perception because an interview is in itself a power-laden situation. However, this does not exclude the possibility to trace moments of non-compliance on part of former applicants.

[198] Interview with Ümit R.
[199] Interview with Emel L.

Non-conformity and resistance were practiced by applicants in the form of secret trickery and evasion. Erol S. narrates such incidences of everyday resistance in the examination:

> Some friends had problems with urine, urea, diabetes. During the examination, those of us who knew their problems took urine from us. 'For God's sake, dear Erol, pee in here, yours is clearer for sure' and things like that. And we did that standing in a line, we helped our friends like that. For example, if somebody had missing teeth, a barber or someone else, well people who were not dentists, made teeth out of the metal of bottle tops to make it look like he had teeth in his mouth (DOMiT 2000, 9b).

Such fooling of the medical staff occurred with great frequency in the serological tests. Dr. Frye, the second last head physician of the recruitment office's medical service, sported a whole collection of bottles, water squirt guns and similar vessels used by applicants to smuggle bought urine into the recruitment office (*Endstation Sehnsucht*, 19). [200] Also, a former medical assistant relates a certain incident in which an applicant went to great lengths to smuggle urine into the examination, albeit without success: he was caught with a manipulated cravat which had a slim pipe running along its backside to a urinary bag. What might sound comic to an outsider had severe consequences for the applicants. Those who were caught while circumventing the examination rules were registered in the file card system (similar to the applicants rejected for medical reasons) and disqualified from recruitment via the Federal Employment Service. [201] Furthermore, attempts at trickery during the taking of urine samples resulted in a strict control of the applicants who often had to pass their urine samples collectively under supervision, another humiliating practice which denied the applicants any privacy.

Incidences of non-compliance were not restricted to the serological part of the examination. Especially in the years before the installation of the recruitment office's

[200] In Berger and Mohr 2010, 59, a photograph of the collection taken by Jean Mohr can be seen. Sometimes the applicants themselves turned out to be the ones tricked, Bernd O. relates how applicants bought supposedly clean urine samples which turned out to be pure water in the tests, interview with Bernd O.

[201] BAVAV, RdErl. 181/61.1.8, Nuremberg, 12 April 1961, BArch, B 119/3351.

radiology department, the x-ray tests constituted a part of the examination which was especially vulnerable to subversion. Employees of the external institutes which conducted the x-ray tests until November 1970 were repeatedly charged with corruption and the acceptance of bribes for deliberately exchanging radiographs. [202] Nor did the opening the recruitment office's radiology department in 1970 stop subversive actions: Bernd O. relates the rather tragic case of an applicant who fearing not to pass the examination sent a sibling to the x-ray test. Both were caught because the sibling was diagnosed with advanced TB. [203]

Applicants even devised stratagems to 'fool' the gaze of the physician in the clinical examination. Teeth made of bottle caps as mentioned by Erol S. are one such example. However, subversion did not end there. A former medical assistant relates how an applicant already once rejected due to the scar of an abdominal operation tried to pass the examination a second time. To avoid a second rejection, he had attached hair over the scar hoping to trick the physician. His attempt remained unsuccessful, though, because his initial rejection had been recorded in the file card system so that the examining physician knew about the scar in advance and deliberately searched for it. [204] The same assistant also narrates an incidence of successful resistance. A female applicant who had initially been rejected in the clinical examination because of a large intestinal operation scar reappeared for a second examination some time later. Unlike the physician, the assistant remembered the woman and told the doctor about the previous operation. However, as no file card existed, the woman successfully claimed that she underwent the examination for the first time. No traces of a scar could be detected and she passed the examination. After the examination, the assistant was so irritated and puzzled about this incidence that she searched the whole archive of the recruitment office until she found the initial examination report which showed the same woman on the

[202] DVT, annual report 1970, BArch, B 119/3016.
[203] Interview with Bernd O.
[204] Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service.

photograph and stated an 18 cm scar as the reason of rejection. Neither the physician nor the assistant could work out how she had managed to conceal the scar. To the applicant's luck, somebody had forgotten to enter her name into the file card system. This neglect, together with her successful concealment of the scar allowed her to journey to Germany as a labour migrant.

The everyday forms of resistance practiced by the applicants should not simply be evaluated with regard to their successfulness. Such a reading would reduce these incidences of resistance to a mere means for entering Germany. Although undoubtedly entrance to Germany was their final aim, these subversive stratagems foremost constituted creative actions on part of the applicants to re-appropriate their bodies in the context of a complex examination logics which was directed in multifold ways at the subordination of the applicants bodies and their forces to economic and public health ends. The applicants' resistance makes apparent how their bodies were no mere passive objects of power/knowledge-inscriptions; rather the very processes of inscription in the context of the medical examination offered the applicants opportunities for a creative re-affirmation of their bodies. However, as successful resistance resulted in an applicant's incorporation into the migrant labour force, these incidences of resistance were never external but intrinsic to the power mechanisms undergirding the examination procedure; instead of transforming the existing system of recruitment, they perpetuated and maintained it by providing a justification for strict health controls in the form of medical selection.

8 Conclusion

Man hat Arbeitskräfte gerufen, und es kamen Menschen. (They have called for labour power, and humans came). – Max Frisch

This famous saying by the Swiss writer Max Frisch succinctly describes the labour migrant's reduction to the body and its labour power. What remains unsaid is that not everyone who wanted to go abroad and work as a labour migrant was accepted. The quotation remains silent on the arduous application and recruitment process which prospective labour migrants had to undergo before entering Germany as officially recruited labour migrants. The medical examination at the German recruitment offices in Turkey is of major significance to this recruitment process; it marks a key moment of transition in which the labour migrant emerges. This thesis concentrated on the various conceptualisations of the labour migrant's body which were decisive in shaping the medical selection of those applicants deemed best suitable for industrial labour in Germany.

The conduction of the medical examination was guided by ability concerns with regard to physical productivity, latency fears with respect to disease and risk considerations concerning the value of the migrant's labour power. Underlying these varying concerns and considerations was a trifold conceptualisation of the body as an industrious machine, a potential carrier of latent disease and a commodity which shaped the medical examination's diverse logics. As a tool of disciplinarisation, a security apparatus and an instrument of risk management, the medical examination generated differing dynamics of inclusion and exclusion. Informed by an imagination of the body as an industrious machine, the medical examination served as an inclusionary tool for the selection of able, productive bodies. In accordance with the requirements of industrial labour, it created both gendered and disciplined working bodies which corresponded to the needs of a gender-segregated labour market and industry's demand for normed, docile and fit bodies. Complying with the common

modernisation discourse of the time, the medical examination was pervaded by and reinforced the German public perception of the 'guest worker' labour migrant as somebody who is backward and non-modern and can only achieve modernity through incorporation into the disciplined work processes of industrial production. Thus, the medical examination formed part of a discourse which both marked the labour migrants as fundamentally 'other' and defined industrial production as the only legitimate site for the realisation of modernity.

As a bio-political security tool, the medical examination aimed at protecting Federal Germany's health boundaries. In safeguarding the health of the national population, the examination procedure pursued an exclusionary logic which constructed the labour migrant's body as a locus of danger because of its potentiality to carry latent chronic and infectious diseases. Norm values emerged as gate-keepers, establishing a line of demarcation between 'normal' acceptable and 'dangerous' excludable bodies and medical technology enhanced the doctor's gaze expanding it into the interior of the body to identify the seemingly 'healthy' as latently 'diseased'. As mirrored by the special formulations of the German-Turkish recruitment agreement with regard to the labour migrants' health status, race concepts which informed the medical examination's implementation played a powerful role in marking the body of the labour migrant as essentially 'dangerous' in comparison to the imagined 'German body' associated with normalcy and health. These racialising effects became most evident in discussions on ESR norm values and the high TB affinity of labour migrants. The dominant discourse constantly reiterated by the Federal Employment Service, German health experts, politicians and the public media which tried to 'explain' the high TB infection rates among migrant workers, contributed to the depiction of the labour migrants as territorially, biologically and culturally alien to German society as well as to the imagination of 'foreign' bodies as having a greater incline for disease than native bodies.

The inclusionary and exclusionary logics of the medical examination were complemented by a third logic which constructed the labour migrant's body as a commodity. As an instrument of risk management, the medical examination had to guarantee that the value of the migrant's body and its labour power satisfied the future employer's expectations. Reducing the labour migrant's body to a mere 'good for sale', the medical examination thus fulfilled the role of a 'quality check' to minimise the risk of recruiting non-employable applicants for whom the employer might make 'return claims'. The institutionalisation of the medical examination, the right of employers to send back sick or unfit labour migrants shortly after their arrival in Germany as 'erroneous recruitments' and the pervasive discourse which depicted sick or disabled labour migrants as a massive burden on the Federal German state underlined how impeccable health and ability were preconditions for the labour migrants to enter and stay in the Federal Republic. This imperative of health and ability sustained the capitalist myth which maintains that the body and its labour power can be treated in analogy with commodities for sale on the market. Simultaneously, this imperative deliberately concealed the fictive character of this commodification process which incidences of disease and disability among the recruited labour migrants necessarily unmasked as being 'fictive'.

Disciplinarisation, normalisation, commodification and racialisation during the medical examination all aimed at a subordination of the labour migrants' bodies. However, this subordination was never complete. In the course of the examination, applicants performed creative strategies of low-profile resistance to reclaim their bodies and reaffirm their agency in the face of the examination procedure's subordinating logics. Similarly, some members of the medical staff who may not have challenged or questioned the overall logics of the examination nevertheless resisted and subverted the examination processes on an everyday level in various instances.

The institutionalisation of a medical selection procedure within the recruitment process and the varying conceptualisations of the body which informed this medical selection are the result of certain developments which date back to the 18th and 19th centuries. The implementation of the medical examination at the recruitment offices only makes sense with regard to the major transformations of labour and production processes from the 18th century onwards which went hand in hand with the emergence of the population as a distinct economic value for the state. During the 19th century, public health politics as a means to control and manage this economic value reached an unprecedented significance and presence in the public and private spheres of capitalist, industrialised societies. Industrial medicine developed as a branch of public health which was directly concerned with the physical condition of the labour force and the maintenance of its physical fitness to guarantee economic growth and stability. In this context, medical examinations of industrial workers by health professionals trained in the field of industrial medicine gained significance at the turn of the 19th/20th centuries. These examinations of workers served both as a means to ameliorate and protect the workers' health and as a means of disciplinarisation through the realisation of constant surveillance. It is these examinations together with the conceptualisation of the worker's body as a productive unit and an economic value which must be protected and enhanced through health measures which have greatly, though not exclusively, informed the logics of the medical examination at the recruitment offices.

However, the medical selection procedure at the recruitment offices was not only concerned with the working body, its health, ability and productivity, but also with the protection of the Federal Republic's health boundaries against the import of disease. Hence, the medical examination bears great semblances with the medical immigrant inspections conducted at the borders of the major immigrant countries which gained increasing significance from the late 19th century onwards in the context of mass migration movements

and the rise of germ theory. The spreading influence of germ theory underpinned nativist discourses which identified 'foreign' bodies as the primary carriers of disease and thus defined disease as a menace originating outside of the nation. The intimate connection between mass migration and nation building processes attributed a new, prestigious role to public health medicine. As the gate-keepers of the nation, public health officers were involved in the selection of those migrants deemed suitable for inclusion into the nation project and the rejection of those who were considered undesirable. Nativist and eugenic fears led to the singling out and exclusion of all those regarded as racially, physically and mentally inferior or morally suspect. Thus, medical practices at the border were never neutral in character but rather generative of certain inclusionary and exclusionary dynamics which arose out of the intermingling of health concerns with contemporary concepts of race, class, disability and gender/sexuality.

The medical immigrant examination at the recruitment offices transcended the physical examinations of workers and the medical immigrant inspections exactly because it combined aspects of both examination types. It was concerned with work suitability as much as border control in the name of public health. Similar to Amy Fairchild, I have argued in this thesis that Federal Germany's medical selection of labour migrants from Turkey did not simply constitute an instrument of immigration restriction but a means to incorporate an able-bodied, productive and healthy labour force into the national economy, at least on a temporary basis. Whereas Fairchild has argued that the either inclusionary or exclusionary aims of the immigrant examinations varied along the borders of the US with regard to who underwent the examination where, I have demonstrated for the case at hand that the exclusionary and inclusionary mechanisms, which Fairchild has located in separate geographical contexts and traced back to differing migration patterns, may well combine in one and the same

examination procedure. While Fairchild has identified race as the language of exclusion and labour as the language of inclusion in the context of US immigration policies, I contended in this thesis that the languages of race and labour are not necessarily opposed in character but mutually influencing. In other words, Federal Germany's recruitment and medical selection of a migrant labour force was in itself a racialised endeavour from the beginning because race concepts informed both the assessment of the applicants' work suitability and general health condition.

However, the medical selection did not only produce racialised but also gendered working bodies. Concentrating only on general criteria of health and ability as preconditions for industrial citizenship, Fairchild largely excludes questions of gender in her analysis of the immigrant examinations as a tool for the incorporation of an industrial labour force. In contrast, the selection of suitable working bodies at the German recruitment offices followed the demands of a gender-segregated labour market. Consequently, the medical examination did not only serve the incorporation of able-bodied labour migrants. Rather, it created gendered working bodies in accordance with the expectations of what constitutes genuinely female and male labour, thus reproducing the very gender norms of the labour market which the selection process had anticipated in the first place.

The medical examination at the German recruitment offices was not a mere combination of industrial worker and migrant medical inspections. It exhibited unique characteristics due to its integration into a state-supervised labour recruitment process. Most significantly, the regulation of 'erroneous recruitment' returns and the way in which the examination procedure contributed to the commodification of the labour migrant's body added a further subordinating quality to the examination which was not present in the medical inspections at factories and nation borders. The question arises what parallels to this commodifying logic of the examination procedure can be found in similar state-organised migrant labour recruitment

programs such as the US-Mexican bracero program. Future research might bring new answers to this question and illuminate comparable commodification practices in other labour recruitment contexts.

Also, future research could further expand the findings of this thesis by concentrating on the procedures of the medical pre-selection of labour migrant applicants on part of Turkish institutions and health experts prior to the applicants' examination at the German recruitment offices. Such research could ask for the ways in which selection dynamics and body conceptualisations emerging in the pre-selections differed from, resembled or contributed to the dynamics and logics inherent to the examinations at the recruitment offices. Further insights into Federal Germany's medical selection procedures of labour migrants could also be gained by a comparative perspective which takes into account the examination processes in Germany's other 'guest worker' recruitment countries of the time.

This thesis does not claim to have dealt exhaustively with the medical selection at the German recruitment offices in Turkey. Many questions and uncertainties with regard to the practical realisation of the examination, the actors involved and the actors' perceptions, identifications and interpretations concerning the examination procedure remain. While this thesis sought to answer some of these questions, further research as well as a critical public reflection on the examination procedures on part of the responsible institutions and parties, which has not occurred until today, will be necessary to overcome the silences which still surround these examinations in the public realm of contemporary Germany.

Appendix

Questionnaires for Interviews

Interview Guide for Interviews with Former Labour Migrants

Part 1: Context Questions

- How and when did you decide to apply for work in Germany, what were your reasons?
- What was your occupation and family situation in Turkey before your application for work in Germany?

Part 2: Recruitment Process and Medical Examination

- How did you apply for work in Germany?
- Can you give an account as detailed as possible of your impressions of the German recruitment office?
- What did you do in the recruitment office? What were the various steps you had to pass there until you were accepted for Germany?
- Can you give an account as detailed as possible of the medical examination? What examinations and tests were conducted?
- Who conducted the examinations, were these people Turkish or German, male or female?
- How did you experience the behaviour of the staff towards the applicants during the examination?
- Can you describe the rooms in which you were examined and the equipment used?
- Were there people who were examined together with you and rejected in the medical examination? Why were they rejected?
- How did the other people who were examined behave during the examination?
- Did you experience any cases of corruption and fraud in the recruitment office?
- (In case the participant was recruited more than once and therefore underwent the examination more than once): Did the proceedings in the examination change over the various times you were examined?
- When you had passed all the examinations, what work in what part of Germany were you recruited for? Was this the same work you had initially applied for?
- Do you have acquaintances that also underwent the medical examination, probably at a different time or place than you? Are their experiences of the examination different or similar to your own experiences?

Part 3: Evaluation and Reflection

- In what way was the medical examination different from or similar to other experiences with medicine and doctors you have had?
- What do you think was the purpose/aim of the medical examination? Do you think it achieved that aim?
- How did the experiences at the recruitment office influence your impression and image of Germany and your imagination of your life there?
- After you started working and living in Germany, did you keep thinking about the medical examination? Were there certain occasions when the memory of the examination was brought back to your mind?

Interview Guide for Interview with Former Physicians

Part 1: Context Questions

- How and why did you start working at the recruitment office? What was your motivation?
- Did you get a prior training on part of the Federal Employment Service concerning your occupation and Turkey before you left Germany?
- Had you ever done a similar job before you started working at the recruitment office?

Part 2: Working at the Recruitment Office

- How were you introduced to your tasks at the recruitment office?
- What was your typical working day like? What were your working conditions like?
- What were the examinations like; can you describe a typical examination procedure?
- In what kind of facilities did you conduct the examinations and what equipment did you use?
- What criteria existed to help you select the applicants? What did you especially have to watch out for while conducting the examinations?
- How do you evaluate these criteria?
- Did you have any manoeuvring room when applying the selection criteria?
- What was the average rejection rate? How do you evaluate the rejection rate?
- How was the cooperation among the various staff members both within the medical service and the recruitment office at large?

- How was the cooperation with the Turkish Employment Service? Were there any medical pre-selections by the Turkish Employment Service?
- How did you experience the work with the applicants? What impression did the applicants leave on you? Were there any attempts at fraud or cheating?

Part 3: Evaluation and Reflection:

- What do you think was the purpose/aim of the medical examination? Do you think it achieved that aim?
- How did you feel about your work at the recruitment office and the examinations you had to conduct?
- How did you perceive your own role in the context of the recruitment of labour migrants from Turkey?

Abbreviations

ÄD	Ärztlicher Dienst (Medical Service)
AOK	Allgemeine Ortskrankenkasse (German Health Insurer)
BArch	Bundesarchiv Koblenz (German Federal Archives in Koblenz)
BAVAV	Bundesanstalt für Arbeitsvermittlung und Arbeitslosenversicherung (Federal Employment Service; term in use until 1968)
BfA	Bundesanstalt für Arbeit (Federal Employment Service; term in use since 1969)
BMA	Bundesministerium für Arbeit (Federal Ministry of Labour)
BKK	German Health Insurer
DVT	Deutsche Verbindungsstelle in der Türkei (German Recruitment Office in Turkey)
IKK	German Health Insurer
PHS	Public Health Service
Ref.	Referat (Department)
RdErl.	Runderlass (Circular Note)
SAA	Siemens Archiv München (Siemens Archive Munich)

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B 119: BAVAV

B 149: BMA

DOMiD-Archiv, Cologne

Interview Record Collection

AL 001

AR 162

Siemens-Archiv, Munich:

SAA 10590

Personal Interviews [205]

Anton E., 23 July 2014 (telephone interview): Anton E. is a former examining physician at the German recruitment office in Istanbul. After completing his internship as an assistant physician, he decided to work abroad for a while in 1973. A colleague convinced him to join the medical team at the German recruitment office in Istanbul. Although Anton E. was not interested in pursuing a career in public health, he accepted the job at the German recruitment office because he was intrigued by the idea to spend a year in Istanbul. Before starting to work at the recruitment office, Anton E. already had made first experiences with industrial medicine and the physical examination of workers while working at the Regional Employment Office in Kiel, Germany, for two months. He took up work in the recruitment office's medical service in March 1973 and conducted medical examinations of prospective labour migrants until the recruitment stop in November 1973. As his contract ended in March 1974, he stayed in Istanbul until that date but conducted no more examinations after the recruitment stop. He did not pursue a public health career after returning to Germany but specialised in the field of internal medicine.

Arif E., Bremen, 9 March 2014: Arif E. is a former male labour migrant who was born in a village near the town of Düzce in Western Turkey. He initially worked as a court clerk and paymaster at the High Criminal Court in Düzce before his migration to Germany in 1973. In 1969 directly after his military service, he applied to the Turkish Employment Service for work in Germany because of the higher income options

[205] All names have been changed.

abroad. Due to the completion of a welding course before his military service, Arif E. applied directly as a skilled welder and in 1973, after deferring the German recruitment office's invitation several times for personal reasons, he underwent the selection procedure at the recruitment office in Istanbul including the work skill test and the medical examination. His application was successful and he was recruited as a welder by the shipyard AG Weser in Bremen where he worked between 1973 and 1979 until he changed his job.

Aliya K., Berlin, 27 February 2014: Aliya K. is former female labour migrant who was born in a village near Sivas, a city in Eastern Anatolia. She grew up helping in farm work. To escape the precarious living conditions in her village, she applied to the Turkish Employment Service for work in Germany. In early 1970, shortly after her application, she was summoned to the German recruitment office in Istanbul-Tophane where she underwent the medical examination. A bad tooth detected by the examining physician required her to get treatment and be re-examined a few days later. After finally passing the examination, Aliya K. was recruited as an unskilled worker for a rubber factory in Berlin where she worked until 1973.

Ayla A., Berlin, 12 March 2014: Ayla A. is a former female labour migrant from a village near the town of Uzunköprü in Western Turkey where she grew up helping in farm work and household work. After her husband had died in 1967, she applied to the Turkish Employment Service for work in Germany in 1969 following the advice of her cousin who already had work experience in Germany. Only six weeks after her initial application, she was summoned to the German recruitment office in Istanbul where she underwent the medical examination. Following the selection procedure, she became recruited as an unskilled worker for a cleaning company in Munich. She continued to work for the company until 1970 when her mother's sudden illness forced her to return to Turkey earlier than planned. In 1972, she reapplied to the Turkish Employment Service for work in Germany and in late 1973, just before the recruitment stop, she once more successfully underwent the selection procedure at the German recruitment office in Istanbul in the course of which she was recruited as an unskilled worker for a cleaning company in Berlin where she started to work in December 1973.

Barış G. and Emine G., Hamburg, 3 March 2014: Barış G. and Emine G. are a married couple from a village near Kayseri, a city in Central Anatolia. They are former labour migrants who migrated to Germany in the early 1970s due to economic reasons. In 1970, Emine G., then aged 21, was recruited by name for a laundry in Hamburg following the recommendation of her elder brother. She underwent the medical examination in the German recruitment office in Istanbul-Tophane. During the examination, she was diagnosed with hypertonia because she was still breastfeeding her first-born son and consequently not accepted as a labour migrant. She stayed in a nearby hotel for a whole month, weaning the infant until her values were deemed

normal and she passed on to Hamburg where she took up work as an unskilled worker in the envisaged laundry.

In 1971, Emine G. arranged for her husband Barış G. to be recruited by name for the same factory. He underwent the medical examination at the German recruitment office in Istanbul but was rejected because of his x-ray results showing traces of pneumonia dating from childhood age. After rejection, he individually entered Germany with a tourist visa in 1971 and moved to Hamburg. In 1976, his work permit was issued and Barış G. subsequently worked for a cleaning company in Hamburg.

Bernd O., 3 June 2014 (telephone interview): Bernd O. worked as a radiologist in the medical service of the German recruitment office in Istanbul between July 1972 and April 1973. After specialising in the field of internal medicine and working as senior internist in a hospital in South Western Germany for two years, Bernd O. desired to work abroad for a change of scenery and new experiences. He first intended to apply for a vacant job position at the German Hospital in Istanbul but as strict requirements were imposed on non-Turkish physicians who wanted to practise in Turkey, he instead accepted a job offer from the recruitment office's medical service. Employed as a radiologist, Bernd O. was exclusively responsible for the evaluation of the applicants' radiographs and did not participate in the physical group examinations. The job at the recruitment office was his first practical experience in the field of industrial medicine. After his return to Germany, her did not pursue a further career in the field of public medicine but continued to work as an internist.

Emel L., Berlin, 10 March 2014: Emel L., born 1941, is a former female labour migrant from Adana, a city in South-Eastern Turkey. In spring 1965, aged 21, she applied to the Turkish Employment Service for work in Germany because of a difficult marriage situation and financial problems in her marriage. Due to her previous completion of a two-year training course in tailoring in Adana, she applied as a skilled worker. A few weeks after her application, she was medically examined by the Turkish Employment Service and then sent to the German recruitment office in Istanbul where she underwent her second medical examination and a work-skill test. Based on her work-experience as a seamstress and the dexterity of her fingers, she was selected for attending a six-week Siemens training course in Istanbul. In December 1965 after the completion of the course, she moved on to Munich where she started working for Siemens doing assembly work and soldering work until she changed her job in 1970.

Emil P., 9 July 2014 (telephone interview): Emil P. is a former examining physician at the German recruitment office in Istanbul. He joined the recruitment office's medical service in early 1973 on a one-year contract basis, directly after the completion of his internship as an assistant physician because he intended to gain work experience abroad. Emil P. had no prior work experience in the field of public health or industrial medicine and he did not aspire to pursue a career in these fields. Until the recruitment

stop in November 1973, he conducted medical examinations of prospective labour migrants. He stayed in Istanbul until the end of his contract in early 1974 but he conducted no more examinations after the recruitment stop. Emil P. did not pursue a public health career after returning to Germany but became a paediatrician.

Ender A., Berlin, 2 March 2014: Ender A., born 1935, is a former male labour migrant from Adana, a city in South-Eastern Turkey. Out of curiosity and adventurism, he applied to the Turkish Employment Service for work in Germany in 1967. As a learned electrician with a good-running job in Adana, he was not economically obliged to search for work abroad. A few weeks after his application, he was first medically examined by the Turkish Employment Service in Adana and then sent to the German recruitment office in Istanbul where he underwent a second medical examination by the recruitment office's medical staff. Due to lack of German language skills, he could not apply as a skilled electrician and had instead applied as an unskilled worker. Consequently, no work-skill examination was conducted. Following his examination, he was recruited for the textile industry in Bremen. After working several years in the textile sector in Germany and learning sufficient German, he started working as an electrician in Germany.

Ülkü E., Berlin, 13 March 2014: Ülkü E., born 1952, is a former female labour migrant from Izmir, a city in Western Turkey. In 1969, she applied to the Turkish Employment Service for work in Germany to escape the precarious financial situation in which she had had grown up, working in a tobacco factory in Izmir since the age of ten. Five months after her application she was summoned to the German recruitment office in Istanbul where she was medically examined. As she had applied as an unskilled worker, no work-skill examination was conducted. Following the selection procedure, she was recruited for the white goods factory AEG in Berlin where she started working as a solderer in January 1970. She remained a worker of the same factory until 2010.

Ümit R., Berlin, 29 January 2014: Ümit R., born 1946, is a former female labour migrant from a village near the city of Izmir in Western Turkey. In late 1969 she applied to the Turkish Employment Service for work in Germany because her husband was seriously ill and money was needed for his treatment. In early, 1970 she underwent the medical examination at the German recruitment office in Istanbul-Tophane. Following the selection procedure, she was recruited as an unskilled worker for Siemens in Berlin.

Other Interviews

Interview by Cord Pagenstecher with Kurt Mader and Heinz von Harrassowski, former members of the recruitment staff in Italy, Yugoslavia and Turkey, Nuremberg, 28 April 1992. Summary of the interview transcript was obtained with Pagenstecher's consent.

Interview by Mathilde Jamin with a former female placement staff member of the recruitment office in Istanbul, 25 Jan. 1996. DOMiD interview record collection.

Interview by Aytaç Eryılmaz with two former assistants of the Istanbul recruitment office's medical service, Istanbul, 1 March 1996. DOMiD interview record collection.

Interview by Aytaç Eryılmaz with former male assistant and female employee of the recruitment office in Istanbul, Istanbul, 13 to 15 Aug. 1996. DOMiD interview record collection.

Interview by Mathilde Jamin and Aytaç Eryılmaz with the last director of recruitment office in Istanbul, a former member of recruitment office's placement staff and a representative of the Federal Employment Service, 29 August 1996. DOMiD interview record collection.

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