**Prologue**

On the morning of Tuesday, November 12, 2019, following a night during which the Israeli army killed a senior Hamas terrorist, air raid sirens were triggered in Tel Aviv in response to rocket fire from Gaza. The sirens are a warning to all those living in the area to proceed immediately to shelters or protected spaces. At the same time, the Home Front Command instructed all residents of the area to refrain from traveling to work or study because of the ongoing threat of rocket fire.

Minutes after the sirens were triggered and these instructions issued, I (the first author) received two text messages. The first was sent on behalf of the nursing and domiciliary care agency though which Emily, my mother’s Indian domiciliary care worker, is employed. The text, addressed to the agency’s care workers, read: “Dear care workers, further to the instructions of the Home Front Command, no work is to take place in your area today. Kindly comply with the instructions. We wish you all a calm and peaceful day, B.T. Care Agency.” The second text arrived a few minutes later, from another team from the same agency. This time it was addressed to patients (or, in reality, to the patients’ relatives with whom the agency liaises.) It read: “Dear patients, in light of the security situation and in accordance with the instructions of the Home Front Command, your care worker will not be coming to work. We will continue to monitor updates and act in accordance with instructions. Have a quiet and peaceful day, B.T. Care Agency.”

At the same time, I also received a WhatsApp message from the tenants’ committee of the apartment building where my mother lives, informing tenants that the air raid shelter in the basement had been opened. My mother lives on the ground floor of a four-story apartment building in north Tel Aviv. The building is about 70 years old, and the basement shelter is at the bottom of a narrow, steep flight of around 20 stairs. The shelter door is usually kept locked, except during emergencies like this. With no elevator in the old apartment building, there is, of course, no elevator access to the shelter.

At that early hour, I had just arrived at the parking lot of the college where I work. The college is in the north of Israel, some distance from the areas affected by the air raid sirens. After receiving the messages, I checked the news, and learned that a short time ago, missiles had indeed been fired and had been intercepted in the skies over Tel Aviv. Half of Israel, from Tel Aviv to the south, was under missile attack and paralyzed. As I was reading the news, my phone rang. My daughter, who lives in Tel Aviv, was calling me in a panic to ask me what she should do, as her building has no shelter and her apartment does not have a reinforced safety room. I could hear the fear in her voice, and tried to calm her down and advise her.

Emily also called me. She too sounded very stressed, and asked me what she should do if the siren went off again. My automatic response was that, in the event of another siren, she should leave my mother in bed, lock the apartment door, and go down to the shelter alone. It was clear to me that there was no point in having Emily try to get Mom down the stairs to the shelter. Mom is not used to going down stairs, is unsteady on her feet, and usually resists when you try to coax her along, so she might fall and injure herself on the way down. Given all this, trying to take her to the shelter would take a long time, and would prevent Emily getting to the shelter in time herself. The thought that flashed through my mind in those moments was, “Mom is old and sick, there is no point in endangering Emily by asking her to try to take Mom to the shelter. I am responsible for Emily’s safety, she is a young woman and the mother of a toddler, she came here from India to take care of my mother, and should not be part of this conflict at all, so I need to tell her to take care of herself and go down to the shelter.”

I listened to my own voice. I told myself that I had done the right thing for Emily. But did I do the right thing for my mother? To leave her alone in bed when sirens were going off? My heart was heavy.

The split-second decision I had to make that morning was about choosing between my obligations as an employer toward the emotional well-being, safety, and security of the care worker who looks after my mother, and my obligation as a daughter responsible for the well-being of my mother, who has severe dementia and cannot take care of herself. What I decided for my mother was to leave her alone in her apartment during such a tense situation, with sirens piercing the air. I made a decision that meant my mother would be exposed to the threat of missiles, with no chance of defending herself and with no one by her side. No one had prepared me for a moment like that, when I would be forced to make such a decision. I did not have any professional ethics to guide my choice. There was no set of rules that could help me decide. And I had no time to think. My employment contract with Emily, the contract that I signed with the B.T. nursing and domiciliary care staffing agency, did not include any reference to such a moment, and the text messages I received from the agency did not contain anything that could guide me. The messages relaying the Home Front Command’s instructions for citizens to remain in their homes and not go outside to avoid exposure to missiles, were completely disconnected from my mother’s situation and had no relevance to it, since my mother’s care worker did not need to leave her home to go to work. In domiciliary care, the home is also the workplace.

This story is unusual. Even for Israel, this was an exceptional event. Yet it does reflect an important, central aspect that is characteristic of the experiences of family members who are both the employers of care staff and also the main caregivers for their relatives. This paper examines the moral dilemmas faced by caregiver family members in their role as employers (in practice) of migrant care staff for their sick relatives. Being a family caregiver who employs a migrant care worker in the home often puts family members at a crossroads, where decisions must be made both on a routine basis and during exceptional events. Lacking a formal therapeutic role, family members do not act according to a professional code of ethics or other clear rules. However, their behaviors and choices are real-world actions that are influenced by connections rooted in cultural, community, familial, and personal values. These decisions involve complex moral human dilemmas, which this paper seeks to shed light on.

**Introduction**

“Aging in place” is a leading gerontological approach that perceives the home as a better alternative for an elderly person’s health, as well as for the peace of mind of her family members (Hoens & Smetcoren, 2021). As “aging in place” becomes a preferred solution in many parts of the world (Ahn et al., 2020), the role of caregiver relatives has become critical. This is a demanding and challenging role, however, especially in cases involving elderly people who require round-the-clock nursing care. One of the main solutions family members find for help in meeting the demands of this role is the employment of migrant care workers, a solution that is becoming increasingly common in many countries around the world, including Israel (Ayalon et al., 2015). However, this arrangement involves the creation and maintenance of complex and challenging relationships (Arieli, 2021; Munkejord, Ness & Silan, 2021; Porat, 2022).

The extensive literature addressing the struggles and difficulties faced by family members who are the primary caregivers for relatives requiring nursing care focuses on how these family members cope with the relationship with their sick loved ones and the burden of care placed upon them. This literature sheds light on the physical and emotional burdens family caregivers face, and the health risks to which they are exposed as a result (Carmeli et al., 2019; Strommen et al., 2020). However, as has been argued previously (e.g. Salami, Duggleby & Rajani, 2017), the international literature does not devote sufficient attention to examining the struggle of caregiver relatives with the important issues that many of them face, in particular the difficulties and dilemmas involved in becoming the employers of migrant care workers, and the obligations that this role involves.

Studies that have incorporated research into this area reveal how people from very different backgrounds (ethnic, national, racial, class, etc.) become entangled in a paradoxical relationship. On the one hand, it is very intimate, since it occurs in the family home, within the most private spaces, such as the bathroom, the kitchen, and the bedroom, but on the toher, it is also an employer-employee relationship (Ayalon, 2009; Martin-Matthews, 2007; Mazuz, 2013; Shinan-Altman & Ayalon, 2019). In this respect, this relationship exists between the private and the public spheres, thus giving rise to considerable ambivalence and ambiguity (Arieli, 2021; Rosenthal, 2007).

Much of the literature on the employment of migrant care workers focuses not on the employers’ experiences, but on those of the migrant care workers themselves, particularly disadvantaged migrant women (Parrenas, 2020). In this research context, family members who employ migrant care workers are often presented as holding power and as being powerful, exploitative, and victimizing (Mehta, 2017). This literature, which seeks to give voice to the workers, includes testimonies from workers who ran away from their employers and who describe cases of starvation, physical and emotional violence, humiliation, and abuse at the hands of their employers (Braedley, Owusu Przednowek & Armstrong, 2018; Ehrenreich & Hochschild, 2013). In Israel, too, many migrant workers reported experiences of abuse and humiliation by their employers (Green & Ayalon, 2016). These difficult reports require attention and intervention. Ways must be sought to prevent their recurrence and measures must be taken against those who behaved so offensively. In addition, there is also a need to obtain more information about the experiences of the employers of migrant care workers. Understanding the types of challenges and difficulties employers face can prove important in finding ways to alleviate these problems and in contributing to the well-being of the workers (Salami, Duggleby & Rajani, 2017).

Caring for a family member who has lost his or her ability to make decisions and act autonomously, such as those with advanced dementia, presents caregivers, whether they are professional care workers or family members, with moral dilemmas. Family members are not formal care workers and are not part of any professional framework that sets out guidelines of professional ethics for them. Their role as employers of migrant care workers presents family caregivers with yet another set of moral dilemmas, but there has been almost no research on this topic. This study seeks to contribute to better understanding this issue by addressing the ethical challenges faced by family caregivers in Israel who employ care workers for round-the-clock domiciliary care for their ailing loved ones. Specifically, this study focuses on the moral dilemmas faced by family members who employ migrant care workers.

**Migrant care workers in Israel**

Migrant workers, referred to in Israel as “*ovdim zarim*” [Heb: “foreign workers”], have been integrated into the Israeli labor market since the beginning of the nineties. They come mainly from developing countries to meet the demand for workers in various sectors of the economy, in particular agriculture, construction, and care.

The regulation of the recruitment and employment of migrant workers is set out in several laws, mainly the Foreign Workers Law (1991). The law has not established a mechanism for recruiting migrant workers, and the recruitment process is mostly carried out through private personnel agencies in Israel and abroad. According to Israeli government policy, in recent years, regulation of the recruitment and employment of migrant workers in Israel, with the exception of the nursing/care sector, has mainly been carried out within a framework of bilateral agreements signed between the Israeli government and the governments of the countries that supply workers. The purpose of these agreements is to improve the process, and in particular to protect the rights of migrant workers when they are recruited to work in Israel, including by preventing private entities in Israel and the workers’ countries of origin from levying recruitment fees and high commissions from workers (Population and Immigration Authority and CIMI (The Center for International Migration and Integration), 2016). In the nursing field, too, the Israeli government is seeking to bring in workers under bilateral agreements with the workers’ countries of origin; in June 2021, the implementation of the first bilateral agreement for nursing signed between Israel and the Philippines, came into effect.

The employment of domiciliary care workers by private individuals who wish to remain in the community is encouraged through the Long-Term Care Benefit. In 1984, Israel enacted the Nursing Law,[[1]](#footnote-1) which enables the financing of domiciliary care through National Insurance (the Long-Term Care Benefit). The Benefit is designed to allow older people to continue to live in the community for as long as possible, through the provision of personal care to those who need assistance with daily living, or supervision[[2]](#footnote-2). This represents a significant development regarding the treatment of older people and people with disabilities in Israel, since for the first time, the need to support these individuals in their home communities (as opposed to in a nursing home) was officially recognized, a need that had grown over the years. The amount of Long-Term Care Benefit to which an individual is entitled is calculated according to the functional capacity of the applicant, and his or her income. The official employer of domiciliary care staff is the patient him- or herself.

In order to employ domiciliary care staff, patients must obtain a valid permit. Valid permits are granted to individuals who need care and assistance during most hours of the day to perform most activities of daily life (including bathing, dressing, mobility, going to the bathroom), according to criteria that are mostly based on functional dependency tests (ADL) conducted by the National Insurance Institute. The main population cared for by migrant care workers in Israel are elderly people with disabilities who are living in the community, and the number of workers in the domiciliary care sector is affected by the size of the demand among the disabled and disabled elderly population. Permits to employ a migrant worker in a domiciliary care capacity are granted by the Population and Immigration Authority, and holders of migrant care worker employment permits must allow the worker to reside in his or her home. Migrant care workers receive a valid visa for one year, which can be renewed annually for a period of five years and three months, or until the death of the last patient with whom they worked before the expiration of their basic visa period.

According to data from the Population and Immigration Authority, in 2021 there were over 70,000 migrant care workers in Israel, of which 57,509 were legal workers and 14,039 were illegal workers (Population and Immigration Authority, 2022, Table 6). Most of the legal migrant workers resident in Israel at the end of 2021 came from the following countries: the Philippines (35%), India (25%), and Uzbekistan (15%). The percentage of illegal migrant workers from the total number of workers resident in Israel and working in the care sector was about 20% at the end of 2021 (Population and Immigration Authority, 2022, Table 6).

The breakdown of the data on migrant workers resident in Israel at the end of 2021 by age shows that the most common age group across all labor categories is 31–40. A breakdown of the migrant worker population by gender shows a large majority of women—83%, the vast majority between the ages of 31–50 (Population and Immigration Authority, 2022, Table 6).

As noted, the main law governing the employment of migrant care workers in Israel is the Foreign Workers Law. The two ministries responsible for this law are: the Ministry of Welfare and Social Affairs, which is in charge of implementing instructions regarding employment conditions and labor law; and the Ministry of the Interior, which is responsible for implementing instructions regarding work permits for migrant workers, their transfer between employers, and for depositing funds for their benefit and to ensure their departure from Israel when their visas expire. A pamphlet published by the Ministry of Welfare and Social Affairs in December 2019[[3]](#footnote-3) sets out the conditions of employment for migrant workers the domiciliary care sector, and includes the following clauses:

1. The private agency must provide workers with information about their rights in a language that they and their employers understand.
2. Prior to the commencement of employment, an employment relations agreement must be signed in a language the worker understands.
3. Workers may only be employed in a full-time position in domiciliary care and only by an employer who holds a valid employment permit. The scope of the worker’s employment contract is six working days per week without specified working hours.
4. Workers are entitled to a weekly rest day of 25 hours, taken at the employer’s home or at another location, according to the worker’s wishes.
5. Absence from work: the rules for absence from work, such as due to illness, that apply to an Israeli employee shall apply to the foreign worker also.
6. Adequate housing: it is mandatory to provide workers with adequate housing for the entire period of their employment and for a period of seven days following the termination of the employment.
7. It is mandatory to arrange medical insurance for the worker for the entire period of his employment.
8. Workers are entitled to paid vacation days, holidays, and recuperation days.
9. Minimum wage: Like all workers in Israel, migrant workers are entitled to at least minimum wage.
10. The labor laws include dismissal conditions that are identical to those for any other worker in the economy.

It should be emphasized that the Entry into Israel Law, which regulates the status of all persons who are not citizens or residents, as well as categories of visas and permits for remaining and working in Israel, stipulates that workers who are not citizens or residents are authorized to work in Israel for a temporary period only with a type B/1 work visa, and must leave Israel upon its expiration. Persons who fail to do so will be subject to arrest and deportation. A migrant worker would also expect to be subject to deportation from Israel in the event of abuse or violation of the law or of any relevant procedures applicable to them, such as making false statements in his or her visa application, entering Israel with the intention of leaving the employer with whom he or she signed an employment contract, or in the event that a worker is found to be unsuitable to work in the profession for which he or she came to Israel, or where the worker is found to have first-degree relatives (other than brothers or sisters) in Israel. The law also states that, if a worker gives birth during her work in Israel, she must remove the infant from Israel upon the completion of her maternity leave. In addition, in exceptional cases, there is an option to apply to the Inter-Ministerial Advisory Committee to the Population and Immigration Authority to determine and grant status in Israel for humanitarian reasons, e.g., in situations where a worker may suffer harm if he or she leaves the country, such as if he or she has a need to remain in Israel for health and recuperation purposes.

**Ethical issues in the employment of migrant care workers**

Numerous ethical dilemmas accompany the employment conditions of migrant workers. These employment conditions are the basis for defining migrant workers as a unique group and for the discussions that take place in many countries around the moral issues of employing migrant care workers (both those with and without professional training) (Perlman, 2012). The harms suffered by migrant care workers may be explained in terms of structural injustice. Structural injustice occurs when social processes (that is, social norms, economic structures, institutional rules, benefit and sanction structures, decision-making processes, and more) place large categories of people under a systematic threat of control or a denial of the means to develop and realize their abilities. At the same time, these processes allow others to control or obtain a wider range of opportunities to develop and realize their abilities (Eckenwiler et al., 2012­).

At the root of the moral issue is the fact of the employment of workers from one country in a second country, under restrictive conditions that differ from those to which citizens of the employing country are subject. However, since the employment is entered into voluntarily and legally, it is difficult at first glance to perceive any moral flaw (Miller, 1990). Even though the employment allows both parties to improve their situation, and even though the arrangement is voluntary, there is nevertheless an alternative theoretical arrangement whose outcome would be more favorable to the workers. That is, for example, if after some period of residence in the country of employment, the migrant workers would be allowed to obtain permanent resident status (as is the case in Canada); or if migrant workers were paid a higher hourly wage than the norm in the local economy; or if their job entailed fewer working hours; and if additional hours beyond the normal eight-hour working day were to be paid overtime. As a result, migrant workers are considered the “exploited party.” The stronger party, the employer, has the ability and interest to block a theoretically fairer deal (Miller, 1990).

Since an “exploitative transaction” nevertheless also benefits the exploited party, it is preferable to a situation where there is no transaction at all. Consequently, the exploited party will choose it, apparently voluntarily, but, in reality, without much choice. It follows that in an exploitative transaction there is a combination of an unfair process with an unfair outcome (Wertheimer, 1996). This issue is expressed on a global level predominantly in the context of professional labor (doctors, nurses, etc.) that is lacking in the poorer countries of origin, but also, and no less so, in the personal ethical issues that arise due to the practical difficulties in employing migrant domiciliary care staff (Brush & Berger, 2004).

A significant number of migrant care workers are women who trained as nursing professionals and who might have held roles in health systems in their countries of origin if they had not sought to work abroad. Others are women with no formal training in healthcare, but who have a role within their families in terms of provision of care to children, the sick, and the elderly. Therefore, their traveling abroad for work should be perceived as conflicting with the health and care needs of their countries of origin, mainly in light of the fact that, in some cases, poorer countries have failing healthcare systems. There are many ways to perceive what is at stake ethically for those living in migrant worker origin countries with failing healthcare systems. They can be said to be harmed because healthcare resources in these countries are not equally distributed, and because the equality of the moral value of certain groups of people, and consequently equality of opportunity, is denied (Daniels, 2000). It can also be argued that their basic interests for living a life of choice, well-being (Ruger, 2006), and basic human rights, are threatened (Eckenweiler, 2020).

The harm to migrant workers in the domiciliary care sector may be explained in terms of structural injustice. Structural injustice occurs when social processes (that is, social norms and economic structures, institutional rules, incentive and sanction structures, decision-making processes, and more) place large categories of people under a systematic threat of control or denial of the means of development and well-being and the realization of their abilities. At the same time, these processes enable others to control or access a wider variety of opportunities to help them develop and realize their abilities (Eckenweiler, 2020). From this perspective, the asymmetry of the migration of domiciliary care workers gives rise to situations that are extremely problematic from an ethical point of view, e.g. in terms of violation of autonomy and the principle of fairness. If we understand autonomy as the basic possibility for an individual to be relatively free to choose their actions and the course of their life from a proper set of options, and if the concept of fairness is based on equal opportunities and a sufficient reward for one’s actions, then the picture that emerges is complex.

Threats to the autonomy and equality of migrant care workers stem from several sources. As part of the feminization of international migration, women seeking work in more affluent countries as maids, nannies, nurses, and other care workers have become a particularly integral part of the global economy (Ehrenreich & Hochschild, 2002). When the global migration of nurses and other care workers is fueled by the “ideological construction of jobs and work in terms of notions of appropriate femininity” and in terms of racial and cultural stereotypes, it presents particular cause for concern. The construction of Filipinas, for example, as caring, obedient, meticulous workers, “sacrificing heroines” (Schwenken, 2008), and of Indian and Caribbean women as naturally warm-hearted and happy, etc.—serves the purpose of governments, industrial organizations, and employers, recruiters, and even families, who consume their services. However, these stereotypes limit the imagination, opportunities, and choices of women and girls, especially those who come from a background of economic hardship.

Moreover, migration from low-income countries often takes place in the context of nationalist rhetoric that supports neoliberal economic policies. One form of this rhetoric is organized around benefits to countries’ economies. Here, the worker’s subjectivity “organizes and adjusts itself” not necessarily because of force or coercion, but (supposedly) because (her) choices align with “community interests.” Another rhetorical strategy implies that migrant workers, and especially women, benefit from expanded opportunities for choice and opportunities for equality (Schild, 2007). These two strategies essentially impose expectations of individual responsibility for family and community well-being. However, although married women with children are encouraged and even pressured by governments, family members, or by the poor conditions they face at home, to provide for their families and countries by taking jobs abroad, and they are ostensibly presented as “modern heroines,” they are also often blamed for social ills, such as divorce, children’s poor school performance, and teen pregnancy in their countries of origin (Parreñas, 2000). Gender norms persist, therefore, and are manipulated, rendering their well-being and personal autonomy even more difficult.

Who is responsible for addressing the harms caused to migrant nursing workers, their families, and communities, and to those in the workers’ countries of origin who face high burdens of disease and labor shortages? The set of agents involved, and therefore responsible candidates, includes governments in the destination countries and in the countries of origin, international recruitment companies, international health corporations, and staffing agencies. But here the question also arises of whether those who employ migrant care workers, benefit from their work, and interact with them not only on an employer-employee basis but also in intimate family interactions, also bear this moral responsibility.

This paper, which seeks to discuss moral questions regarding the employment of migrant care workers, does not address global moral questions. Instead, we address the ways in which broad moral questions translate into the everyday practicalities of domiciliary care. Specifically, the paper focuses on moral dilemmas faced by caregiver family members in Israel who employ migrant domiciliary care workers to look after elderly parents who require round-the-clock care. These family members are not professional care workers, and do not have professional ethical guidelines to assist them. Nevertheless, their role as employers requires them to deal with moral questions with weighty practical consequences on an almost daily basis. Despite the considerable importance inherent in understanding how family caregivers cope with their role as employers of migrant care workers, the literature to date has barely touched on this topic. This paper seeks to fill in some of the gaps.

**Methodology**

This paper is based on an autoethnographic field study conducted by the first author, which dealt with home care for the elderly in Israel (xxx, 2021). The fieldwork included keeping a field diary, as well as interviews with caregivers, family members who employ caregivers, and service providers in the field. This paper will focus on one of the important themes that arose from that study relating to the experiences of family members in dealing with moral dilemmas arising from their dual role as family caregivers and employers. The paper is written as a case study. According to Yin (2018), a case study is experimental research, empirical in nature, which investigates a phenomenon that is part of the fabric of everyday life. Stake (1995) created a typology for three types of case studies: (1) internal case studies, intended for in-depth acquaintance with a case to understand its essence and to gain insights about it; (2) instrumental case studies, which are not carried out for the case itself but to gain additional insights regarding a certain topic; and (3) collective case studies—a study of a collection of specific cases, with the help of which, either through their similarity or differences, general insights are obtained.

This paper focuses on a single case, which demonstrates the tensions that exist between the multiple roles if family members. This multiplicity of roles stems from the fact that, on the one hand, family members are entrusted with preserving the quality of life of a sick relative, especially when it comes to those with advanced dementia who cannot express their own opinion and will; while on the other, they are also the employers of migrant care workers and have a legal as well as a moral responsibility to care for the workers’ welfare.

The case described below is real, but several identifying details have been changed to protect the identity of those involved. The study obtained approval from the ethics committee at the authors’ academic institution, and the interviewee whose story is presented below signed an informed consent form and gave consent for her story to be included in academic publications resulting from the study.

To analyze the case and address the complex ethical issues that arise from it, we use the Ethical Assessment Screen (Boland-Prom & Anderson, 2005). This model is particularly suitable for analyzing cases that have difficulties that professionals in therapeutic fields refer to as “dual relationships.” The model presents 14 questions, the answers to which should lead to an answer regarding the appropriate action in an ethical dilemma, and in particular in a dual relationship dilemma. The questions include matters such as the conflict of values and emotions that are inherent in the issue, the possible courses of action, and the impact of decisions that will be taken on the various parties involved. The discussion of dual relationships must also include considerations related to the context of the case: to what extent are the parties involved independent and able to choose autonomously? What are the laws involved in the issues at hand? What are the cultural norms of those involved in the dilemma? (Boland-Prom & Anderson, 2005).

Other considerations include identifying characteristics of the relationship, such as the extent to which it involves physical intimacy, personal favors, emotional needs and dependence, actions with altruistic motivations, and unplanned dual relationships. In the context of all these types of relationships, it is important to identify the elements of power and vulnerability, and the cultural norms of the population (often, more than one population) to which those involved in the dilemma belong, since these populations are also “parties to the dilemma” (Gottlieb, 1993). Other important dimensions that shape the ethical dilemma, according to Gottlieb, are the power relations between those involved, the length of the relationship, and its extent, and how clear the end of the relationship is (Gottlieb, 1993).

**The case: “And then she got pregnant”**

Eden’s mother Ruth (names changed) is completely paralyzed, bedridden, and does not communicate at all. Ruth has been diagnosed with Alzheimer’s and has been living with a domiciliary care worker for eight years. In our interview, Eden opened up about her upsetting visits to her mother’s home, the guilt she felt when she did not visit for several days, her own suffering in the face of her mother’s pain and sores, her own and her sister’s dilemmas regarding various decisions that had to be made, and her feelings of helplessness, uncertainty, and anxiety. Eden described a whole world of hardships, and only after she had finished expressing these feelings did the interview begin to focus on its defined aim—to learn about Eden’s relationship with her mother’s caregiver. Lynne, a migrant care worker, had lived with Ruth for seven years and for some of that period they enjoyed a pleasant relationship. But then, all kinds of disturbing things began to happen, until finally, about a year ago, Eden and her sister Moran (name changed) fired Lynne and brought in another migrant care worker to replace her.

This is the story that Eden related about the events that led up to Lynne’s dismissal:

*Most of the time it was usually OK. There was a sense of trust…in many ways she could be trusted. But in other ways she was…there were all kinds of unpleasant incidents. For example, the agreement was that she would have Saturday or Sunday off, and that she would travel to her friends, and we asked if she could get us an auxiliary to replace her, and she told us that the auxiliary costs such and such money. So, one day we asked the woman who stood in for her on Sundays how much she was getting paid and it turned out that Lynne was pocketing the agency fees. We asked her about it and we were very upset. And she said that it was very difficult to get an auxiliary to stand in and all kinds of things that we didn’t understand. In short, she continued fooling us for a while.*

*About my sister and me… we both saw things a bit differently. Like, my sister was very upset and even thought about getting rid of her, but I really got it. Like, I thought about the fact that she’s got a daughter who stayed behind, and a husband who stayed behind…Like, I always thought about the price the care worker had to pay so she could come take care of my mom. I can’t help seeing that, and I think that no money is going to make up for the fact that these care workers aren’t raising their own kids. So, what I’m saying is, even if she slipped a bit more money into her pocket, well I really got that. Maybe it’s going to sound like I’m a soft touch or something, but I understood where she was coming from. And we kept Lynne with us.*

*There was a time when she told us that she had a boyfriend in Tel Aviv and that sometimes he would come visit her in the house and we agreed to that. And one day she told me with a very pained, long face that she’d found out that this boyfriend had a wife in the Philippines and another girlfriend in Tel Aviv, and she’d dumped him. At the same time, there was a guy who hung around the house a lot who she said was her cousin. At that time, after the breakup, this cousin was in the house a lot. He helped take my mom down, bathe my mom, he was an auxiliary and we paid him. We didn’t know he was sleeping there. It turned out he was sleeping there. Then one day she said she was pregnant and she said it was with the man from Tel Aviv who she’d broken up with, that at the last minute she’d gotten pregnant by him. And she decided to keep the baby. She worked with mom until right before the birth and this cousin was around the whole time.*

*When the baby was born my sister was against Lynne continuing to live with my mother with the baby. She made all kinds of claims that it would disturb mom. I was actually in favor of them staying, but my sister said that apart from the fact that having a baby in the house would disturb mom, having two care workers in the house wasn’t a good idea. Lynne couldn’t carry on working as a care worker after the birth, so the other care worker we brought in to replace her would probably have some tensions with Lynne. Anyway, basically I was convinced and Lynne moved to some rental apartment in town, and after three months she took the poor baby to her parents in the Philippines and she stayed there several months. We actually didn’t see her for five months, and then she came back.*

*What we were not aware of, but what became clear to us later, was that the guy we thought was her cousin was actually her boyfriend. We don’t know if it was the same guy from Tel Aviv, but we found out that he was the father of the baby. We found that out from the new care worker we hired for my mom, to replace Lynne. This caregiver we brought was illegal. She was amazing, full of joy, and I loved her very much. She would give stale bread to the birds that would come to mom’s balcony, and she would sing, she was just an angel. And she told us about Lynne because she and Lynne overlapped.*

*I remembered something else. When Lynne came back from the Philippines after she’d taken the baby there, a few months later, it turned out that she had cancer in one of her ribs. She was really scared and she had surgery, and we brought the replacement care worker in again during the surgery. The care worker told us that the cousin was coming to the house, that he came home drunk, that he was actually living in the house without us knowing, and that one time he even beat Lynne, and Lynne had told her, ‘look I can’t live without him,’ and Lynne also told her that he was actually the father of her baby.*

*My sister and I went to talk to her together and we asked her if he really was the father of her son, and why hadn’t she asked permission for him to live there with her. Anyway, she shrugged it off and said he was her cousin and not her son’s father, and also that he didn’t live there, he’d just left some stuff there but didn’t live there.*

*I don’t know who to believe because it was obvious to me that there was serious competition between them about who was going to stay working with us. So, to this day I don’t know. But a lot of things built up and we actually parted ways with Lynne.*

*My sister was more in charge of handling the firing but I think Lynne also knew that she couldn’t go on working for my mother because of her physical condition; she couldn’t do serious physical labor. So, it was obvious that she couldn’t continue to work for us because of that. I gave her a reference. My sister didn’t want to give her one. I gave it her so she could go get another job, and she did in fact get a job after us, with people who are ambulatory and aren’t in such a difficult care situation*.

**Discussion**

The literature on transnational migrants from developing countries, and their relationships with employers in developed countries, often portrays images of the “harmful employer.” Employers of migrant workers are often described as violating moral values and being motivated by utilitarianism, greed, and exploitation (Begum, 2016; Ehrenreich & Hochschild, 2013). In this paper we seek to challenge this one-dimensional image, and examine the employers’ perspective and their relationships with the workers they employ in a way that recognizes the challenges and moral dilemmas arising from their simultaneous roles as employers of disadvantaged workers and family members responsible for the safety and well-being of their dependent sick parent or spouse. These questions concern the limits of the employer-family members’ responsibility for the migrant workers’ physical, emotional, and financial well-being, as well as questions of how they should act when their commitment to the migrant care worker’s well-being conflicts with their commitment to the well-being of their sick parent.

As the opening example and the case described above show, the daily reality of domiciliary care can give rise to conflict between a family member’s moral commitment to the migrant care worker under their employ and their commitment to their sick relative—and in many cases also to the employer-family member’s own well-being. Family members face a moral commitment to fair employment as well as a commitment to their sick relative and to their own needs for security, order, and certainty. Life creates situations in which family members must make decisions where they are forced to choose to prioritize the well-being of one partner in the therapeutic triad—the migrant caregiver, the sick family member, and their own self—at the expense of another partner or partners.

The law does not provide an answer to most of these questions and issues. The regulations and laws that regulate the employment of migrant workers mostly concern the minimum amount of remuneration and social conditions to which the worker is entitled. This is the nature of laws—they are mainly concerned with formal relationships, and cannot address questions about personal relationships. It is impossible to enact laws and regulations sufficient to encompass all the situations and complexities inherent in such relationships. Thus, there remain issues that different people face depending on their personalities, resources, perceptions, and life circumstances. There are no prescribed actions that can regulate such complex and intimate relationships.

Israeli family values emphasize the familial bond, which, even if at times complex or conflicted, is marked by intensity and commitment. Universal moral values call for a fair, humane, respectful, and even empathetic attitude towards all people, and in particular those from disadvantaged groups. Caregiver family members who employ migrant domiciliary care workers may encounter moral dilemmas when differing, and often conflicting, value and moral systems propel them into making conflicting decisions. This complexity may spark conflict between various family members who seek to take contradicting actions. It can also create internal conflict stemming from each family member’s internal struggles in choosing between their different obligations.

When family members “step into the role” of employer, they are not provided with any guidance, training, mentorship, or support. The various organizations and institutions that are involved in this relationship—the nursing and domiciliary care staffing companies, the health system, and the National Insurance Institute—regulate its technical aspects, but they do not intervene, except in extreme and exceptional cases—especially when it comes to issues of ethics and values.

We will examine the case study set out above based on different models of decision-making in dilemmas of dual relationships (e.g. Boland-Prom & Anderson, 2005; Gottlieb, 1993; Reamer, 2012). The first question is, who is involved in this case? One person involved is, of course Ruth, the elderly mother and Alzheimer’s patient. Ruth is the legal employer of domiciliary care worker Lynne and the homeowner who was supposed to make the decisions, but she is not able to make her voice heard and her wishes are not clear.

There are also two sisters involved, who have a moral responsibility for their mother’s well-being, and who are also Lynne’s actual employers. What are their motives? Their values? Each has her own values and personality, as well as a professional background, which influences their positions. Eden is a psychotherapist. To begin with, she feels bad that Lynne, the domiciliary care worker, left her child behind in the Philippines when she came to work in Israel. Eden, believing this harms the child, feels guilty. The values that drive her are empathy, compassion, a sense of responsibility toward Lynne and her family, protectiveness toward the helpless (Lynne’s child who was left behind and the baby that was about to be born). Her sister Moran, as Eden puts it, is “the more practical of the two of us.” For Moran, her commitment is mainly (perhaps only) to her mother. Moran wanted to fire Lynne even prior to this incident. The values that drive her are mainly efficiency, and a commitment to protect her mother.

It is also not possible to ignore personal motivations that are not necessarily moral. Thus, for Eden, peace of mind includes relief from her feelings of guilt toward Lynne, but also the knowledge that there is someone taking good care of her mother. To her sister Moran, peace of mind means having no messy situation in her mother’s home, and the knowledge that her mother is receiving the best possible care. Since both sisters are also heirs to their mother’s property, they may also have an interest in protecting it from unauthorized parties entering the house, such as Lynne’s boyfriend. It is important to note that Eden’s and Moran’s relationship with Lynne, and in particular this dilemma, created tension between them (and also brought out old tensions). Outwardly, each of them represented a different moral position, but it is also possible that inside each of them, the two moral positions existed in conflict.

Another person involved in this dilemma is Lynne, the care worker. She has lived in Ruth’s house for seven years. In practice, this is her “home” in Israel. The sisters visit the house once or twice a week, while Lynne lives there all the time. She has a room there, while they do not. Right now, at this stage, before giving birth, Lynne wants her bed, her room, “her” house, that familiar and safe space. Also, it will save Lynne money if she can stay in Ruth’s house. Her personal interest is clear. Her unborn child is also affected by this decision. We cannot ask him, but most likely he needs the conditions in which his mother feels best. Do Eden and Moran have any obligation to this baby?

Another person involved and affected is the man who was around Lynne, who is likely the father of her baby. When it comes to this man, the facts are not clear. Is he the baby’s father, or is he just Lynne’s current boyfriend? Is he really violent toward her? Is he a legal resident in Israel? Does he live in Ruth’s house or does he only stay there sometimes? Although bringing him into Ruth’s home is in violation of Lynne’s work contract, it is her human right to intimate relations and—if he is the father of Lynne’s baby—he has a human right to exercise his paternity. Is this man someone who can and should be considered in this complex dialogue?

The substitute care worker is an additional woman involved in this case. It is clear that she wants Lynne’s job. She is critical of Lynne, the permanent care worker, and certainly does not want Lynne to remain in the house and breathe down her neck. She wants to please Eden and Moran, and reports to them about things that are allegedly going on behind their backs. However, it is possible that these reports are true, that she is motivated by a sincere desire to care for her patient (Eden’s mother) and protect her from any inappropriate things happening in her home. It is hard to know what her motives are, and what the values behind her actions are. Is she motivated by devotion and protectiveness toward Ruth, and loyalty to her employers, or perhaps by self-interest and benefit?

A question that is asked when ethical dilemmas arise is: which values are in conflict and thus are creating difficulties in deciding on a course of action? In the present case, there may not be any conflicting values, since the central value is care and concern for someone else’s well-being. The dilemma creates conflict because one of the sisters, Moran, is committed to realizing these values for her mother, while the second, Eden, feels responsible for realizing these values with regard to Lynne, the migrant care worker. However, we should not ignore the fact that, more broadly, there is a conflict here between the human responsibility to provide fair employment/proper human treatment, the preservation of a helpless person’s dignity, and the Biblical commandment to “honor thy father and mother,” which is central to Judaism.

The possible courses of action are presented as dichotomous: either Lynne will move to an alternative apartment for the duration of her maternity leave, or she will stay in Ruth’s home as she wishes. Are the no other options? Perhaps it is possible to look for compromises in the dialogue. For example, if Ruth’s home is large, it may be possible for Lynne to stay with the baby in this house, in a different wing or floor, even though there is no legal obligation for this, and even though there will be an additional cost to the family (in terms of water, electricity, etc.). Maybe there is a suitable place for Lynne to live in the neighborhood? We can assume that there are other practical options that could solve this issue.

As in many cases of ethical dilemmas in general, and of this dual relationship type in particular, every choice the sisters make will have consequences and will affect those involved. If the sisters demand that Lynne leave the house and live in a rental apartment, it will be difficult for Lynne and her baby to cope in a new and strange place, and with the high costs of renting an apartment in Israel. In addition, Eden and perhaps also Moran will feel guilty about Lynne, the woman who cared for their mother for such a long time. However, if Lynne stays in Ruth’s house as was her wish, there is a reasonable chance that Ruth’s care and well-being will be compromised, the baby will be a disturbance, there will be tension between the sisters, the father of the baby will visit without permission, and the cost of having another person (Lynne and her baby) in the house will increase the costs for caring for Ruth, which are already high. Thus, the sisters’ peace of mind may be harmed because of the complex situation in their mother’s home.

It seems, then, that there is no simple solution to this case. Yet, many families encounter ethical dilemmas both similar and different than this one, and must make decisions and choose their own outcomes.

What course represents the greatest mutual respect between people? It seems that what is key here is dialogue aimed at understanding people’s needs and trying to meet as many of these as possible. The ethical difficulties in the case described above arose, among other things, because the sisters did not have an open and honest dialogue with Lynne, and disregarded her as an autonomous subject (Anthias, 2008). Finding answers through dialogue, where all parties can express their needs and concerns, and seek strategies that can address everyone’s needs as far as possible, would meet the basic concept of ethics of care as presented by Gilligan (1982). This stage of Gilligan’s theory discusses finding solutions that attempt to meet the majority of needs of the majority of those involved in a conflict, with the understanding that it is impossible to fully satisfy all the wishes of all the parties. Gilligan views this understanding as the highest stage in the development of moral thought.

For this to occur, dialogue is essential. And for there to be dialogue, there is often a need for a third party to mediate and guide the parties. Regarding dialogue between people from different cultures, who speak different languages—which is the case in the relationship between migrant workers and their employers—the involvement of a third party is especially important. This mediator could be someone familiar with the culture and language of the local family and the migrant worker, and who has an empathetic and understanding approach to the needs of all the parties involved, but who is otherwise disinterested, in that he or she does not represent either the family or the worker.

Such empathetic dialogue should take into consideration that there is no perfect solution to be found, and no one-size-fits-all formula that can be applied to all cases. The ethical principle that should be followed here is that of striving to do as little harm as possible to the various parties involved: in other words, to attempt to meet as many of the needs as possible of those involved, with the understanding that sometimes (or maybe always) the needs of some or all the parties will not be met. This is consistent with the ethical principle of non-maleficence.

The Israeli government would like elderly people who require domiciliary care and support to receive this care within the community, as far as possible. However, for domiciliary care to occur in a benevolent way, there needs to be a shift in attitude towards those involved in it. To enable cooperation and mutual support between migrant care workers and their employers, and to ensure the well-being of all concerned, a great deal more institutional support is required than is currently available. This should include guidance, advice, and emotional and social support. There is also a need to train professionals who can provide mediation services that are based on ethical principles and the development of mutual empathy among all involved, so that the needs and values of all parties can be taken into consideration.

Finally, support is essential so that people do not have to face these situations alone, and become ticking time bombs that threaten to explode and harm those around them. This support should be predicated on familiarity and understanding of the many challenges involved, including the ethical dilemmas inherent in complex employment relationships within a domiciliary care context. Further, this support should not be predicated on the idea that one party is a victim and the other is abusive and exploitative. Rather, all parties should be treated with compassion. Systemic support is essential to view the patient, the family members, and the migrant care giver as a single unit, one that requires optimal conditions to exist and function with dignity.

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1. This is not a law in itself, but one of the articles (article 10) of the National Insurance Law. [↑](#footnote-ref-1)
2. See the Annual Report of the National Insurance Institute 2017 <https://www.btl.gov.il/Publications/Skira_shnatit/2017/Documents/chap-3-04-siud.pdf> [↑](#footnote-ref-2)
3. <https://www.gov.il/BlobFolder/generalpage/employment-foreign-workers-nursing/he/employment-foreign-workers-nursing.pdf> [↑](#footnote-ref-3)