

First Issue: Material Care Studies

Contents

Editorial

themed section

Material Care Studies Isabel Atzl, Lucia Artner	1
Electroconvulsive Therapy (ECT) and Nursing Practice in the Netherlands, 1940-2010 Geertje Boschma	17
Crossing the Boundaries. Nursing, Materiality and Anaesthetic Practice in Germany and Britain, 1846-1945 Karen Nolte, Christine E. Hallett	40
The Fake Three-Sided Key. Patient-Fabricated Duplicate Keys in Psychiatry around 1900 Martina Wernli	67
The Quality of Time and Its Quantifications. Negotiations about the Feeding Tube at the End of Life Jeannette Pols	87

open section

European Nursing Traditions and Global Experiences. An Entangled History Susanne Kreutzer	106
History of Public Health Nursing in Spain and the International Context María Eugenia Galiana-Sánchez	124

Editorial ENHE

1 “Material Care Studies”

The history of nursing is a research area that has been evolving into a specialised academic field in the past 30 years. Ethics of care is also recognised as an independent field within ethics. Yet, in the past, historical and ethical issues have not been considered together. Ethical discussions are usually embedded in a philosophical framework of argumentation. Yet, ethical questions also have a history and many historical issues are based within a long tradition of ethical reflection. Furthermore, changes of the social context influence how (and which) questions are raised. Such links between history and ethics are often ignored and even in historical papers ethical dimensions are often only implied rather than explicitly addressed. This observation of mutual barriers of reception is a crucial motivation for founding a new journal.

The Open Access eJournal will create a dialogue between the history and the ethics of nursing while providing new impulses for advancing the subfields of the history as well as the ethics of nursing. The project accounts for the growing area of research in both the history and the ethics of nursing and provides researchers in European history of nursing with a new venue for publication. The journal is open to researchers in history, history of medicine and history of science, cultural and social studies, health and nursing studies and also philosophy and theology (and in particular ethics).

This online journal is publishing articles in English while simultaneously offering the opportunity to publish the article in the source language to reflect the linguistic pluralism in Europe. All contributions undergo a blinded anonymous peer review and appear free of charge in Open Access.

In its first issue the European Journal for Nursing History and Ethics focuses on a young and innovative field of nursing research: research on the objects of nursing, for which Lucia Artner and Isabel Atzl coined the term “Material Care Studies” in their leading article in this issue.

The “Practice Turn” in recent years¹ has shifted the focus not only towards the practices of nursing but also its objects. The researchers investigate not only the function, materiality and production of these objects, they also attribute an independent activity to the objects and subsequently an influence on daily nursing activities and situations.² The form, function and materiality of objects can also open up new perspectives towards nursing practices with their tasks and routines and the objects thus transform into significant historical sources.³

Simultaneously, dealing with and using objects in nursing always also implies an ethical dimension in the relationship between nurse and patient: One might think of handling modesty and disgust when using instruments for emptying a patient’s bowels⁴ or of the implementation and daily management of a feeding tube for artificial feeding. The feeding tube is associated with the blame of stretching out an unbearable life. Yet, it can provide

¹ Reckwitz 2000, pp. 282–301.

² Manz 2015; Artner et al. 2017.

³ Sandelowski 2000; Atzl 2017.

⁴ Artner/Atzl 2016.

severely ill patients time and a scope for action, as Jeanette Polls illustrates in this edition. In the field of nursing in psychiatry certain objects can imply repression and the restriction of personal freedom. Martina Wernli examines, in her article "Collection of Keys," the assortment of 90 keys that patients had copied, collected by the Swiss psychiatrist Walter Morgenthaler. The copy of the key refers to the power of the keyholder that the nurses represent and simultaneously questions that power. Geertje Boschma addresses the ambivalent effect of the electric shock apparatus that promised an effective therapy but was also used as a disciplinary tool against psychiatric patients. Yet, objects can also mark (fluctuating) borders between the health professions, as Christine Hallett and Karen Nolte illustrate with a transnational comparison of how anaesthesia was administered.

In the section with open topics, Susanne Kreutzer in her conception piece develops perspectives for a European history of nursing that addresses the pluralisms, differences and mutual exchange processes within Europe but also the demarcations and numerous relationships with non-European countries. María Galiana-Sánchez investigates the influence of international organisation on the professionalization of public health nursing in Spain and she discusses the effect of the Spanish Civil War and the Franco regime.

2 References

- Artner, Lucia/Isabel Atzl/Anamaria Depner et al. (eds.): *Pflegedinge. Materialitäten in Pflege und Care*. Bielefeld 2017.
- Artner, Lucia/Isabel Atzl: Pot and Power. The Role of the Nonhuman in a Very Human Business. In: *On_Culture. The Open Journal for the Study of Culture* 2 (2016). <http://geb.uni-giessen.de/geb/volltexte/2016/12355/>, Last accessed December 3, 2018.
- Atzl, Isabel: Das materiale Erbe der Pflege. Historische Pflegedinge in Sammlungen und Museen und ihr Potential für die (pflege-)historische Forschung. In: Artner, Lucia/Isabel Atzl/Anamaria Depner et al. (eds.): *Pflegedinge. Materialitäten in Pflege und Care*. Bielefeld 2017, pp. 51–86.
- Manz, Ulrike: Ein anderer Blick auf die Dinge? Von "Pflegehilfsmitteln" zu "Partizipanden des Tuns". In: *Pflege und Gesellschaft* 20 (2015), 3, pp. 213–226.
- Reckwitz, Andreas: Grundelemente einer Theorie sozialer Praktiken in sozialtheoretischer Perspektive. In: *Zeitschrift für Soziologie* 32 (2000), pp. 282–301.
- Sandelowski, Margarete: *Devices & Desires. Gender, Technology, and American Nursing*. Chapel Hill 2000.

Material Care Studies

Isabel Atzl, Lucia Artner

Abstract

This contribution outlines the meaning of Material Care Studies in terms of thematising and researching the material aspect of nursing and care, and what new insights and findings this approach can generate. Starting from a broad definition of care – which encompasses nursing as well as the help for people of all ages, in cases of sickness, disability, psychological or physical disorder, from physical and/or psychological support, advice and care (medical or otherwise) to medical assistance in the consulting room or operating theatre – Material Care Studies seeks to focus on the material aspect, examining and investigating nursing and care on the basis of things. We outline how Material Care Studies is informed by the recent discussions on material culture in general, we define historical things of nursing as material cultural heritage, and thus subjected to the requirements expected of other “special collections”. Moreover, mainly due to the historical legacy of nursing and care, Material Care Studies can also be located in the conflictive field of the gender-sensitive approaches taken in recent debates on care. Its *raison d'être* as a new scientific field comes from the specifics of how people interact with one another using things in situations of nursing and care, and of the specific approaches to physicality and corporeality related to nursing and care. The establishment of Material Care Studies does justice to the aspect of materiality, as there has been very little research until now into the concrete “materialities” of nursing and care or how things shape the processes involved.

1 Introduction

The aim of this contribution is to briefly outline the meaning of Material Care Studies in terms of thematising and researching the material aspect of nursing and care, that is, their things¹, and what new insights and findings this approach can generate.

Prima facie, the expression ‘Material Care Studies’ seems an enigmatic term. Rather than ‘material care’ referring to caring for, or even looking after, things in terms of their material nature, this subject is not about maintaining technological apparatus. Instead, Material Care Studies refers to the idea perhaps already suggested by the term’s similarity to ‘Material Culture Studies’. The latter is a transdisciplinary undertaking with various methodologies and themes; its explanatory power derives from the fact that it examines extremely multifaceted contexts. The field considers things in terms of their material nature, exploring how they are embedded in and interrelate with interactions, social ties and discourses and investigates how they produce and reproduce social contexts. In the same way, Material Care Studies seeks to focus on the material aspect, examining and investigating nursing and care on the basis of things. On the one hand, its *raison d'être* as a separate field of research comes from the specifics of how people interact with one another using things in situations of nursing and care (which are characterised by forms of dependency and requiring sensitivity)², and of the

¹ Based on the definition by Hans Peter Hahn, we understand things as being all ‘material objects’, and specifically not only those produced by people (artefacts) but also those of natural origin which are used (sometimes in a modified form) by people (Hahn 2014, p. 19, translation by the authors).

² Artner et al. 2017.

specific approaches to physicality and corporeality related to this field³. On the other hand, the establishment of Material Care Studies does justice to the aspect of materiality, as there has been very little research until now into the concrete materialities of nursing and care or how things shape the processes involved.⁴

In Material Care Studies, the term 'care' refers to a broad field, from childcare and child-raising to caring for and nursing the elderly, people with disabilities or people suffering from psychological or physical disorders, who are in need of physical and/or psychological support and advice and care (medical or otherwise) to medical assistance in the consulting room or operating theatre – these are all areas where care is provided. Alongside pedagogical/socio-pedagogical fields of work, nursing (using a very broad understanding of the word, as defined by the International Council of Nurses⁵) is understood here as a key area within the wider field of care, and will be the main focus of this contribution. In this article, when statements are made in which 'care' is understood as extending beyond nursing, this will be explicitly indicated; otherwise, what will be outlined is the narrower field of nursing the sick and elderly, which is the main focus of this journal.

It seems remarkable that there are very few studies tackling the things used in nursing, when one considers that the very first textbooks and instructions on caring for the sick in the early 19th century went into great detail on the material form of patients' physical environment, granting it a central position.⁶ Although more recent studies also testify to that interest in the context of nursing, they tend to be purposive or evaluative studies from the fields of healthcare, nursing, architecture or medical geography. There are very few empirical, qualitative studies, and of these only a few deal with the tangible things specific to nursing.⁷

The contribution which Material Care Studies can make is, firstly, to highlight and explain how things are part of current or past processes in the field of nursing. Until now, their role has only rarely been considered in research into nursing – even though nursing cannot be imagined without such things. Secondly, as a source of information which has so far been neglected, things can enrich and extend research into nursing and (more broadly) care, as

³ Remmers 2011, 2016.

⁴ Kollwe et al. 2017, pp. 17f.; One important exception is the joint project funded by the Federal Ministry of Education and Research from February 2014 to January 2017: 'Care and Things – Objects and their Significance in Past and Present Nursing Practice' (grant number 01UO1317A-D). At this juncture, the authors would like to express their special thanks to Anamaria Depner, André Heitmann-Möller and Carolin Kollwe for their many years of extremely productive collaboration.

⁵ International Council of Nurses 2018.

⁶ For example Dieffenbach 1832, Gedike 1837, or also Nightingale 1859.

⁷ For an overview, see Kollwe et al. 2017; exceptions include Messecar et al. 2002; Morgan/Stewart 1997, de la Cuesta/Sandelowski 2005, Sander 2008; Manz 2015. Other exceptions include works on the role of technology in nursing (see, for example, Sandelowski 2000, Manzei 2011, Remmers/Hülsken-Giesler 2011, Hielscher et al. 2015) or, in the broader sense of care as looking after people, on subjects such as technical devices (cf. Mol et al. 2010, Schillmeier/Domènech 2010, Pols 2012). New developments in the field of age and aging are discussed in the *Frontiers in Sociology*, issue 3 (<https://www.frontiersin.org/research-topics/6076/materialities-of-age-and-ageing>). Also the transnational network "Material Gerontology" should be mentioned here (<https://materialgerontology.wordpress.com/>).

taking materiality into account can open up new insights which would not be revealed without things.

Last but not least, this is also a means of countering the general invisibility of the topic of nursing in academic and public discourse, as although nursing can be described as a central practice of human interrelations and social cohesion⁸, and it receives a great deal of attention in current political debates, for a long time it led a shadowy existence in academic (and public) perception.⁹ Currently, a great deal of attention is being focused on things, whether in research funding or the public eye¹⁰, meaning that addressing the topic of nursing through the lens of things could make it more attractive.

In the following, we sketch out a rough outline of the field of Material Care Studies. We see its central approaches as coming from Material Culture Studies, which we will specify below for our own subject field (1). We define things of nursing which come from the past (historical things of nursing) as material cultural heritage, and thus subjected to the requirements expected of other specialised collections (2). Moreover, mainly due to the historical legacy of nursing and care, Material Care Studies (3) can also be located in the conflictive field of the gender-sensitive approaches taken in recent debates on care, for example, as discussed in Feminist Materialism or Science and Technology Studies.

2 Material Care as Material Culture

One central point of Material Care Studies, whose methods are heavily based on Material Culture Studies, is the fundamental assumption that things are ambiguous and uncertain.¹¹ This inability to pin them down due to their ambiguity, which Hahn labels 'polyvalence', applies particularly strongly to the things of nursing, as nursing is characterised by multi-professionalism (welfare-based, treatment-based, medicinal or therapy-based approaches and so on), and things can be used for various purposes, or even repurposed. In view of this, things in general, and in this case in particular, constantly appear impossible to determine. It seems possible to read their 'script' in a variety of ways¹². Nurses can use a kidney dish, for instance, in dental care, as somewhere to place a set of dentures, or in medical assistance, to hold unsterile instruments, or in post-operative care, to collect bodily fluids such as blood or stomach contents. All these uses are based on different interactions, social structures and processes of negotiation regarding how to deal with things or people.

⁸ Peplau 1995.

⁹ Dorfmeister 2010, Kumbruck 2010.

¹⁰ This can be seen, for example, in the three application rounds for the funding stream 'The Language of Objects' from the Federal Ministry of Education and Research or the debates on the technologisation of nursing which have been taking place for some years now (for example, see Sandelowski 2000, Manzei 2011, Remmers/Hülsken-Giesler 2011, Hielscher et al. 2015).

¹¹ Hahn 2005, 2015.

¹² Akrich 1992, 1995.

In the wake of the ‘material turn’¹³ in the Arts, Humanities and Social Science, and following various (misguided) attempts to explain things as actors which are ‘equal’ to people¹⁴, the focus is increasingly on relational construction via the relationship between people and things (for example, their things)¹⁵. What is meant by this is that things are only given meaning through their relationship with people, with people’s behaviours and with other things. For things to be put to productive use when researching into nursing, they thus have to be studied and understood in their various social contexts. With regard to the balance between things and social actions, Hahn summarised the situation of research into the everyday world (a category in which we also place nursing) as follows:

Everyday life in society is not only affected by material things, but neither is it only affected by actions and knowledge. It is only when these two dimensions are brought together that an approach for understanding everyday life can be found. The connection between the material and the immaterial should be seen as something contemporaneous: neither does the immaterial come after the material, nor should ways of thinking be seen as preceding things, i.e. as their origin and source.¹⁶

For Material Care Studies, in the sense of advanced research into the things of nursing¹⁷ from a historical, a cultural and a socio-scientific point of view, this implies what the social historian Dorothee Wierling describes as ‘self-socialisation as a basic process of coexistence’¹⁸:

In my opinion there is nothing social in things. Everything that could be implied when talking about “the social life of things” is the meaning we ascribe to things through our (social) actions. Apart from our interaction, nothing else is social, which is why I consider it more appropriate to speak of what is social about things, by examining how things are put to social use.¹⁹

The way people deal with and make reference to things in nursing is influenced by a range of factors. On the one hand, there is their materiality and the effects they have, in accordance with the laws of nature. A urinal bottle made of glass, for example, can be expected to be used differently to one made of plastic. On the other hand, the way things are used – how people relate to things – is also affected by their sensory perceptions.²⁰ With regard to the physical design of nursing settings, for instance, Michael Heinlein²¹ discovered that patient lifts or hoists can have negative associations for people in need of nursing, even though their intended purpose has the positive effect of safely moving people with restricted mobility. Using these devices, which involves patients being strapped in or placed in slings, can make

¹³ Hicks 2010.

¹⁴ Latour 2008.

¹⁵ Hodder 2014, Fowler/Harris 2015.

¹⁶ Hahn 2014, p. 9, translation by the authors.

¹⁷ Kollwe et al. 2017.

¹⁸ Wierling 2016, n. pag., translation by the authors.

¹⁹ Wierling 2016, n. pag., emphasis in original.

²⁰ Nevile et al. 2014.

²¹ Heinlein 2003, pp. 95–112.

them immediately aware of their failing physical condition, it is made abundantly clear to them in a manner which they cannot ignore.

This has consequences in terms of how the things of nursing are dealt with scientifically: when the polyvalence of things is being investigated, it calls for different levels of context and meaning to be examined in each case. At the same time, there has to be a constant effort to return to the material itself, that is, the physical source: „The analysis is generally carried out in three steps, covering the materiality of the things, how they are used and the meaning they are ascribed.“²² In other words, when analysing things, research has to go beyond simply looking for and describing the information and meanings attached to the things, in order to reconstruct them in their particular contexts. Meanwhile, Material Care Studies places an emphasis on research into the materiality of things, an aspect which is often lost sight of: this is its central method. A good way of achieving this is via collections-related research, as established in scientific collections: here, investigating the materiality of objects is understood as the first step in analysing things.²³

Whether in a firmly historical or contemporary light or in view of approaches to the material culture of nursing in the social sciences or cultural studies: the different interests in things, including things of nursing, share an approach to (material) objects which sees them as resources and participants in social interactions, rather than as a result or expression of broader structures.²⁴ As in Material Culture Studies, with regard to Material Care Studies this means reconstructing the concrete role and meaning of a thing, for example, a thing of nursing, in view of its observed (or historically reconstructed) usage; a usage which is always contextualised and socially situated.²⁵ This implies a firmly praxeological approach to things²⁶, whether these are historical or contemporary things of nursing. The activities which are understood as nursing (and care) are also materially mediated, historically and socially contextualised practices which are subject to constant change. In this respect, the added benefit of Material Care Studies is that it shifts the focus onto the things of nursing as a source of research into present and past nursing that has so far been disregarded and promises a wealth of new findings.

3 Material Care as Material Cultural Heritage

Material Care Studies aims to give the things of nursing a new (enhanced) status as historical artefacts and as part of a society's cultural heritage. For this reason, Material Care Studies explicitly concentrates not only on things which are currently in use but also on the material remains of cultures in contexts of nursing. In both cases, this means researching into the things of nursing as bearing material testimony to the culturo-historical genesis of nursing as an aspect of care. In 2011, the German Council of Science and Humanities emphasised the

²² Ludwig 2011, n. pag., translation by the authors.

²³ German Museums Association (DMB) 2006, pp. 18–19.

²⁴ Ludwig 2011, Artner et al. 2017.

²⁵ Miller 1987, Hahn 2005, Hahn 2014.

²⁶ Reckwitz 2003.

significance of material heritage (not only of things in the context of nursing) in relation to academia and society:

Its acquired properties give an object not only its fascination but also the significance of a cultural asset; through them it can provide social self-reassurance and construct identity, bear material witness to the past, provide answers to various questions and spark further probing questions.²⁷

Internationally, there is no question that objects are accorded great significance for culture and society in Germany and elsewhere. In its 'Standards for Museums', for example, the German Museums Association (Deutscher Museumsbund (DMB)) describes a museum's central role as collecting, conserving, researching into and communicating objects, noting that:

Museums collect original remains of culture and history. These are conserved, documented and passed down to future generations for the purposes of research and education. Museums' collections are the material cultural memory of humanity and our environment.²⁸

Moreover, initiatives such as the European Union's 2018 Year of Cultural Heritage show that objects are also increasingly coming into the focus of social and political discourse, as our material legacy.

Fundamentally, all these statements and initiatives are based on the assumption that three-dimensional objects acquire great social and academic relevance through, because of and with their materiality, as they reveal information and connections that would otherwise remain hidden. Despite this significance, and although care and nursing are academically and socially relevant fields, at present their objects have slipped through the net of well-known collection classification systems in the context of material heritage. Over decades there has simply been no special place for them to be collected, conserved, researched into or presented.²⁹ Until now (in Germany, at least), neither care nor nursing, nor the things related to them, have come up in the discussion on material cultural heritage. Instead, nursing and its historical things have largely been conserved in the context of medical history collections, which, however, mainly deal with medical issues from the perspective of doctors.³⁰

Nursing, however, brings up its own politically and socially widely discussed questions which are highly charged in light of demographic change. These reflect not only specific issues regarding policy implementation but also the field's own ethical and social aspects, and challenges for society.³¹ Nursing is a practice that is considered central to human relationships and a society's social cohesion. It shapes both the communities of people where it is practiced and the welfare state that provides the structural conditions required for nursing to be performed. Nursing is thus a society's silent social capital. Material Care Studies' view of the

²⁷ Wissenschaftsrat 2011, p. 11, translation by the authors.

²⁸ DMB 2006, p. 15, translation by the authors.

²⁹ Atzl 2017a.

³⁰ Atzl 2017a.

³¹ Peplau 1995.

things of care and nursing as material heritage shifts the focus onto the cultural and historical significance of care and nursing, with all their ambivalence.

Over the years, many different disciplines have tackled the subject of nursing in its numerous forms. From the point of view of their different fields, experts in the fields of Nursing Studies, Sociology, Social Pedagogy and Cultural Studies have all examined the current nature and practice of nursing – for example, the form of nursing arrangements – on personal, institutional, structural or social levels.³² To face up to future social challenges, however, it is equally important to remember the historical roots of the practice of nursing; to uncover them and interpret them in the light of our knowledge of past contexts, allowing us to view current developments (sometimes critically) through the lens of past experiences and develop possibilities in building for the future. Although nursing is a socioanthropological constant, throughout its history it has continually been reshaped in line with social, political, personal or moral requirements.³³ The ways and means by which nursing was and is carried out thus reflect part of a society's cultural identity.³⁴

The task of researching into and appraising the historical roots of the practice of nursing falls under the remit of the History of Nursing. Although there are numerous international chairs dedicated to the History of Nursing or museums on the subject, this development is only in its infancy in Germany. However, researchers from diverse faculties are increasingly turning towards this relatively new discipline in German academia. While written sources from German-speaking countries are increasingly used³⁵, until now little attention has been paid to the material evidence of the history of nursing in the research.³⁶ One reason for this is that, to date, there has been no special place in Germany for the historical things of nursing, in the form of a scientifically run collection or a comprehensive, professionally run museum. Things of nursing do exist, but are not recognised as such. This is despite the fact that things played a crucial role in the practice of nursing in the past, just as they do today. Material Care Studies, which examines both care and nursing as cultural heritage which is, and can be, conveyed materially, thus not only examines interactions and interpersonal relationships within nursing but also the way in which things made, and still make, nursing and care possible in the first place, or how they influenced, and still influence, the social order and the form it took and takes.³⁷ Many of the things of nursing which we are familiar with today were developed in former situations of need or supplied to nurses to use at particular times. Research into these aspects also provides us with a deeper understanding of later developments and of nursing as we know it today.

Just like modern objects, things of nursing from the past can be subjected to historical and praxeological interpretation to offer a unique insight into the field of nursing, its

³² Koch-Straube 1997, Heinlein 2003, Schroeter/Rosenthal 2005, Sander 2008.

³³ Hähner-Rombach 2009, Thiekötter et al. 2009, Braunschweig 2006.

³⁴ Leininger 1991.

³⁵ For example, see Hähner-Rombach 2009, Rueß/ Stölzle 2012.

³⁶ With the exception of Artner, Atzl /Kollewe 2016, Artner/Atzl 2016, Atzl 2017a, Atzl 2017b, Atzl 2017c, Atzl/ Depner 2017.

³⁷ Artner et al. 2017.

history/histories and past social situations or ideas. As material cultural heritage, historical things of nursing open up aspects which can provide compelling insights, opportunities for self-reflection and stimuli in the present, or equally for the future. They inform issues related to nursing, as well as ethical and social questions. They also enable interdisciplinary transfer between nursing, medicine, Cultural Studies and the social sciences.³⁸

4 Material Care as a Gender-Sensitive Outlook on Forms of Materiality

Parallel to the issue of the lack of collections, the invisibility of things in nursing and care is also related to nursing and care being rarely accorded the recognition due to them as one of a society's central social practices (and have historically scarcely received that recognition).³⁹ The historical and current reason behind this is that nursing and care are occupations and fields of activity with feminine connotations, in part because they have always been considered tactile, emotional and sensorial.⁴⁰ However, one of the central premises of Material Care Studies is that it should shift the focus onto the physical component of interactions between people and things in contexts of nursing. This perspective is especially significant with regard to the subjects of nursing, as patients' bodies (whether regarded as ill or old bodies, with disabilities, etc.) themselves become the subject of nursing practices and the use of things. It is partly because their bodies run the risk of being materially and discursively degraded to the status of 'misfits'⁴¹ that Material Care Studies firmly sees itself as among the gender-sensitive ways of engaging with care, as set out below.

Somewhat similarly to the relevant feminist debates on care, in the field of Feminist Materialism and some works in Science and Technology Studies, a broad definition of the term 'care' is used (extending beyond interpersonal relationships), whilst at the same time an emphasis is placed on reciprocity and interdependency in the relationships between people and things. Both are discussed in the context of how the way people are dealt with and/or the material environment in situations of nursing and care are affected by, and simultaneously help to reproduce, gendered inequalities.⁴²

This approach to care is relevant to Material Care Studies insofar as nursing (or looking after and caring for people and things, see below) is primarily about interpersonal relationships and interactions between people and things. In the practice of nursing, even more than in other fields, interdependencies and vulnerabilities, dependencies and affective actions particularly

³⁸ For example, Artner/Atzl 2016, Atzl/Depner 2017.

³⁹ Wahl 2014.

⁴⁰ Simpson et al. 2012, p. 168; cf. Sandvoll et al. 2015, Backes et al. 2008, Bolton 2005, Wolkowitz 2002.

⁴¹ Garland-Thomson 2011, p. 592.

⁴² Ostner/Beck-Gernsheim 1979, Backes et al. 2008, Leira/Saraceno 2002, Ostner 2009. According to Margit Brückner, care as a 'paradigm' (Brückner 2008, p. 167) describes both an academic school of thought and political positions towards care as work (Brückner 2010). Both, she believes, lead to criticism of the social attitude towards care (and nursing), carried out as a formal occupation subject to compulsory insurance and/or as a familial arrangement involving different generations or within friendships, neighbourhoods or communities, etc. (Scheiwe/Krawietz 2014, Artner/Schröer 2013).

come to the fore. This, in turn, requires the focus to be turned towards relationships between people or between people and things, and how these relationships are experienced in different contexts and situations – just as feminist works have been doing for quite some time.⁴³ The feminist psychologist Carol Gilligan⁴⁴ stresses especially strongly that nursing relationships should be viewed from the point of view of those in (relatively) powerless positions, such as the people being nursed.⁴⁵

The primary focus of Material Care Studies is not so much about calling into question social balances of power and thus criticising unequal patriarchal, capitalist relationships, but about an inclusive way of thinking that is especially sensitive to the fact that the use of things is embedded in specific discursive formations, social structures and normative notions which are permeated with power. For this reason, Material Care Studies is close to Feminist Materialism, even though (unequal) power relations have to be situationally reproduced in the form of concrete interactions, characterised partly – mainly – by their material manifestations (showing that Material Care Studies is primarily aligned towards Material Culture Studies). Accordingly, when analysing Material Care Studies (which is based on things), there is a focus on the micro-politics of power which often occur in the background and rarely come to attention. Things generally become part of routines; they add routine to actions⁴⁶ and thus (indirectly) help reproduce the status quo and thus structurally organised inequalities. However, as this always has to be repeated, there is always also some room for manoeuvre. Relationships can change. Some things, if especially awkward and disruptive, can even provoke that change. Karen Barad⁴⁷ lays emphasis on the interplay between discursive ascription and materiality, which can basically not be separated from one another, as (immaterial) meaning and material circumstances are always a material/discursive interweaving of different patterns of meaning and objects.

From the (gender-sensitive) perspective of Material Care Studies, interdependency thus not only occurs between people, but also between people and things, and is thus initiated by things.⁴⁸ Transferred to the field of nursing, this implies that an electronic lift (hoist) opens up new courses of action both to nurses and to people whose mobility is limited and whom they help to stand up – but at the same time, they are dependent on the thing (in this case the lift).⁴⁹ However, it is not only feminist works that stress the interdependency between people and things (and ideas, notions, discourses etc.). ‘Conventional’ (socio-scientific) research into objects has also done so for some time now. Daniel Miller, for instance, criticises the ‘tyranny of the subject’, meaning the overly strong focus on people in the social sciences.⁵⁰ Instead, he calls for a „dialectical republic in which persons and things exist in mutual self-construction

⁴³ Kuhse/Singer/Rickard 1998.

⁴⁴ Gilligan 1982.

⁴⁵ Green 2013.

⁴⁶ Reckwitz 2003.

⁴⁷ Barad 2007.

⁴⁸ Puig de la Bellacasa 2011.

⁴⁹ Heinlein 2003, pp. 95 ff.

⁵⁰ Miller 2005, p. 45.

and respect for their mutual origin and mutual dependency”⁵¹. Feminist works such as that by Barad similarly underline the processual, incomplete nature of material/discursive entanglements⁵². A thing’s meaning and what it does with people changes, it cannot be fixed, but is subject to constant change and contingencies.

Some works from the field of Science and Technology Studies can also be compared with these perspectives. Here, too, particular attention is paid to the material aspects of social interactions, but with a stronger focus on technologies or technical/technological circumstances. Science and Technology Studies, spearheaded by the anthropologists Annemarie Mol and Jeanette Pols, place greater emphasis on the idea that technology itself also requires care.⁵³ The interactions between people and technology are constantly being examined and re-examined to determine how they can socially produce care.⁵⁴ By contrast, one point which has emerged from Material Care Studies that are oriented towards Feminist Materialism is that things (not just technical items but all material objects) are also matter⁵⁵; objects and (significant) circumstances. Accordingly, a social constructivist analysis of science and technology should always be connected to a critical view of how, in the reproduction of gendered orders, specific epistemological cultures contribute to the rational and technological being ascribed to masculine connotations.⁵⁶ This critical view is also similarly applied to nursing, where interpersonal, more tactile work – touch as an aspect of nursing and care work – is considered sensorial and feminine and thus as not ‘threatening’ but instead pleasant and gentle.⁵⁷

Yet the things of care and nursing are not only connected to current, gendered orders that are permeated with power. As things’ materiality allows them to last beyond their era, these orders can be reconstructed, in terms of their historical trajectories and more. Things generally bear testimony to the historical genesis and current state of nursing. Material Care Studies thus examines not only the things of the present, but also, always, nursing’s material cultural heritage.

5 Conclusion

The argument in favour of setting apart Material Care Studies as its own area of research is based firstly on the specific personal interplay and the interactions mediated by things which are of relevance in nursing situations (requiring research that shows particular sensitisation and sensitivity) and secondly on the potential offered by things when investigating the topics that fall under nursing (and care), which has so far been accorded too little attention. Understanding things as a central element of nursing (and care) and including them, as in this volume, or even making them the focal point and thus taking them seriously as a source of

⁵¹ Miller 2015, p. 37.

⁵² Dionne 2016.

⁵³ Mol et al. 2010.

⁵⁴ Mol et al. 2010.

⁵⁵ Hird 2009, p. 330.

⁵⁶ Hird 2009, p. 330 f.

⁵⁷ Simpson et al. 2012, p. 168; Bolton 2005, Sandvoll et al. 2015.

information, promises a deeper understanding of the historical processes and developments behind nursing and care.

Isabel Atzl (MA), Institute for History of Medicine (Robert Bosch Foundation), Germany

Lucia Artner (Dr), Institute for Organisational and Social Pedagogy, University of Hildesheim, Germany

6 Bibliography

- Akrich, Madeline: The Se-Scripton of Technical Objects. In: Bijker, Wiebe E./John Law (eds.): Shaping Technology, Building Society. Studies in Sociotechnical Change. Cambridge, London 1992, pp. 205–224.
- Akrich, Madeleine: User Representations: Practices, Methods and Sociology. In: Rip, Arie/Thomas J. Misa/Johan Schot (eds.): Managing Technology in Society: The Approach of Constructive Technology Assessment. London 1995, pp. 167–184.
- Artner, Lucia/Wolfgang Schröer: Care, Commons, Citizenship – How Social Work is Affected. Transnational Social Review. In: A Social Work Journal 3 (2013), pp. 141–154.
- Artner, Lucia/Isabel Atzl/Carolin Kollwe: Über die Notwendigkeit einer “Pflege der Dinge”. Wie Dinge die historische und gegenwärtige Pflege erfahrbar machen. In: Sozial Extra 40 (2016), pp. 41–43.
- Artner Lucia/Isabel Atzl: Pot and Power: The Role of the Nonhuman in a Very Human Business. In: On_Culture: The Open Journal for the Study of Culture 2 (2016), http://geb.uni-giessen.de/geb/volltexte/2016/12355/pdf/On_Culture_2_Artner_et_al.pdf, accessed January 31, 2019.
- Artner, Lucia/Isabel Atzl: Working Paper: „Material Care Studies – Objekttheoretische Zugänge zu Pflege und Care“. Hildesheim 2018. Online publication (open access), DOI: 10.18442/758.
- Artner, Lucia/Daniela Böhringer: Die Veralltäglicung grenzwertiger Arbeit durch Pflegedinge. In: Artner, Lucia/Isabel Atzl/Anamaria Depner/André Heitmann-Möller/Carolin Kollwe (eds.): Pflegedinge: Materialitäten in Pflege und Care. Bielefeld 2017, pp. 169–198.
- Artner, Lucia/Isabel Atzl/Anamaria Depner/André Heitmann-Möller/Carolin Kollwe (eds.): Pflegedinge: Materialitäten in Pflege und Care. Bielefeld 2017.
- Atzl, Isabel (ed.): WHO CARES? Geschichte und Alltag der Krankenpflege (Ausstellungskatalog). Frankfurt am Main 2011.
- Atzl, Isabel: Das materiale Erbe der Pflege. Historische Pflegedinge in Sammlungen und Museen und ihr Potential für die (pflege-)historische Forschung. In: Artner, Lucia/Isabel Atzl/Anamaria Depner/André Heitmann-Möller/Carolin Kollwe (eds.): Pflegedinge: Materialitäten in Pflege und Care. Bielefeld 2017a, pp. 51–84.

- Atzl, Isabel: Pflegedinge und Pflegealltag im Krankenhaus. In: *Historia Hospitalium, Jahrbuch der Deutschen Gesellschaft für Krankenhausgeschichte* 30 (2017b), pp. 113–138.
- Atzl, Isabel: Pflegende, Patienten und Ärzte in Objekten. Ein Plädoyer für die akteurszentrierte Forschung als Chance für Museumsartefakte und Fachgeschichte. In: *Blätter für Technikgeschichte* 78 (2017c), pp. 79–89.
- Atzl, Isabel/Anamaria Depner: Home Care Home. Reflections on the Differentiation of Space in Living and Care Settings. In: Chivers, Sally/Ulla Kriebner (eds.): *Care Home Stories. Aging, Disability, and Long-Term Residential Care*. Bielefeld 2017, pp. 265–282.
- Backes, Gertrud M./Martina Wolfinger /Ludwig Amrhein: Geschlechterungleichheiten in der Pflege. In: Bauer, Ulrich/Andreas Büscher (eds.): *Soziale Ungleichheit und Pflege. Beiträge sozialwissenschaftlich orientierter Pflegeforschung*. Wiesbaden 2008, pp. 132–153.
- Barad, Karen: *Meeting the Universe Halfway: Quantum Physics and the Entanglement of Matter and Meaning*. Durham, London 2007.
- Bolton, Sharon C.: Women's Work, Dirty Work: The Gynaecology Nurse as 'Other'. In: *Gender Work and Organization* 12/2 (2005), pp. 169–186.
- Braunschweig, Sabine (ed.): *Pflege – Räume, Macht und Alltag*. Basel 2006.
- Brückner, Margrit: Kulturen des Sorgens (Care) in Zeiten transnationaler Entwicklungsprozesse. In: Homfeldt, Hans G./Wolfgang Schröer/Cornelia Schweppe (eds.): *Soziale Arbeit und Transnationalität. Herausforderungen eines spannungsreichen Bezugs*. Weinheim 2008, pp. 167–184.
- Brückner, Margrit: Entwicklungen der Care Debatte - Wurzeln und Begrifflichkeiten. In: Apitzsch, Ursula/Marianne Schmidbaur (eds.): *Care und Migration*. Opladen, Farmington Hills 2010, pp. 43–58.
- De la Cuesta, Carmen/Margarete Sandelowski: Tenerlos en la casa: The Material World and Craft of Family Caregiving for Relatives with Dementia. In: *Journal of Transcultural Nursing* 16/3 (2005), pp. 218–225.
- Depner, Anamaria: *Dinge in Bewegung. Zum Rollenwandel materieller Objekte. Eine ethnographische Studie über den Umzug ins Altenheim*. Bielefeld 2015.
- Dieffenbach, Johann Friedrich: *Anleitung zur Krankenwartung*, Berlin 1832.
- Droysen, Johann Gustav (1882/1960): *Historik. Vorlesungen über Enzyklopädie und Methodologie der Geschichte*. Edited by Hübner, Rudolf. München, Berlin 1832.
- Dionne, Emilie: *Desiring Ambiguity, Engaging with Agential Matter: Toward an Ethical Project of Pluri-Personhood*. Job Talk, presentation held at University of Ottawa, June 14 2016.
- DMB [Deutscher Museumsbund/ICOM, The International Council of Museums] (eds.): *Standards für Museen*. Berlin, Kassel 2006.
- Dorfmeister, Michaela: Invisible Care – ist Pflege unsichtbar? Eigen- und Fremdwahrnehmung unter der Lupe. In: *Procure* 15/8 (2010), pp. 32–36.

- Fowler, Chris/Oliver J. T. Harris: Enduring Relations: Exploring a Paradox of New Materialism. *Journal of Material Culture* 20 (2015), 2, pp. 127–148.
- Frers, Lars: Automatische Irritationen. Überlegungen in Video zur Initiativentfaltung der Dinge. In: Gesellschaft für Ethnographie e.V., Tietmeyer, Elisabeth/Claudia Hirschbergerandere (eds.): *Die Sprache der Dinge: Kulturwissenschaftliche Perspektiven auf die materielle Kultur*. Münster 2010, pp. 195–202.
- Garland-Thomson, Rosemarie: Misfits: A Feminist Materialist Disability Concept. In: *Hypathia. A Journal of Feminist Philosophy* 26 (2011), 3, pp. 591–609.
- Gedike, Carl Emil: *Anleitung zur Krankenwartung. Zum Gebrauch für die Krankenwart-Schule der Berliner Charité-Heilanstalt sowie zum Selbstunterricht*, Berlin 1837.
- Gesler, Wilbert: Therapeutic Landscapes: Medical Issues in the Light of the New Cultural Geography. In: *Social Science and Medicine* 34 (1992), pp. 735–746.
- Gilligan, Carol: *In a Different Voice. Psychological Theory and Women's Development*. Cambridge, London 1982.
- Grant, L. A./A. R. Sommers: Adapting Living Environments for Persons with Alzheimer's Disease. In *Geriatrics* 53 (1998), pp. 61–65.
- Green, Catherine: Philosophic Reflections on the Meaning of Touch in Nurse-patient Interactions. In: *Nursing Philosophy* 14 (2013), pp. 242–253.
- Hähner-Rombach, Sylvelyn (ed.): *Alltag in der Krankenpflege: Geschichte und Gegenwart*. Stuttgart 2009.
- Hahn, Hans Peter: Dinge des Alltags – Umgang und Bedeutungen. Eine ethnologische Perspektive. In: König, Gudrun (ed.): *Alltagsdinge. Erkundungen der materiellen Kultur*. Tübingen 2005, pp. 63–79.
- Hahn, Hans Peter: *Materielle Kultur. Eine Einführung*. 2nd, proofed edition, Berlin 2014.
- Hahn, Hans Peter: Der Eigensinn der Dinge. Einleitung. In: Hahn, Hans Peter (ed.): *Vom Eigensinn der Dinge. Für eine neue Perspektive auf die Welt des Materiellen*. Berlin 2015, pp. 9–56.
- Heinlein, Michael: *Pflege in Aktion. Zur Materialität alltäglicher Pflegepraxis*. München, Mering et al. 2003.
- Hicks, Dan: The Material-Cultural Turn: Event and Effect. In: Hicks, Dan/Mary Carolyn Beaudry (eds.): *The Oxford Handbook of Material Culture Studies*. Oxford 2010, pp. 25–98.
- Hielscher, Volker/Sabine Kirchen-Peters/Christine Sowinski: Technologisierung der Pflegearbeit? Wissenschaftlicher Diskurs und Praxisentwicklungen in der stationären und ambulanten Langzeitpflege. In: *Pflege & Gesellschaft* 20 (2015), 1, pp. 5–19.
- Hird, Myra J.: Material Feminist Engagements. In: *Feminist Studies* 35 (2009), 2, pp. 329–346.
- Hodder, Ian: The Entanglements of Humans and Things: A Long-Term View. In: *New Literary History* 45/1 (2014), pp. 19–36.

- International Council of Nurses: <http://www.icn.ch/who-we-are/icn-definition-of-nursing/2018>, accessed April 04, 2018.
- Koch-Straube, Ursula: *Fremde Welt Pflegeheim. Eine ethnologische Studie*. Bern et al. 1997.
- Kollewe, Carolin/André Heitmann-Möller/Anamaria Depner/Isabel Atzl/Lucia Artner: *Pflegedinge – Materialitäten in Pflege und Care. Theoretischer Rahmen und interdisziplinärer Ansatz*. In: Artner, Lucia/Isabel Atzl/Anamaria Depner/André Heitmann-Möller/Carolin Kollewe (eds.): *Pflegedinge: Materialitäten in Pflege und Care*. Bielefeld 2017, pp. 15–44.
- Kuhse, Helga/Peter Singer/Maurice Rickard: *Reconciling Impartial Morality and a Feminist Ethics of Care*. In: *Journal of Value Inquiry* 32 (1998), pp. 451–463.
- Kumbruck, Christel: *Menschenwürdige Gestaltung von Pflege als Interaktionsarbeit*. In: Becke Guid/Peter Bleses/Wolfgang Ritter/Sandra Schmidt (eds.): *„Decent Work“*. Wiesbaden 2010, pp. 187–207.
- Latour, Bruno: *Wir sind nie modern gewesen. Versuch einer symmetrischen Anthropologie*. Berlin 2008.
- Leininger, Madeleine: *Culture Care Diversity and Universality. A Theory of Nursing*. New York 1991.
- Leira, Arnlaug/Chiara Saraceno: *Care Actors, Relationships and Contexts*. In: Hobson, Barbara/Jane Lewis/Birte Siim (eds.): *Contested Concepts in Gender and Social Politics*. Cheltenham 2002, pp. 55–83.
- Linde, Hans: *Sachdominanz in Sozialstrukturen. (Gesellschaft und Wissenschaft; Vol. 4)* Tübingen 1972.
- Ludwig, Andreas: *Materielle Kultur: Version: 1.0*, in: *Docupedia-Zeitgeschichte*, 30.05.2011 http://docupedia.de/zg/ludwig_materielle_kultur_v1_de_2011
- Manz, Ulrike: *Ein anderer Blick auf die Dinge? Von Pflegehilfsmitteln zu Partizipanten des Tuns*. In: *Pflege & Gesellschaft* 20 (2015), pp. 213–226.
- Manzei, Alexandra: *Zur gesellschaftlichen Konstruktion medizinischen Körperwissens. Die elektronische Patientenakte als wirkmächtiges und handlungsrelevantes Steuerungsinstrument in der (Intensiv-)Medizin*. In: Keller, Rainer/Michael Meuser (eds.): *Körperwissen*. Wiesbaden 2011, pp. 207–228. Doi: https://doi.org/10.1007/978-3-531-92719-0_10
- Messecar, Deborah C./Patricia G.Archbold/Barbara J. Stewart/Jane Kirschling: *Home Environmental Modification Strategies Used by Caregivers of Elders*. In: *Research in Nursing and Health* 25 (2002), pp. 357–370.
- Miller, Daniel: *Material Culture and Mass Consumption*. Oxford 1987.
- Miller, Daniel: *Materiality: An Introduction*. In: Miller, David (ed.): *Materiality (Politics, History and Culture)*. Durham, London 2005, pp. 1–50.

- Mol, Annemarie/Ingunn Moser/Jeanette Pols (eds.): *Care in Practice: On Tinkering in Clinics, Homes and Farms*. Bielefeld 2010.
- Morgan, Debra G./Norma J. Stewart: The Importance of the Social Environment in Dementia Care. In: *Western Journal of Nursing Research* 19 (1997), pp. 740–761.
- Morgan, Debra G./Norma J. Stewart: The Physical Environment of Special Care Units: Needs of Residents with Dementia from the Perspectives of Staff and Family Caregivers. In: *Qualitative Health Research* 9 (1999), pp. 105–118.
- Nevile, Maurice/Pentti Haddington/Trine Heinemann/Mirka Rauniomaa: On the International Ecology of Objects. In: Nevile, Maurice/Pentti Haddington/Trine Heinemann/Mirka Rauniomaa (eds.): *Interacting with Objects. Language, Materiality, and Social Activity*. Amsterdam, Philadelphia 2014, pp. 3–26.
- Nightingale, Florence: *Notes on Nursing. What It Is and What It Is Not*. London 1859.
- Ostner, Ilona: Abschied vom Maternalismus? Zur sozialpolitischen Neujustierung des Verhältnisses zwischen Familie und Gesellschaft im „konservativen“ deutschen Wohlfahrtsstaat. In: Obinger, Herbert/Elmar Rieger (eds.): *Wohlfahrtsstaatlichkeit in entwickelten Demokratien*. Frankfurt am Main 2009, pp. 319–346.
- Ostner, Ilona/Elisabeth Beck-Gernsheim: *Mitmenschlichkeit als Beruf. Eine Analyse des Alltags in der Krankenpflege*. Frankfurt 1979.
- Peplau, Hildegard: *Interpersonale Beziehungen in der Pflege*. Basel 1995.
- Pols, Jeanette: *Care at a Distance: On the Closeness of Technology*. Amsterdam 2012.
- Puig de la Bellacasa, Maria: Matters of Care in Technoscience. Assembling Neglected Things. In: *Social Studies of Science* 41 (2011), pp. 85–106.
- Reckwitz, Andreas: Grundelemente einer Theorie sozialer Praktiken. Eine sozialtheoretische Perspektive. In: *Zeitschrift für Soziologie* 32 (2003), pp. 282–301.
- Remmers, Hartmut: Pflegewissenschaft als transdisziplinäres Konstrukt. Wissenschaftssystematische Überlegungen. Eine Einleitung. In: Remmers, Hartmut (ed.): *Pflegewissenschaft im interdisziplinären Dialog. Eine Forschungsbilanz*. Osnabrück, Göttingen 2011, pp. 7–47.
- Remmers, Hartmut: Zur Relevanz des Körpers im Kontext pflegerischen Handelns. In: Uschok, Andreas (ed.): *Körperbild – und Körperbildstörungen. Handbuch für Pflege- und Gesundheitsberufe*. Bern, Hogrefe 2016, pp. 25–43.
- Remmers, Hartmut/Hülsken-Giesler, Manfred: E-Health Technologies in Home Care Nursing. Recent Survey Results and Subsequent Ethical Issues. In: Ziefle, Martina/Röcker, Carsten (eds.): *Human-Centered Design of E-Health Technologies. Concepts, Methods and Applications*. Hershey 2011, pp. 154–178.
- Rueß, Susanne/Astrid Stölzle (eds.): *Das Tagebuch der jüdischen Kriegskrankenschwester Rosa Bendit, 1914 bis 1917*. Stuttgart 2012.

- Sandelowski, Margaret: *Devices and Desires: Gender, Technology and American Nursing*. Chapel Hill 2000.
- Sander, Kirsten: Machtspiele im Krankenhaus: „Doing Gender“ oder „Doing Profession“? In: *Forum Qualitative Sozialforschung/Forum Qualitative Social Research* 9 (2008), Art. 4. <http://nbn-resolving.de/urn:nbn:de:0114-fqs080146>, accessed December 15, 2017.
- Sandvoll, Anne Marie/Ellen Karine Grov/Kjell Kristoffersen/Solveig Hauge: When Care Situations Evoke Difficult Emotions in Nursing Staff Members: An Ethnographic Study in Two Norwegian Nursing Homes. In: *BMC Nursing* 40 (2015), pp. 1–6.
- Scheiwe, Kirsten/Johanna Krawietz (eds.): *(K)Eine Arbeit wie jede andere? Die Regulierung von Arbeit im Privathaushalt*. Berlin 2014.
- Schillmeier, Michael/Miquel Domènech: *New Technologies and Emerging Spaces of Care*. Ashgate & Aldershot 2010.
- Schroeter, Klaus R./Thomas Rosenthal (eds.): *Soziologie der Pflege. Grundlagen, Wissensbestände und Perspektiven*. Weinheim, München 2005.
- Simpson, Ruth/Natasha Slutskaia /Patricia Lewis/Heather Höpfl: *Dirty Work: Concepts and Identities*. Basingstoke 2012.
- Stichler, Jaynelle F.: Creating Healing Environments in Critical Care Units. In: *Critical Care Quarterly* 24 (2001), pp. 1–20.
- Thiekötter, Andrea/Heinrich Recken/Manuela Schoska/Eva-Maria Ulmer (eds.): *Alltag in der Pflege. Wie machten sich Pflegenden bemerkbar?* Frankfurt am Main 2009.
- Wahl, Stefanie: Auf der Suche nach Anerkennung – Prekarität und Missachtungserfahrungen in der Pflegearbeit, in: Krawietz, Johanna/Stefanie Visel (eds.): *Prekarisierung transnationaler Care-Arbeit - Ambivalente Anerkennung*. Münster 2014, pp. 20–36.
- Wierling, Dorothee: Besitzen und Benutzen, Geben und Nehmen. Die Dinge in der Alltagsgeschichte. In: *Zeitgeschichte-online*, December 2016, <https://zeitgeschichte-online.de/kommentar/besitzen-und-benutzen-geben-und-nehmen>, accessed January 31, 2019.
- Wissenschaftsrat (ed.): *Empfehlungen zu wissenschaftlichen Sammlungen als Forschungsinfrastrukturen*, printed papers 10464. Berlin 2011.
- Wolkowitz, Carol: The Social Relations of Body Work. *Work, Employment and Society* 16 (2002), pp. 497–510.

Electroconvulsive Therapy (ECT) and Nursing Practice in the Netherlands, 1940–2010

Geertje Boschma

Abstract

Electroconvulsive therapy (ECT) has been applied in mental and general hospitals in the Netherlands since 1939, but we know little about nurses' role in the transformation brought about by the ECT machine and its use. Based on archival documents, interviews and a case study of nurses' work in ECT at the university hospital in the city of Groningen, this article shows how nurses' professional identity was depicted and changed within the application and practice of ECT. Although nursing was an integral part of ECT practice from the outset, it was also affected and changed by it, especially as public debate and controversy over ECT arose in 1970s. During this time mental health grew as an interdisciplinary field, pressuring nurses to articulate their psychiatric nursing expertise. New governmental ECT guidelines in the 1980s also shaped nurses' work. Once protest over ECT subsided in the 1990s, reflecting a new acceptance of biological psychiatry, use of ECT increased again and nurses obtained a specialized role in ECT. The article concludes that whereas nursing's traditional close ties to medical knowledge and practice has been a source of professional tension, the connection also gave nurses new opportunities to renegotiate their expertise when the use of ECT increased during the 1990s. It realigned them with medicine in new ways, opening new professional avenues in specialized ECT nursing practice.

1 Introduction

We know little about the history of Electroconvulsive Therapy (ECT) and the transformation the introduction of the ECT machine brought about from the point of view of nurses. This article examines psychiatric nursing practice and the way nurses' role changed in response to the introduction of the ECT machine and its application in the Netherlands from 1940 to 2010. ECT has been applied in mental hospitals and psychiatric departments of general and university hospitals in the Netherlands since its first application in 1939. I will mainly focus on developments in one general hospital as a case study, the university hospital in the city of Groningen, where ECT was first performed in 1941 and continued to be applied in the psychiatric clinic to the present day.

The analysis builds upon nursing and medical history scholarship that examines medicine, nursing and machines in hospitals in its historical and social context.¹ It examines ECT as a therapeutic approach that involved the use of a machine, the working and application of which transformed psychiatric practice, including nursing. As such the introduction of ECT and its historical development is considered within a broader understanding of the history of medical and nursing technology and the relational context of nursing care, that is, as part of larger cultural, social and technological transformations.² ECT was adopted into an existing structure

¹ Fairman 1998, 2000; Howell 1989; Keeling 2004; Pinch/Bijker 1987; Toman 2001.

² Much of the initial historiography on nursing technology and the negotiation of professional jurisdiction between medicine and nursing focused on general nursing in hospitals the North-American context, using a history of technology framework. Recently a broader perspective on care in practice extends this scholarship,

and hence changed it.³ When ECT was applied nurses' work and knowledge were an integral part of that structure and praxis.⁴ In one of the most recent analyses of the history of ECT, Max Gawlich considers three domains in which the ECT machine worked as a practice-transforming agent or tool: firstly the handling of medical information, documentation and recordkeeping, secondly the technology and fabrication of the machine itself, and thirdly, the therapeutic and hospital praxis.⁵ The examination of ECT through the lens of nursing in this article mostly pertains to the third domain, exploring the way nursing became part of ECT practice and the way it structured their work and nurses' responses to it. My analysis centers on nurses' professional identity as a response to and part of ECT use. I examine how nurses took up this work and how their professional identity was depicted during the initial decades of the therapy's use in the 1940s and 1950s, and how it changed, especially during the time public debate over ECT arose in 1970s, fueled by a rising anti-psychiatric movement, and in the decades thereafter.

Following a period of dwindling use and much controversy over ECT in the late 1970s and 1980s, its application increased again in the Netherlands over the last 30 years. During this time outpatient or psychiatric clinics in general hospitals gradually became the dominant environment for ECT, whilst nursing obtained a central and specialised role in ECT. In the latest, 2010, ECT guideline of the Dutch Association of Psychiatry, for example, the role of nurses is explicitly included; moreover, the guideline lists 36 ECT Centres, the majority of which are located in psychiatric departments of general and university hospitals.⁶

The current specialized professional role of a Nurse Specialists in Mental Health Care, appointed as an ECT Coordinator, and supported and formalized by legislation under the Dutch Act on the Health Professions, indicates a profound shift away from the controversy that surrounded the treatment in the 1970s and 1980s.⁷ ECT's controversial 1970s portrayal is vividly kept alive, for example, in the world-famous movie *One Flew Over the Cuckoo's Nest*, not only depicting ECT as a contentious practice in unmodified form, but also stereotyping the nurse as a cold and heartless figure in the controlling character of nurse Ratched.⁸ Such conflicting images warrant a more thorough historical examination, which is a key goal of this article. The conflicting images in role development underscore how a machine is not a neutral object but part of a complex techno-social system in which the use and working of a machine is embedded in a complex relational web, in which power relationships are negotiated, socially, politically, ethically, professionally and culturally. All of these aspects, influences and relationships form the way a machine "works" in

providing fresh perspectives on technology and care practices in relational and community contexts: Mol/Moser/Pols 2010; Pols 2017, 2012; Twohig 2005.

³ Gawlich 2018; Vijselaar 2013.

⁴ Braunschweig 2013, pp. 188–207; Aan de Stegge 2012, pp. 599–603.

⁵ Gawlich 2018.

⁶ Van den Broek et al. 2010, pp. 136, 177. For historiography on ECT see: Gawlich 2018; Kneeland/Warren 2002; Sadowsky 2017; Shorter/Healy 2007; Vijselaar 2013.

⁷ The title Nurse Specialist in Mental Health Care is the literal translation of "Verpleegkundig Specialist Geestelijke Gezondheidszorg" - the legislation referred to is the Wet op the Beroepen Individuele Gezondheidszorg [the Act regulating the Health Professions], artikel 14; Interview with nurse Franklin Dik by author, 20 June 2011.

⁸ On a history of the movie: Hirshbein/Sarvananda 2008; the movie is based on Kesey 1962.

practice.⁹ A second goal, therefore, is to provide a more nuanced view on the development of nursing expertise and nurses' role in the use of technological tools by situating nurses' role in ECT in its social, ethical and technological context, which I argue, provides a portrayal that emphasizes the complexity of the development of nursing as a competent, professional and ethical practice inherently shaped by the circumstances and relational context in which it evolves.¹⁰

In order to put nurses' role in ECT in perspective, I examine developments in one general hospital in the Netherlands in particular, the university hospital in the city of Groningen.¹¹ In the psychiatric clinic of this hospital, ECT was first performed in 1941 and has continued to be applied to the present day. Competent nursing was a key component in ECT treatment from the outset. Although nursing's close ties to medical knowledge and practice have been a source of ambivalence and professional tension, this connection, I argue, also gave nurses new opportunities to renegotiate their expertise in the domain of biological psychiatry during the last quarter of the 20th century. Mental health nursing and the evolution of nurses' role in ECT mirror shifts in jurisdictional control that marked general nursing when hospitals and community service changed in the latter half of the twentieth century.¹² Changes in social welfare, public health insurance, health science and technology transformed hospital care. In the process, certain measures and interventions, such as taking vital signs, measuring blood pressure, giving injections, and so on, once central to the jurisdiction of medicine, were transferred to nurses with concurrent realignment of professional authority and power relationships.¹³ A similar process of realignment of responsibilities can be observed in the use of ECT, particularly when its application increased during the 1990s.

⁹ Gawlich 2018.

¹⁰ ICN (=International Council of Nurses) Code of Ethics 2012; for an analysis of nursing role development in community mental health care see Boschma 2012.

¹¹ Based on information from secondary literature and comparison of information from the records of the university hospital in Groningen and those of the St. Canisius hospital in Nijmegen clinical developments in Groningen appeared to be comparable to similar institutions in the Netherlands at the time. Whereas in many places ECT was no longer used in 1970s and 1980s, in the Groningen hospital it never disappeared although its use decreased there as well during this time. See also Boschma 2013. Unique to the Groningen case study was the inclusion of interviews with nurses on their experience with ECT using oral history. The nurses I interviewed were all registered nurses. They had leading roles as nurse manager or ECT coordinator at the time of interview or had worked for a substantial number of years in the 1980s on units in the Groningen psychiatric clinic where ECT was regularly performed. Where appropriate biographical details are included in the text. Information from interviews with psychiatrists is also included. The latter all had performed ECT at some point in their career and had leading roles in psychiatry at the time of the interview.

¹² Boschma 2012; Fairman 1998; Hallett/Madsen/Pateman/Bradshaw 2012; Twohig 2005.

¹³ ECT nursing, I argue, reflects a process of professional and technological renegotiation between medicine and nursing comparable to similar processes identified for example in intensive and cardiac care nursing. See Fairman 1998, 2000; Keeling 2004; Toman 2001. Historical analysis of advanced nursing practice, nurse consultant and specialty roles in the European context is emerging: McKenna/Richey/Keeney/Hasson/Sinclair/Poulton 2006; Doody 2014. In the Netherlands specialized, advanced nursing roles emerged from the late 1980s onwards, involving transfer of medical-technological responsibilities and initially often called 'nurse-practitioner.' Currently the accepted terminology is Nurse Specialist [Verpleegkundig Specialist], now a formalized specialty role in Dutch nursing (see also note 8); Roodbol/Lolkema 2002; Borguez 2005.

In this article I first explore how nurses took up their work in ECT in the 1940s and 1950s. Then, I examine the way they negotiated their professional identity in the face of dwindling ECT use and fierce anti-psychiatric critique in the 1970s and 1980s. Finally, I discuss how ECT use increased again during the 1990s, after governmental regulation of ECT had been introduced in response to the political controversy. The way it increased affected nurses' professional knowledge, their work ethic and authority over ECT. From the 1990s onwards, nurses developed new specialised roles in ECT shaped by their expertise in both general and psychiatric nursing.

2 Somatic treatments, ECT and nursing in the Groningen clinic until the 1950s

Since its first application in Italy in 1938, ECT provoked mixed public responses. Its use and side-effects have been the subject of controversy and debate. Current debates centre on the effects on memory, whereas in the past, unmodified treatment sometimes resulted in fractured bones or vertebrae.¹⁴ In current mental health practice, ECT entails the induction of a convulsion instigated by a short electric impulse through the brain for less than a second. It is commonly given with an anesthetic and muscle relaxant under close monitoring and, if necessary, delivery of oxygen in a well-equipped surgical room in a hospital or outpatient clinic. According to current guidelines of the Dutch Association for Psychiatry depression is the primary indication for ECT with varying rates of effectiveness reported.¹⁵ Patient or family permission and informed consent for ECT has to be obtained, according to the same guidelines.¹⁶

In the Netherlands, ECT was first applied in 1939 at the mental hospital in Heiloo by psychiatrist Johannes Barnhoorn. He reported on its use at the spring meeting of the Dutch Association for Psychiatry and Neurology in 1941.¹⁷ In that same year, Willem van der Scheer, Professor and Head of Psychiatry at the Groningen University Hospital, decided to buy an ECT machine.¹⁸ He reported with great optimism about the new, so-called 'somatic treatments' in the Dutch Journal of Psychiatry and Neurology. Medical confidence in somatic treatments had gained momentum in the 1920s, nationally as well as internationally, starting with the application of malaria fever

¹⁴ Interview with psychiatrist Walter van den Broek by author, 23 March 2011. See also: Vijselaar 2010, pp. 193-195; Meeter/Murre/Janssen/Birkenhäger 2011. For a contemporary patient view on ECT: Dukakis/Tye 2006.

¹⁵ ECT is indicated in particular for medication resistant depression, for which antidepressant medications have not been effective; for depression with characteristics of psychosis it might be the primary indication: Van den Broek et al. 2010, pp. 31, 36-39. Research reports on healing effects, or effectiveness reported in terms of remission percentages, vary from 28% to 68% for patients with medication resistant depression, and from 41% to 91% for patients with non-medication resistant depression: Van den Broek et al. 2010, p. 40.

¹⁶ Van den Broek et al. 2010, pp. 31-35, and 139-145; on nursing in ECT: Fitzsimons 1995; Fitzsimons/Mayer 1995; Munday/Deans/Little 2003. Recommendations to inform families of the risks of ECT and ask their permission were included in nursing textbooks from the 1950s: Hamer/Haverkate 1950, pp. 509; Hamer/Tolsma 1956, p. 558.

¹⁷ Barnhoorn 1940, 1941.

¹⁸ Jaarverslag [Annual Report (AR)] van het Algemeen, Provinciaal, Stads, en Academisch Ziekenhuis te Groningen (APSAZG) [General, Provincial, City and University Hospital in Groningen] 1941, pp. 4. Hereafter cited as AR-APSAZG.

treatment and deep sleep therapy.¹⁹ Subsequently, shock treatments with insulin and metrazol were introduced in the 1930s. Van der Scheer conducted a survey on the results of the latter treatments used for patients with schizophrenia during the 1930s.²⁰ These treatments generated a comatose state in a patient using insulin, or artificially evoked a convulsion using metrazol, both of which allegedly had a healing effect. Although Dutch psychiatrists were well aware of the risk these therapies also posed, they considered them to be promising because of beneficial effects at least for some of the patients. It had been noted for example, in the application of metrazol therapy, that patients could experience a frightening sense of hopelessness, sometimes described as near death experience, just before the onset of the convulsion. Some suggested that accompanying psychotherapy might mitigate such effects. Still, with few effective treatments available, psychiatrists embraced the new somatic treatments as approaches with promise and potential for cure.²¹

Importantly, these new somatic treatments depended on competent nursing.²² Probably not unrelated to the popularization of these treatments by the mid-1920s the clinic in Groningen had increased its nursing staff significantly and nursing education was expanded. The psychiatric clinic had grown from a 40-bed-unit in 1915 to one for 127 patients ten years later.²³ Each year a few student nurses sat the exam in psychiatric nursing and obtained the so-called B-diploma.²⁴ A training course in psychiatric nursing was introduced as well. By 1930, the clinic counted 30 student nurses and several graduated nurses.²⁵ Labour intensive somatic treatments may have raised the demand for nurses, not only for more nurses but also for nurses with particular competencies to be able to attend to the patient, monitor bodily functions and patient reactions resulting from the treatments and intervene as required to keep the patient safe.²⁶ Application of the new somatic treatments entailed new medical knowledge on how to best apply the therapy, which psychiatrists shared in professional journals and during conferences or site visits,

¹⁹ Vijselaar 2010, pp. 183-198; Gijswijt-Hofstra/Oosterhuis/Vijselaar/Freeman 2006, pp. 44-47; Schmuhl/Roelcke 2013.

²⁰ Van der Scheer 1941.

²¹ Vijselaar 2013; Hutter 1941.

²² Jelgersma 1937.

²³ AR-APSAZG, 1915, 1925.

²⁴ AR-APSAZG, 1911, 1915. Similar to the United Kingdom, the Netherlands had a separate register for psychiatric nurses. The A-registry was for graduates of general hospital schools (A-diploma). Graduates of nursing schools in mental hospitals received a B-diploma and were registered on the B-registry. See: Aan de Stegge 2012.

²⁵ AR-APSAZG, 1930.

²⁶ Jelgersma 1937; Hamer /Tolsma 1956, pp. 558-559. The latter textbook explicitly stated the need for schooled personnel in case of monitoring patients during insulin treatment for example, which, according to the description, typically involved a 30-day routine of a daily hypoglycemic coma lasting one to one-and-a-half hours whereafter the patient was awoken by administering a sugar or glucose solution typically given by tube feeding. Nurses had to monitor bodily temperature and respiration, monitor for signs of transpiration, changes in skin color, properly inserting feeding tubes, and, in case of a crisis, intervene by stopping the comatose state by administering glucose or giving an injection. They also provided the patients with a meal and a bath afterwards, and provided consolation. Physicians had to be on call, the authors pointed out, whereas nurses stayed with the patients, who were not to be left alone.

but it also expanded the need for nursing knowledge and training, so nurses would be able to assist with treatments and careful monitoring of patients.²⁷

A detailed account in the Dutch Journal of Nursing in 1937 of the application of metrazol therapy, the fore-runner of ECT, by psychiatrist Jelgersma gives insight in the demand for and acknowledgement of nursing competency during this therapy. He pointed out that the therapy required four nurses: 'While the physician prepares the injection,' Jelgersma wrote, 'one of the nurses ties the arm, a second nurse stands on the other side of the patient with a rubber mouthpiece (to hold between the teeth during the insult), a third holds the arm still for the injection, and preferably a fourth nurse is available to help.' Because of its complexity, he asserted, 'competent help of nurses, who understand what is going on and what needs to happen is therefore required.' Afterwards a patient could vomit, experience a head ache, or be 'in great need of company or can be confused or unpredictable in their actions,' he stated, and would need close observation, bed rest and regular checks of the pulse.²⁸ Jelgersma's instructions also reveal the work was conceived as a hierarchical relationship suggesting a power differential reflected in the organization of the work: nursing assistance during the treatment and careful observation was essential, while the physician took charge of the diagnosis, prescription and technical part of preparing and giving the injection. Nurses also provided consolation and close monitoring afterwards, staying with the patients.

Considering the extent of this hierarchical arrangement around ECT and other somatic treatments, it is noteworthy that the report of the launch of another type of therapy, the so-called Active Therapy, related in the annual report of the Groningen clinic in 1931, affirmed the involvement of nurses differently. Van der Scheer had been instrumental in introducing this therapy in the Netherlands – a form of occupational therapy introduced in the 1920s and 1930s – as superintendent of the Santpoort Asylum near Amsterdam, prior to his appointment in Groningen.²⁹ He wanted to start it in the Groningen clinic too. To familiarize nurses with this work, which entailed involving patients in meaningful activities, the report noted that Van der Scheer sent two of them off to his former workplace, 'to study this topic.'³⁰ Being send off to study suggests a slightly different power differential around the role of nurses envisioned and the knowledge developed. Probably because this work required domestic, behavioural and pedagogical knowledge more so than bio-medical expertise, doctors might have found it easier

²⁷ Vijselaar 2013; Aan de Stegge provides an analysis of psychiatric nursing textbooks, and found that information on somatic treatments was newly included in the 1929 edition of a regularly used (and reprinted) nursing textbook; additional textbooks on basic physics and chemistry for nurses appeared in 1926 and 1936 respectively: Aan de Stegge 2012, pp. 445-447. Boschma 2013; Nolte 2017. Karen Nolte makes a similar point about nursing expertise and early use of ECT based on an analysis of patient records in the University Clinic of Würzburg in the 1930s and 1940s: Nolte 2017, pp. 140-147. She found that results of ECT therapy were mixed and patients often feared it, especially during the time it was administered unmodified.

²⁸ Jelgersma 1937, pp. 476-478. Translation of quotes by the author. Metrazol therapy included administration of metrazol by injection.

²⁹ Aan de Stegge/Oosterhuis 2010.

³⁰ AR-APSAZG 1931, 6. Italics and translation by the author.

to allow nurses some independence in developing this work as compared to biomedical treatments, such as ECT.³¹

ECT was applied widely throughout the 1950s characterised by the described hierarchical work relationship. Jaap Prick, a psychiatrist from the St. Canisius Hospital in Nijmegen who had started his career in 1947, confirmed: 'Yes,' he said, 'ECT I did myself, indeed, push the button'.³² He regularly performed ECT with help of nurses: 'ECT you always did together, especially before anesthesia. A nurse had to put a piece of rubber or towel between the jaws.' Prick noted the importance of competent nursing:

'For severe neurotic cases we did insulin shock. We brought the patient into a hypoglycemic state. But you had to watch carefully. When the patient began to sweat, or turned red, you had to give them sugar, using a tube. The tube had to be put in the stomach properly. Nurses had to be properly instructed and knowledgeable.'

Work relationships had to be negotiated as an act of mutual dependency indicating how the use of the machine was part of a technological system, in which expertise was negotiated and appraised in a relational context. Prick, for example, preferred to hire nurses with a diploma in general hospital nursing (the "A"), as well as the B-diploma in psychiatric nursing as both areas of expertise were necessary and enhanced the success of somatic therapies. Nurses' expertise in close observation of the patient, provision of comfort and ability to check bodily functions was important in conducting ECT. Similarly, a 1956 textbook for psychiatric nurses contained detailed instructions on required nursing care, competence and assistance during and after ECT.³³ Prior to the procedure nurses had to ensure quietness and calm for the patient. If the patient was anxious a sedative could be asked for. Also, the necessary equipment had to be prepared, and nurses had to make sure the patient would not take any food prior to the procedure to avoid risk of aspiration, especially in cases where curare was used as an anesthetic, the book stated. The patient should have urinated prior to ECT as well. Experience with anesthetics was in its infancy then and required careful attendance.³⁴ During the procedure the nurse had to provide comfort, placing a pillow under the head and back, a rubber device in the mouth, and gently hold the arms and shoulders because of the risk of fractures. Equipment for giving oxygen also should be ready for use, making sure cylinders were filled, as was equipment of intubation, in case such was necessary. These were nursing responsibilities as was assisting in administering them. Care after the procedure required competence as well, because the patient could be restless, was at risk of falls, and therefore "one never should leave the patient alone" until they were fully awake and in a calm state. Vital functions had to be checked. Risk of difficulty with breathing or mucus secretion needed to be attended to, as was the responsibility to attend to fears patients might have, or to experiences of disorientation or amnesia afterwards. Nurses were also in a position

³¹ Aan de Stegge/Oosterhuis 2010.

³² Interview with psychiatrist Jaap Prick by author, 21 April 2011. Quotes from this and all other interviews are translated by the author. St. Canisius hospital had a clinic for psychiatry since 1926. Jaarverslag [Annual Report] St. Canisius Ziekenhuis 1926.

³³ Hamer/Tolsma 1956, pp. 555-559.

³⁴ A point confirmed by Goos Zwanikken, psychiatrist in Nijmegen who had started his career in the 1950s and regularly conducted ECT. Interview with Goos Zwanikken by author, 24 February 2011.

to overhear patients' conversations amongst themselves about the procedure. Such bonding might be beneficial, it was stated, but it should not digress into patients making each other anxious - nurses should attend to these conversations. Interestingly, it also was spelled out that the maintenance of the ECT machine itself was a nursing responsibility, followed by more detailed instructions: making sure the electrodes to be placed against the head were moist before the procedure, putting no moist electrodes on the machine, and rinsing them afterwards. Cords should not be overstretched, the machine kept 'dust- and stain free,' and not be damaged by bangs or bumps when transported.³⁵ It should be noted that the nursing textbook knowledge was all framed and written by psychiatrists, who carefully controlled the relationship and training of nurses. As such, the textbooks appeared to be an instructional device that not only told nurses what to do but also instilled them with a framework of interpretation of their work that was grounded in careful listening to what the doctor had to say. At that point in time nurses had little control over their education. Psychiatrists provided the education and also wrote the bulk of the nursing textbooks.³⁶

3 Decline in ECT and increase in biological psychiatry: A new role for nurses

In addition to mental hospitals and university clinics, general hospitals also became an attractive site for specialized psychiatric departments from the 1960s onwards.³⁷ These sites' attractiveness grew, in part because of new schemes of public health insurance supporting admission, but also because a psychiatric department in a general hospital seemed a less stigmatizing alternative for mental hospital admission.³⁸ Still, the use of ECT decreased from the late 1950s onwards, mainly for two reasons. Firstly, intra-professional tension arose in psychiatry in the interwar period between medical-biological and psychogenetic, or psychoanalytic, explanations of mental disease, with the latter gradually growing more prominent. Psychiatrist Prick, for example, favoured a biogenetic view of psychiatry, ascribing the cause of psychiatric diseases to neurological and physiological explanations.³⁹ Yet, a psychogenetic, or psychodynamic view was grounded in psycho-analytic theory, and assumed that psychological causes or conflicts formed the basis of mental illness. Freud had been influential in claiming this point. While Prick was a proponent of the medical-biological view, leaning towards neurology, this gradually became a minority standpoint. Psycho-analysis and therapy began to dominate psychiatry despite the new stimulus of the somatic treatments.⁴⁰ Secondly, the advent of psychotropic medication in the 1950s further reduced ECT use during the 1960s. Whereas for some the new medications confirmed the organic nature of psychiatry, finally enabling treatment of organic causes with chemical remedies, proponents of psychotherapy saw medication (and ECT) as a measure to

³⁵ Hamer/Tolsma 1956, pp. 555-559. The quote is on p. 555, the description of the machine's maintenance on p.557.

³⁶ Aan de Stegge 2012, pp. 155-197, 421-504. This power dynamic began to shift in the 1970s and 1980s.

³⁷ Boschma 2012, 2013.

³⁸ Dolk 1956.

³⁹ Interview Prick.

⁴⁰ Abma/Weijers 2005, pp. 63-106, 175.

apply psychotherapeutic treatment more effectively.⁴¹ Moreover, psychiatry and neurology were formally split into separate medical fields in the early 1970s in the Netherlands, and a psychodynamic perspective dominated psychiatry over a medical-biological one.⁴²

Mixed results of ECT therapy, limited theoretical explanation of its working, and the way its therapeutic use could be justified in a variety of ways may have played into this ambivalence, making medication seem a more viable approach.⁴³ Although ECT brought considerable, and often rapid relief to some patients experiencing severe despair in psychotic depression, and was therefore sought after by some, others did not experience any improvement at all and fear for the treatment persisted. Power to refuse the treatment might have been very limited, or non-existent for involuntary admitted patients. Even though ECT could be used effectively in case of depression, it also was understood and used as a way to counter excessive agitation. Without a clear therapeutic rationale, or, as medical historian Joel Braslow has effectively argued, within a therapeutic relationship in which a patient's symptoms of agitation might be considered a reason for ECT, the alleged legitimate use of the therapy could tip over into a form of restraint, and be used as a disciplinary or corrective measure instead of as a helpful, empathic intervention, both of which reportedly did occur. From a social and ethical perspective, doctors' views as to the necessity of the treatment typically took precedence over insights or preferences of patients. In the late 1978 formal procedures for informed consent were only beginning to be considered in medical practice and patients had little say in their treatment.⁴⁴ Still, the way in which ECT resulted in rapid and effective relief in some cases of severe depression (in ways medication did not) remained a significant clinical insight; practical results were not only vividly remembered and recalled in interviews by patients as well as professionals, but also figuring as an argument in support of ECT when controversy over its use grew.⁴⁵

The clinic in Groningen revealed this trend in the 1960s and 1970s, showing how the practice of ECT did not entirely disappear, nor did biological explanations. Although neurology and psychiatry had split into two medical specialties, psychiatry still included reliance on biological approaches, particularly as the use of psychotropic medication became more prominent. In 1963, Kuno van Dijk, a prototypical psycho-analyst, was appointed Professor and Head of Psychiatry at the clinic. With substantive foresight that psychiatry would continue to require a biological foundation in addition to social and psychological ones, he encouraged the establishment of a

⁴¹ The movie *Snakepit* (1948) exemplifies this viewpoint, which also has been described as an effect of other somatic treatments. Vijselaar 2010, p. 191.

⁴² Interview Prick. Abma en Weijers 2005, pp. 94-99, 104-106. In the early 1970s the law on registration of medical specialties changed and in this process neurology and psychiatry became two separate medical specialties each with their own registries and training requirement. The split was formally enacted in 1972. Abma/Weijers 2005, p. 105.

⁴³ Interview with Zwanikken and Joke Zwanikken-Leenders (nurse) by author, 10 and 24 February 2011.

⁴⁴ Bradslow 1997, pp. 104-117; Vijselaar 2010, pp. 193-95; Shorter 1997, pp. 214-224; Rooijmans 1978. About the introduction and regulation of informed consent: Koster 1992; Witmer/de Roode 2004.

⁴⁵ Interview Zwanikken and Zwanikken-Leenders; Interview with psychiatrist Fons Tholen by author, 15 March 2011; Aan de Stegge 2012, pp. 602; Nolen 1999.

new subfield of biological psychiatry to enhance the scientific foundation of medication use.⁴⁶ In 1966, he appointed one of the first professors in biological psychiatry in the Netherlands, Herman van Praag, who became internationally known for his physiological and biochemical based research in depression.⁴⁷ Van Praag was instrumental in maintaining ECT treatment in this clinic, which he occasionally applied.⁴⁸

To assist him in the new biological research, Van Praag hired a nurse, Louise Dols. The expansion of her nursing role beyond immediate patient care illustrates the way new research contexts of psychiatry also created new nursing roles, albeit in this case within a traditional medical hierarchy.⁴⁹ Dols worked with Van Praag from 1968 onwards until he left for an appointment in Utrecht in 1977. The 1960s were turbulent times in the Netherlands, Dols remembered: 'There was a very permissive attitude suddenly'.⁵⁰ Significantly, it was Dols' general hospital training that made her well suited for the job. She had obtained her A-diploma in general nursing and knew very little about psychiatry and had no B-diploma. Probably Van Praag appreciated her general hospital background and the fact that she was neither affected by the anti-psychiatric mood nor steeped in psychoanalytic approaches. Dols did know medication and nursing, two ingredients essential to the new screening of patients in new biological research. She was appointed as a 'research nurse,' a new role she herself helped to create: "Why don't you call me a research-nurse," she had suggested, similar to 'research-lab technician', an already existing position in the hospital.⁵¹ Dols pioneered a new domain of research involvement for nurses. She had to be diplomatic about her work because the idea of biomedical research and screening of patients was met with resistance amongst the nurses in the clinic: 'Application of numbers,' Dols remembered, 'nurses saw as objectifying patients'; allegedly 'there was no [therapeutic] relationship.' She recalled how Van Praag occasionally did apply ECT treatment, in cases of severe depression. It was always done with anesthesia, 'very carefully', she noted, but infrequently, reflecting the drop in its use in the 1960s.⁵² Use of anesthesia in combination with muscle relaxants grew more common in ECT treatment to reduce adverse effects, but it also stimulated its application in a general hospital environment where expertise in anesthesia was more readily available.⁵³ When Van Praag left in 1977 his successor also occasionally performed ECT, Dols recalled, and hence the treatment never disappeared in the Groningen clinic.⁵⁴

⁴⁶ Interviews with: Tholen; with psychiatrist Willem Nolen by author 15 March 2011; with psychiatrist Frans Zitman by author, 17 March 2011.

⁴⁷ Van Praag 1980; Interview Nolen.

⁴⁸ Interview with nurse Louise Dols by author, 22 March 2011.

⁴⁹ For historiography on clinical nursing research in mental health in the US, see Smith, 2018. In the Netherlands clinical nursing research evolved in the 1980s. A university department for nursing science opened in 1980 at the University of Maastricht.

⁵⁰ Interview Dols.

⁵¹ Interview Dols; Interview with nurses Piet Gruisen and Hans Warning by author, 22 March 2011; Dols' position was newly created.

⁵² Interview Dols.

⁵³ Interview Van den Broek.

⁵⁴ Piet Gruisen also remembered how Van Praag's successor, Rudy van den Hoofdakker, occasionally applied ECT. Interview Gruisen and Warning.

4 Anti-psychiatry and controversy over ECT in the 1970s and 1980s

Meanwhile, from the late 1960s onward, a rising countercultural movement criticised psychiatry. Mental hospitals, with their alleged authoritative medical model, were perceived as inadequate and triggered activism. Political tension arose over the realities and inadequacies of long-term admission in mental hospitals.⁵⁵ Under the influence of broader social, emancipatory, and emerging patient rights movements, internationally the public view of psychiatry turned critical and the Netherlands was no exception.⁵⁶ Mental hospitals became the target of social controversy. According to the critique, too many patients were kept in hospital for too long, too isolated from society, and under inadequate circumstances. Biomedical approaches and treatments were seen as inadequate, oppressive and objectifying individual human beings, obstructing their capacity for self-development and obscuring social causes of mental illness.⁵⁷ The countercultural-inspired occupation of one mental institution by vocal representatives of an emergent patient movement, Dennendal, became headline news in the mid-1960s and triggered unprecedented political turmoil over psychiatric care.⁵⁸ Activism also centered on biological psychiatry, which was seen as representing the alleged objectionable and narrow-focused medical model, with ECT becoming an essential symbol of the critique. Its alleged widespread use in mental hospitals, particularly as a method of discipline and punishment, stirred public debate and provoked political action. Professionals, activists, family members, and patients alike protested against the use of ECT. The editorial board of the newly established newspaper, the *Gekkenkrant* [The Mad-News] was an instrumental force in bringing diverse activist groups together and sparking media attention. In 1977 their rallies culminated in a National Anti-Shock Action (NASA) protest.⁵⁹ Names of psychiatrists who continued to perform ECT were placed on a 'black-list.' Van Praag was also targeted; at a symposium on biological psychiatry in Utrecht in the late 1970s, a smoke-bomb was thrown into the lecture hall. At another symposium on ECT in 1984, the Mobile Police Unit was called for assistance.⁶⁰

At several mental hospitals' nurses joined the anti-psychiatric revolt and formed action-groups – student nurses, bonded through their training, protested not only oppressive patient treatment, but also authoritarian educational structures. In Arnhem, for example, a group of psychiatric nurses from the Wolfheze mental hospital joined the ECT protest at the gate of the municipal

⁵⁵ During the 1950s family awareness and resistance against inadequate institutional care began to gain momentum. Corrie van Eijk-Osterholt was one of the first family members to express her concerns to the Mental Health Inspectorate. Hunsche 2008; Van Eijk-Osterholt 1972.

⁵⁶ Aan de Stegge 2012, pp. 706-716; Blok 2004; Gijswijt-Hofstra/Oosterhuis/Vijselaar/Freeman 2006; Beyer 2017; Rotzoll 2017.

⁵⁷ Blok 2004.

⁵⁸ Activists included academics, ex-patients and professionals alike: Heerma van Voss 1978; Fox/Van Herk/Esselink/Rijkschroeff 1983.

⁵⁹ Blok 2004; "Speciaal Voor U: De Zwarte Lijst [Van Artsen Die Shocken] [Especially For You: The Black List of Doctors who Shock] 1977, pp. 10-12.

⁶⁰ Interviews Nolen and Dols.

hospital in the June 1977 rallying to stop ECT.⁶¹ Their anti-psychiatric stand was intertwined with their increasing discomfort with the strict rules, regulations and medical hierarchy of their training system.⁶²

Trying to stem the turmoil among nurses, the editors of the Journal of Nursing started a discussion series on ECT in 1977, but without much success; no nurse responded. Perhaps because psychiatrists wrote the series, nurses did not react – nurses began to resist medical domination. Instead, they felt pressured to articulate their own professional identity in the face of new competition from a variety of new occupational groups in psychiatry, such as pedagogical mental health workers, therapists, and institutional assistants. These groups intruded into their occupational terrain, while nurses still were controlled in a medically dominated hierarchy. ‘Is this profession of psychiatric nursing still viable,’ one nurse leader lamented, showing an identity crisis among nurses over their profession.⁶³ Gradually, reform began to transform nursing the education of both general and psychiatric nurses.⁶⁴ In general hospitals and university clinics, nurses seemed less involved in political activism. These nurses were ‘more encapsulated’ in the medical model, one former leader of the anti-psychiatric movement pointed out to me.⁶⁵

The controversy over ECT soon generated debate within municipal councils and the national parliament, in part because several of the mental hospitals in which activism was stirred were municipal institutions or linked to municipal or provincial governments.⁶⁶ Hence politicians with ties to such local interest groups began to raise the matter in municipal and provincial councils and the national parliament. In response, the national government requested formal advice on ECT from the National Health Council. In 1983 the Council concluded that ECT had its value as a medical treatment and should be allowed under certain restrictions, such as regular inspection for compliance with regulations, as a measure of last resort, and only with patient or family permission by means of informed consent. To not withhold a treatment that might have benefit to some people was an important ethical consideration, but procedures for informed consent were also implemented, which was a considerable change in view of the fact that public debate over informed consent in medical practice was only beginning to take shape.⁶⁷ Using ECT as a measure of last resort only after other treatments such as medication had been tried seemed a compromise adapting to the Dutch context.⁶⁸ Based on this advice, governmental ECT guidelines were accepted and published in 1985 and an inspectorate established, including a registration system for the treatment. Eventually, in the 1990s, this system of governance was transferred to the psychiatric profession overseen by the ECT Working Group of the Dutch Psychiatric

⁶¹ Newspaper clipping 1977a, 1977b.

⁶² Heerma van Voss 1978.

⁶³ Vermaas 1980.

⁶⁴ Aan de Stegge 2012, p. 737. For Germany see Rotzoll, 2017; for the UK see Nolan, 1993.

⁶⁵ Flip Schrameijer, sociologist (Seminar presentation, University of Utrecht, 28 March 2011).

⁶⁶ Vos 2007, p. 143.

⁶⁷ Koster 1992; Witmer/de Roode 2004.

⁶⁸ Nolen 1985.

Association. The publication of the ECT guidelines seemed to stem the tide of widespread public protest.⁶⁹

5 Towards a new acceptance of ECT: A new specialized role for nurses

In a sense, the governmental ECT guidelines acknowledged ECT as an acceptable treatment, and from this time on ECT treatment gradually expanded again, although protests continued throughout the 1980s. In 1985, for example, the anti-psychiatric 'Nuts Foundation' in Nijmegen organised a public debate when ECT was reintroduced in the Nijmegen University Hospital.⁷⁰ The panel, which attracted over 200 attendants, included a nurse, Ganny Boer. She was among a list of well-known public speakers on the topic, such as the provincial Inspector of Mental Health Care, and the Patient Ombudsman. Her presentation clearly reveals the shift towards acceptance, and the professional opportunity ECT eventually provided for nurses.

Ganny Boer represented the Dutch Nurses Association. Her speech gives insight into nurses' changing professional involvement in ECT.⁷¹ Ganny told the public how she had been delighted at first to be invited on the panel to voice nurses' opinion. But she soon found herself disillusioned when preparing her speech. It transpired that her Association did not have a formal standpoint on ECT and her own views 'were all from pre-1978'. She probably remembered the NASA anti-shock actions, but had little knowledge of what had happened since. Upon inquiry, she learned about the new 1985 ECT guidelines. To find more information, she contacted a colleague from the Psychiatric University Clinic of Groningen, who had presented 'a small study' on ECT at a symposium in 1984.⁷² To her dismay, that survey of 40 nurses working in the Groningen clinic revealed that 'only one of them turned out to be against ECT'. Still not convinced that these results were fair, Ganny surveyed another 20 of her own colleagues from the Nurses Association. She was surprised to find these 20 colleagues were also in favour of ECT; it had given them an opportunity to participate in decision-making in multi-disciplinary teams in their workplace, they told her, enabling them to influence policy and practice. The clinics most of these nurses referred to or were employed at had become referral centres for ECT, established in response to the governmental ECT guidelines, where clients came for a six-week observation before ECT was performed as per the new guidelines. To Ganny's surprise, nursing care plans and systematic observation by nurses actually mattered in these clinics. Nurses' input was valued by the interdisciplinary team. Nurses had gained a professional voice, Ganny concluded, a significant change from their earlier subservience to the medical model. Significantly, ECT had enhanced their professional status and identity, Ganny now argued, and this new identity provided an opportunity to advocate for the patient. Ganny's view had clearly changed. Implicitly her speech serves as a commentary on the shifting professional context for nurses during the 1980s, both

⁶⁹ 'Richtlijnen Over Electroconvulsie-Therapie' [Guidelines on ECT] 1985; Interview Van den Broek. The ECT workgroup (Werkgroep ECT Nederland) was established in 1995.

⁷⁰ 'Terugkeer van de Elektroschock' [Return of ECT, Report] 1986.

⁷¹ Ganny Boer represented "Het Beterschap" [Dutch Nurses Association]. Her speech is listed in 'Terugkeer van de Elektroschock', pp.10-13, see previous note.

⁷² The study was reported in Nolen 1985, p. 298.

in terms of education and professional emancipation. Their participation in ECT had provided them with new professional avenues.

My oral history interviews in the Groningen clinic confirmed this observation. During the 1980s, few nurses in this clinic were against the application of ECT. The nurses I interviewed had worked in the clinic during the 1980s on the unit where ECT was applied.⁷³ Two of them were graduates of the B-psychiatric nursing education program at the clinic, but also had their general hospital nursing diploma [A-diploma] prior to their enrolment in the psychiatric nursing training. Gerard Meurs had worked in intensive care prior to enrolling in the clinic's last class of the B-diploma in psychiatric nursing. Curiosity had attracted him to psychiatry. He did not remember whether ECT had been covered in his courses, but when he was appointed on the unit where ECT was occasionally given, he did not mind. Whilst it was controversial to some, he observed that patients sometimes benefited from ECT: 'Often it was a situation of which you thought, "things can't continue like this," and then ECT was a measure of last resort.'⁷⁴ Moreover, the technical side of the care actually appealed to him. He was well grounded in physiological care and medical intervention as a result of his previous education 'in the A [i.e. the general hospital].' Meurs remembered that one of the nurses, who happened to be on duty that day, would accompany the patient to ECT treatment, but always on a voluntary basis. His colleague Piet Gruisen, had a similar memory: 'among the general public the image of ECT as "not done" prevailed. Some looked down on the fact that the [university hospital] still did this', he noted, 'but I am actually glad that [we] still continued it'.⁷⁵ Having seen its effect, both nurses were in support of ECT and considered it a useful medical intervention in some instances.

Procedures were followed, they noted, and guidance of an anesthetist accompanied the treatment: 'At first there was a designated room on the unit', Gruisen remembered. 'The anesthetist came there too, and the equipment was there.' But in the early 1980s, ECT was performed in a better equipped operating room. These general hospital rooms enabled proper monitoring and anesthesia. When patients were transported in a shuttle bus over the hospital grounds, a nurse always accompanied and stayed with them afterwards, regularly checking vital signs, Gonda Stallinga remembered. She had worked in surgery and general medicine before coming to psychiatry in 1982. ECT sparked her curiosity: 'I was neither positive nor negative, but mostly curious', she said.⁷⁶ 'When I came to work [in this mood disorder unit] I noticed an ECT schedule hanging on the office wall. Certain patients, particularly ones depressed for a long time, [were on ECT]. They already had tried medication or sleep-deprivation,' she recalled, 'If nothing worked ECT was given.' Stallinga's comments illustrate the effect of the 1985 governmental guidelines on ECT procedures in that ECT would be recommended only after other available treatments had been tried. Stallinga was interested in the medical side of things: 'It interested me, I already had a liking for somatic care.' She recalled, 'The actual treatment lasted only for a short moment, patients had to stay in bed for a while, and we had to check vital signs.' Grounded

⁷³ Interviews by author with nurses Gerard Meurs (23 Feb 2011), Gonda Stallinga (15 March 2012), Piet Gruisen and Hans Warning (22 March 2011).

⁷⁴ Interview Meurs.

⁷⁵ Interview Gruisen and Warning.

⁷⁶ Interview Stallinga.

in medical thought and treatment, these nurses were accepting of ECT and saw it as an acceptable option when other treatments failed.

A last uprising of ECT protest in the Netherlands occurred in 1990, when three Amsterdam hospitals decided to reintroduce it.⁷⁷ Indicative of nurses' ambivalence over its use, in one hospital half of the nurses of the psychiatric department resigned overnight in protest.⁷⁸ Despite the commotion, then head of the department Frank Koerselman used the walk-out as an opportunity to appoint a new group of nurses who were in support of ECT.⁷⁹ Soon thereafter protest died down; as biological psychiatry gained ascendancy in psychiatry, ECT's acceptance grew.

In the Groningen clinic, the responsibility of guiding and observing the patient before, during, and after ECT developed into a specialised nursing role during the 1990s. One of the staff nurses took the new post-graduate course for Nurse Specialists and became responsible for coordinating ECT care in the clinic, Gruisen recalled.⁸⁰ In 2010, another nurse, Hans Warning, was appointed, who took on the role of ECT coordinator. He was formally appointed as a Nurse Specialist in consultation (liaison) psychiatry.⁸¹ Prior to his appointment at the Groningen clinic, he had set up protocols for ECT in a nearby general hospital, at which ECT had been introduced in the 1990s.⁸² Consultation-psychiatric nursing was Warning's specialty. As ECT coordinator, he took on a more independent and specialised role, grounded in specialised nursing education and the new, formally legislated professional responsibility of a Nurse Specialist.⁸³

At another mental health facility nurse Franklin Dik had obtained a similar specialised role and formal appointment as Nurse Specialist. Similar to Warning, he was appointed as psychiatric-liaison and ECT nurse specialist at a new mental health clinic adjacent to one of the general hospitals in Rotterdam.⁸⁴ As discussed, new legislation under the Health Profession Act in the Netherlands had formalised new advanced nursing practice roles such as those of Warning and Dik.⁸⁵ Both of them had obtained new appointments in the dual role of psychiatric-liaison nurse and ECT coordinator with considerable professional independence and specialized expertise. Some scholars have argued that domains of nursing with high use of technology, such as intensive care or emergency nursing, tend to attract more male nurses, indicating patterns shaped by cultural influences of masculine values and career opportunities.⁸⁶ Although ECT nursing could be argued to be such a domain, whether such general patterns are adequately

⁷⁷ Koerselman/Smeets 1992.

⁷⁸ Interview with psychiatrist Frank Koerselman by author, 6 July 2011.

⁷⁹ Interview Koerselman.

⁸⁰ Interview Gruisen and Warning.

⁸¹ See note 8 regarding the legislation providing the legal framework for this designation and role. Interview Gruisen and Warning.

⁸² Interview Gruisen and Warning.

⁸³ Interview Gruisen and Warning; Note 8 above.

⁸⁴ Interview with nurse Franklin Dik by author, 20 June 2011.

⁸⁵ While there were slight differences in the designated roles of Franklin Dik and Hans Warning, both had an expanded set of professional responsibilities and were involved in a shifting context of clinical decision-making context over ECT.

⁸⁶ Evans 2004; Lindsay 2007.

perceived or might have been at play in these nurses' career choices would be difficult to judge based on these two particular situations, and would require further study.⁸⁷ The opportunity the new ECT nursing role provided them to advance nursing practice based on their clinical expertise figured as a particularly motivating influence for Warning and Dik.⁸⁸

Franklin Dik was one of the first nurses in the Netherlands to be qualified and certified under the Act to perform ECT under arms-length guidance of a psychiatrist in 2011.⁸⁹ The particular afternoon I interviewed Dik he was managing the ECT clinic held that afternoon in a day hospital setting, a site purposefully used to accommodate ECT treatment and recovery afterwards. He had five patients scheduled for ECT therapy that afternoon. Some came from home, others from a nearby mental hospital accompanied by a nurse, and others from the adjacent mental health clinic. Typically each patient received a series of ECT treatments on a weekly or monthly basis. Dik had arranged that the patients would come with the same nurse as much as possible to assure consistency and continuity in their care. To make the care less intimidating, 'I also have moved ECT from the (old) operating room' and brought it over to the Day Treatment Clinic, he noted: '[That old operating room] instilled too much fear in the patients.' Still, that location had already been a major improvement from the way ECT was conducted prior to that arrangement, Dik pointed out. Then it was conducted on the grounds of the mental hospital where 'the facilities were not optimal', Dik recalled. As the managing nurse, Dik was able to establish a care ethic that not only addressed individual patient needs, but also implied directing the care environment, indicating the professional stance of an advanced practice role. In this role he also provided consultation to other units and nurses in mental health settings in the region. During the afternoon's visit, I was able to observe the treatment and care provided in well-equipped rooms, both for the procedure and recovery. Patients remained at the Day Treatment Clinic for a couple of hours following the procedure, closely observed by the recovery room nurses who consulted with Dik on a consistent basis. Dik's leading role in the clinic built upon a longstanding career in mental health nursing in which he had not only observed the transformations in the performance of ECT, but also helped establish them, similar to Warning's role in the Groningen clinic. Their advanced expertise on the matter was clearly needed and relied upon. The expansion of consultation (liaison) psychiatry, the need for more complex close observation during and after ECT treatment, increased application of ECT since the 1990s, and the new cultural acceptance of biological psychiatry all shaped the expansion of this new advanced nursing role.

6 Conclusion

The historical analysis of ECT in Dutch psychiatry affirmed that nurses were involved with ECT from the outset. Both medicine and nursing are characterised by a long history of transferring procedures and interventions once central to the jurisdiction of medicine to nursing whether that entailed measuring vital signs or advanced practice skills such as IV-therapy and hemodialysis.⁹⁰

⁸⁷ New perspectives from masculinity studies on men in nursing: Schwamm 2017; On gender constructions in caring work: Davies 1995; Wecker 2006; On the history of men and gender in psychiatric nursing: Boschma 2003, pp. 175-196; Boschma/Yonge/Mychajlunow 2005.

⁸⁸ Interviews Gruisen and Warning, and Franklin Dik.

⁸⁹ Interview Franklin Dik.

⁹⁰ For details see notes 2-4 above.

From the theoretical perspective of objects and use of technology as a complex social system, the transfer of ECT coordination to nurses seems another example of such jurisdictional renegotiation. Nurses' engagement and the transformation of their role in ECT and the way the introduction of the ECT machine reshaped nursing practice must be understood in its complex relational and social context. The ability for nurses to define and control nursing knowledge and practice in the psychiatric domain was circumscribed and influenced by the dominance of the psychiatric profession over the field of nursing. On the one hand, this dominance drove nurses to join broader social protest in the 1970s and 1980s – they wanted more say and participation – but it also compelled nurses to define their expertise in a widening range of therapeutic roles in the mental health field from the mid-1980s onwards. Although nursing's traditional close ties to medicine and medical knowledge and therapies has been a source of ambivalence and professional tension, the connection also gave nurses new opportunities to renegotiate their expertise in the domain of biological psychiatry. As ECT became more accepted during the 1990s, nursing's grounding in the medical domain realigned them with medicine in new ways, opening new professional avenues in nursing expertise and advanced practice.

Acknowledgement

I gratefully acknowledge the junior visiting fellowship from the Descartes Centre for the History and Philosophy of Science and Humanities at the University of Utrecht, the Netherlands in 2011 supporting this research. I thank Dr. J. Vijselaar for his guidance and the nurses and other professionals for the interviews. Ethical approval for the project was obtained from the University of British Columbia Behavioral Research Ethics Board. I also thank the reviewers for their comments. This paper is in part drawn from Boschma, G: Beyond the Cuckoo's Nest: Nurses, Electro-Convulsive Therapy and Dutch General Hospital Psychiatry. In: Gerard M. Fealy/Christine E. Hallett/Susanne Malchau Dietz (eds.): Histories of Nursing Practice. Manchester 2015, 100–122, and is used with permission.

Geertje Boschma (Prof Dr), School of Nursing, University of British Columbia, Canada

7 Bibliography

- Aan de Stegge, Cecile: Gekkenwerk: De Ontwikkeling van het Beroep Psychiatrisch Verpleegkundige in Nederland, 1830–1980/Crazy Work: The Development of the Psychiatric Nursing Profession in the Netherlands. Maastricht 2012.
- Aan de Stegge, Cecile/Harry Oosterhuis. Geen Dressuur Maar Opvoeding: August Stärcke en de Actievere Therapie /Not A Drill But Pedagogy: August Stärcke and the Active Therapy. In: Maandblad Geestelijke Volksgezondheid/Mental Health Monthly 4 (2010), pp. 271–284.
- Abma, Ruud/Ido Weijers: Met Gezag en Deskundigheid. De Historie van het Beroep Psychiater in Nederland/With Authority and Expertise. The History of the Profession of Psychiatrist in the Netherlands. Amsterdam 2005.

- Barnhoorn, J. A. J.: Mededelingen Over de Toepassing van de Convulsietherapie Door Middel Van Electroshock /Information On the Use of Convulsiontherapy Using Electroshock. In: Nederlands Tijdschrift voor Geneeskunde/Dutch Journal of Medicine, 84 (1940), pp. 290–300.
- Barnhoorn, J. A. J.: Convulsietherapie Door Middel Van Electroshock/Convulsion Therapy Using Electroshock. In: Psychiatrische en Neurologische Bladen/Psychiatric and Neurological Papers, 45 (1941), pp. 279–287.
- Beyer, Christof: From Nurse to “Sociagouge”? Ambitions, Realisation and Practice of Social Psychiatric Training at Hannover Medical School Against the Background of the German Psychiatric Reform. In: Hähner, Sylvelyn/ Karen Nolte (eds.): Patients and Social Practice of Psychiatric Nursing in the 19th and 20th Century. Stuttgart 2017, pp. 199–208.
- Bijker, Wiebe E/T. P. Hughes/T. J. Pinch (eds.): The Social Construction of Technological Systems. New Directions in the Sociology and History of Technology. Cambridge 1987.
- Blok, Gemma: Baas in Eigen Brein. Antipsychiatrie in Nederland 1965–1985/Boss in Your Own Brain: Anti-psychiatry in the Netherlands. Amsterdam 2004.
- Borguez, Heather A.: A New Domain in Dutch Healthcare. The Nurse-practitioner. In: Clinical Excellence for Nurse Practitioners 9:1 (2005), pp. 31–36.
- Boschma, Geertje: Beyond the Cuckoo's Nest: Nurses, Electro-Convulsive Therapy and Dutch General Hospital Psychiatry. In: Gerard M. Fealy/Christine E. Hallett/Susanne Malchau Dietz (eds.): Histories of Nursing Practice. Manchester 2015, 100-122.
- Boschma, Geertje: Geïntegreerd of apart? Ervaringen van psychiatrisch verpleegkundigen in de Nederlandse Ziekenhuispsychiatrie/Integrated or set apart? Experiences of Psychiatric Nurses in Dutch General Hospital Psychiatry. In: Aan de Stegge, Cecile/ Cornelis van Tilburg (eds.): Helpen en Niet Schaden. Uit de Geschiedenis van Verpleegkunde en Medische Zorg /To Help and Not to Harm. From the History of Nursing and Medicine. Antwerp 2013, pp. 99–122.
- Boschma, Geertje: Community Mental Health Nursing in Alberta, Canada: An Oral History. Nursing History Review 20 (2012), pp. 103–135. DOI: 10.1891/1062-8061.20.103.
- Boschma, Geertje/Olive Yonge/Lorraine Mychajlunow. Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930-1975. In: Nursing Inquiry 12:4 (2005), pp. 243-255.
- Boschma, Geertje: The Rise of Mental Health Nursing. A history of Psychiatric Care in Dutch Asylums, 1890-1920. Amsterdam 2003.
- Braslow, Joel: Mental Ills and Bodily Cures. Psychiatric Treatment in the First Half of the Twentieth Century. Berkeley 1997.
- Braunschweig, Sabine: Zwischen Aufsicht und: Berufsbildung und Arbeitsalltag der Psychiatriepflege am Beispiel der Basler Heil- und Pflegeanstalt Friedmatt, 1886 - 1960. Zürich 2013.
- Davies, Celia: Gender and the Professional Predicament in Nursing. Buckingham 1995.

- Dolk, J. E.: De Functionele Verhouding Tussen de Psychiatrische Afdeling van een Algemeen Ziekenhuis, een Psychiatrische Kliniek, en de Psychiatrische Inrichting/Functional Relationships Between General Hospital Psychiatric Departments, University Psychiatric Clinics and the Mental Hospital. In: Het Ziekenhuiswezen/The Hospital System 29:6 (1956), pp. 200–209.
- Doody, Owen: The Role and the Development of Consultancy in Nursing Practice. British Journal of Nursing 23:1 (2014), pp. 32–39. DOI: 10.12968/bjon.2014.23.1.32.
- Dukakis, Kitty/ Larry Tye: Shock. The Healing Power of Electroconvulsive Therapy. New York 2006.
- Evans, Joan: Men in Nursing. A Historical and Feminist Perspective. In: Journal of Advanced Nursing 47:3 (2004), pp. 321–228. DOI: 10.1111/j.1365-2648.2004.03096.x.
- Fairman, Julie: Alternate Visions: The Nurse–Technology Relationship in the Context of the History of Technology. In: Nursing History Review 6 (1998), pp. 129–146.
- Fairman, Julie: Economically Practical and Critically Necessary? The Development of Intensive Care at Chestnut Hill Hospital. In: Bulletin of the History of Medicine 74 (2000), pp. 80–106. DOI: 10.1353/bhm.2000.0016.
- Fitzsimons, Linda: Electroconvulsive Therapy: What Nurses Need to Know. In: Journal of Psychosocial Nursing 33:12 (1995), pp. 14–17.
- Fitzsimons, Linda/ Rupert Lawrence Mayer: Soaring Beyond the Cuckoo’s Nest. Health Care Reform and ECT. In: Journal of Psychosocial Nursing 33:12 (1995), pp. 10–13.
- Fox, Becky/Bert van Herk/Rozemarijn Esselink/Rally Rijkschroeff: Psychiatrische Tegenbeweging in Nederland/Anti-psychiatry Movement in the Netherlands. Amsterdam 1983.
- Gawlich, Max: Eine Maschine, die wirkt. Die Elektrokrampftherapie und ihr Apparat/A Device that works. ECT and its Device, 1938-1950. Paderborn 2018.
- Gijswijt-Hofstra, Marijke/Harry Oosterhuis/ Joost Visselaar/ Hugh Freeman (eds.): Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century. Amsterdam 2006.
- Hallett, Christine E./Wendy Madsen/ Brian Pateman/Julie Bradshaw: Time Enough! or Not Enough Time! An Oral History Investigation of Some British and Australian Community Nurses’ Responses to Demands for “Efficiency” in Healthcare, 1960–2000. In: Nursing History Review 20 (2012), pp. 136–161. DOI: 10.1891/1062-8061.20.136.
- Hamer, B.C. /J. H. Haverkate (eds): (Schermers’) Leerboek bij het Verplegen van Geestes- en Zenuwzieken/ (Schermers’) Textbook for the Nursing of Mental and Nervous Patients, 8th revised edition. Amsterdam 1950.
- Hamer, B. C./F. J. Tolsma (eds.): Algemeen Leerboek voor het Verplegen van Geestes- en Zenuwzieken/General Textbook for the Nursing of Mental and Nervous Patients, 9th revised edition. Leiden 1956.
- Heerma van Voss, Arend J.: De Geschiedenis van de Gekkenbeweging: Belangenbehartiging en Beeldvorming Voor en Door Psychiatrische Patientten, 1965–78/The History of the Mad

- Movement: Advocacy and Portrayal For and By Psychiatric Patients. In: Maandblad Geestelijke Volksgezondheid/Mental Health Monthly 33 (1978), pp. 398–428.
- Hirshbein, Laura/Sharmalie Sarvananda: History, Power and Electricity: American Popular Magazine Accounts of Electroconvulsive Therapy, 1940–2005. In: Journal of the History of the Behavioral Sciences 44 (2008), 1, pp. 1–18. DOI: 10.1002/jhbs.20283.
- Howell, Joel D.: Machines and Medicine: Technology Transforms the American Hospital. In: Diana E. Long/Janet Golden (eds.): The American General Hospital: Communities and Social Contexts. Ithaca NY 1989, pp. 109–134.
- Hunsche, Petra: De Strijdbare Patiënt: Van Gekkenbeweging tot Cliëntenbewustzijn – Portretten 1970–2000/The Rebellious Patient: From Mad Movement to Client Awareness - Portraits. Amsterdam 2008, pp. 19–20.
- Hutter, A. De Electriscche Krampbehandeling van de Endogene Melancholie/The Electroconvulsion Therapy of Endogenic Melancholia. Nederlands Tijdschrift voor Geneeskunde/Dutch Journal of Medicine 85:3 (1941), pp. 3317–3321.
- International Council of Nurses (ICN) Code of Ethics (2012), <http://www.icn.ch/who-we-are/code-of-ethics-for-nurses/>.
- Jaarverslag/Annual Reports (AR) van het Algemeen, Provinciaal, Stads, en Academisch Ziekenhuis te Groningen (APSAZG)/of the General, Provincial, City and University Hospital in Groningen, 1903–1970; 1971–1991; 1992–2004. University Library Groningen, KH'GA 17, closed stacks.
- Jaarverslag /Annual Reports St. Canisius Ziekenhuis/Hospital, 1926–1954. Regionaal Archief Nijmegen, J33.
- Jelgersma, H. C.: De Convulsietherapie bij Lijders aan Schizophrenie/Convulsion Therapy for Sufferers of Schizophrenia. In: Tijdschrift voor Ziekenverpleging /Journal of Nursing 47 (1937), pp. 474–478.
- Keeling, Arlene W.: Blurring the Boundaries Between Medicine and Nursing. Coronary Care Nursing Circa the 1960s. In: Nursing History Review 12 (2004), pp. 139–164.
- Kesey, Ken: One Flew Over the Cuckoo's Nest. New York 1962.
- Kneeland, Timothy W./Carol A. B. Warren: Pushbutton Psychiatry: A History of Electroshock in America. Westport CT 2002.
- Koerselman, Frank/Rob Smeets: ECT in Amsterdam: Een Persoonlijk Verslag/ECT in Amsterdam. A Personal Account. In: Maandblad Geestelijke Volksgezondheid/Mental Health Monthly 47 (1992), pp. 131–140.
- Koster, Annemiek M.: Informed Consent bij Elektroconvulsietherapie/Informed Consent in Electroconvulsion Therapy. In: Tijdschrift/Journal voor Psychiatrie 34:2 (1992), pp. 70–77.
- Lindsay, Sally: Gendering work: The Masculinization of Nurse Anesthesia. In: Canadian Journal of Sociology 32:4 (2007), pp. 429–448.

- McKenna, Hugh/Roberta Richey/Sinead Keeney/ Felicity Hasson/Marlene Sincleair/Brenda Poulton: The Introduction of Innovative Nursing and Midwifery Roles. In: *Journal of Advanced Nursing* 56:5 (2006), pp. 553–562. DOI: 10.1111/j.1365-2648.2006.04047.x.
- Meeter, Martijn/Jaap M. Murre/Steve M. Janssen/Tom Birkenhäger /Walter W. van den Broek: Retrograde Amnesia after Electroconvulsive Therapy. A Temporary Effect? *Journal of Affective Disorders* 132 (2011), pp. 216–222. DOI: 10.1016/j.jad.2011.02.026.
- Mol, Annemarie/Ingunn Moser/Jeanette A. Pols (eds.): *Care in Practice. On Tinkering in Clinics, Homes and Farms*. Bielefeld 2010.
- Munday, Jo/Cecil Deans/John Little: Effectiveness of a Training Program for ECT Nurses. In: *Journal of Psychosocial Nursing* 41:11 (2003), pp. 21–36.
- Newspaper clipping 1977a: GZ zet Shockbehandeling Niet Stop. NASA-project in Arnhem/Municipal Hospital Does Not Stop ECT. NASA Project in Arnhem. In: *Arnhemse Courant/Arnhem Newspaper* 7 juni 1977.
- Newspaper clipping 1977b: Shock-Gevaar. Pas Op/Shock Danger. Watch It. In: *De Nieuwe Krant. Dagblad voor Arnhem en Omgeving/The New Newspaper for Arnhem and Region* 27 juni 1977.
- Nolan, Peter: *A History of Mental Health Nursing*. London 1993.
- Nolen, Willem A: Electroconvulsietherapie: Aanvaardbaar op Voorwaarden/ECT: Acceptable on Conditions. In: *Maandblad Geestelijke Volksgezondheid/Mental Health Monthly* 40 (1985), pp. 295–300.
- Nolen, Willem A: De Geschiedenis van de Electroconvulsietherapie (ECT) in Nederland/The History of ECT in the Netherlands. In: Van den Broek, Walter W./A.F.G. Leentjes/Bas Verwey (eds.): *Elektroconvulsietherapie*. Houten 1999, pp. 1–7.
- Nolte, Karen: Shock Therapies and Nursing in the Psychiatric Clinic of the University of Würzburg in the 1930s and 1940s. In: Hähner-Rombach, Sylvelyn/Karen Nolte (eds.): *Patients and Social Practice of Psychiatric Nursing in the 19th and 20th Century*. Stuttgart 2017, pp. 135–152.
- Pols, A. Jeanette. Good Relations with Technology. Empirical Ethics and Aesthetics in Care. *Nursing Philosophy*, 18:1, e12154 (2017). DOI: 10.1111/nup.12154.
- Pols, A. Jeanette. *Care at a Distance. On the Closeness of Technology*. Amsterdam 2012.
- Richtlijnen Over Electroconvulsie-Therapie 1985/Guidelines on ECT. Issued by the Geneeskundige Inspectie Geestelijke Volksgezondheid/Medical Inspectorate for Mental Health. Staatstoezicht op de Volksgezondheid/State Inspectorate of Public Health. Leidschendam 1985.
- Roodbol, Petrie/Wietie Lolkema: Het Verschil met de Gespecialiseerde Verpleegkundige en de Verpleegkundig Specialist: de Functie Nurse-practitioner/Differences between the Specialized nurse and the Nurse Specialist: The Role of the Nurse-practitioner. In: *Tijdschrift voor Verpleegkundigen/Journal for Nurses* 8 (2002), pp. 26–27.

- Rooijmans, Harry G. M: Electroshockbehandeling/ECT. In: Nederlands Tijdschrift voor Geneeskunde/Dutch Journal of Medicine 43 (1978), pp. 1669–1671.
- Rotzoll, Maïke: Fundamentally Changed Duties. The Introduction of Advanced Training for Nurses at the Psychiatric University Hospital Heidelberg as Part of the Early Psychiatric Reform in West Germany. In: Hähner-Rombach, Sylvelyn/Karen Nolte (eds.): Patients and Social Practice of Psychiatric Nursing in the 19th and 20th Century. Stuttgart 2017, pp. 185–198.
- Sadowsky, Jonathan: Electroconvulsive therapy in America. The Anatomy of a Medical Controversy. Abingdon and New York 2017.
- Schmuhl, Hans-Walter/Volker Roelcke (eds): Heroische Therapien/Heroic Therapies. Die Deutsche Psychiatrie im internationalen Vergleich 1918-1945/German Psychiatry in International Comparison. Göttingen 2013.
- Schwamm, Christoph: Every Male Nurse Must Withdraw from Basic Care. Masculinities in West-German Nursing Organizations, 1960-1975. Paper presented at the Institute for the History of Medicine of the Robert Bosch Stiftung, Conference: Marketplace, Power, Prestige. Healthcare Professions in the Twentieth Century, Stuttgart 15.-17. November 2017.
- Shorter, Edward: A History of Psychiatry. From the Era of the Asylum to the Age of Prozac. New York 1997.
- Shorter, Edward/ David Healy (eds.): Shock Therapy: A History of Electroconvulsive Treatment in Mental Illness. Toronto 2007.
- Smith, Kylie M.: Different Places, Different Ideas: Reimagining Practice in American Psychiatric Nursing after World War II. In: Nursing History Review, 26 (2018), pp. 17–47.
- Speciaal Voor U: De Zwarte Lijst (Van Artsen Die Shocken)/Especially For You: The Black List (of Doctors who Shock). In: Speciaal NASA Klapnummer van de Gekkenkrant /Special NASA Edition of the Mad-Newspaper 22 (Juni 1977), pp. 10–12.
- 'Terugkeer van de Elektroshock': Een Verslag van het Openbaar Debat op 26 Juni 1986 in het Kolpinghuis te Nijmegen/Return of ECT - A Report of a Public Debate on 26 June 1986 at the Kolpinghouse in Nijmegen by Stichting De Nuts/The Nuts Foundation. Nijmegen 1986.
- The Snake Pit [Film], 1948, directed by Anatole Litvak, producers Robert Bassler, Anatole Litvak, and Darryl F. Zanuck; distributed by 20th Century Fox.
- Toman, Cynthia: Blood work. Canadian Nursing and Blood Transfusion, 1942–1990. In: Nursing History Review 9 (2001), pp. 51–78.
- Twohig, Peter: Labour in the Laboratory. Medical Laboratory workers in the Maritimes. Montreal and Kingston 2005.
- Van den Broek, Walter W. et al.: Richtlijn Electroconvulsietherapie /Guideline ECT, Dutch Association for Psychiatry, 2nd edn. Utrecht 2010.
- Van der Scheer, Willem M.: De Resultaten van de Shockbehandeling Met Insuline en Cardiazol Bij Dementia Praecox/The Results of the Shock Treatment With Insulin and Metrozol in

- Dementia Praecox. In: Psychiatrische en Neurologische Bladen/Psychiatric and Neurological Papers 45 (1941), pp. 252–278.
- Van Eijk–Osterholt, Corrie: Laat Ze Het Maar Voelen/Let Them Feel It. Amsterdam 1972.
- Van Praag, Herman (ed): Handbook of Biological Psychiatry. New York 1980.
- Vermaas, Hendrik: Psychiatrische Verpleegkunde. Heeft dit Vakgebied nog Levensvatbaarheid/ Psychiatric Nursing. Does this Profession Have a Future? In: Tijdschrift voor Ziekenverpleging/ Journal of Nursing 33 (1980), pp. 1027–1040.
- Vijsselaar, Joost: Het Gesticht. Enkele Reis of Retour/The Asylum: One Way or Return Trip. Meppel 2010.
- Vijsselaar, Joost: A Hole in the Armour of Dementia Praecox. Somatic Cures within the Context of Psychiatry in Multiplicity. In: Schmuhl, Hans-Walter/Volker Roelcke (eds): Heroische Therapien/Heroic Therapies. Die Deutsche Psychiatrie im internationalen Vergleich 1918-1945/ German Psychiatry in International Comparison. Göttingen 2013, pp. 168-184.
- Vos, Jozef: De oudste PAAZ van Nederland. Ziekenhuispsychiatrie in het Gemeente Ziekenhuis Arnhem/The Oldest Psychiatric Department in General Hospitals in the Netherlands. The Municipal Hospital in Arnhem. In: Vijsselaar Joost/ Leonie de Goei (eds): Van Streek. 100 Jaar Geestelijke Gezondheidszorg in Zuid-West Gelderland/Off Track. 100 Years of Mental Health Care in South-West Gelderland. Utrecht 2007.
- Wecker, Regina: Geschlecht Macht Beruf – Beruf Macht Geschlecht [Gender Shapes Professions – Professions Shape Gender]. In: Sabine Braunschweig (ed.): Pflege - Räume, Macht und Alltag [Nursing – Space, Power and Everyday]. Zürich 2006, pp. 15-25.
- Witmer, Johannes M/Robinette de Roode: Implementatie van de Wet Geneeskundige Behandelingsovereenkomst (WGBO)/Implementation of the Medical Treatment Agreement Act. Van Wet naar Praktijk/From Law to Practice, Deel 2. Informatie en Toestemming/Information and permission. Koninklijke Nederlandse Maatschappij tot bevordering der Geneeskunde (KNMG). Utrecht 2004.

Crossing the Boundaries

Nursing, Materiality and Anaesthetic Practice in Germany and Britain, 1846-1945

Karen Nolte and Christine E. Hallett

Abstract

In Germany and Britain the administration of anaesthetics during surgery was, for a limited time, one of the operating-room nurse's tasks. Yet, there were very significant differences between the British and the German cases – particularly in relation to the timing of the creation and dissolution of the role of “nurse anaesthetist”. In this paper, we argue that these differences can be interpreted from a gender-history perspective by examining both the written record and the material culture of anaesthesia in the late nineteenth and early twentieth centuries. Our analysis is grounded in some of the relevant literature surrounding the distinct trajectories of professional development in the two countries. We address the ethical issues at the heart of decision-making about whether nurses should administer anaesthesia. In doing so, we offer a particular focus on the role the objects used during anaesthesia played in supporting arguments for both the professionalisation and de-professionalisation of nurse anaesthetists. During the later twentieth century in both countries, one key competence of nursing, namely the holistic concept of monitoring the patients, was largely transferred to machines.

1 Introduction

For a limited period and in the context of the respective historical settings of Germany and Britain initiating and monitoring anaesthesia was one of the nurses' tasks. In Britain nurses administered anaesthesia for only a few years during the First World War. By contrast, in West Germany nurses with a special additional training were responsible for anaesthesia from the second half of the nineteenth century until well into the 1950s.¹ The conduct of operating-room anaesthesia is steeped in moral and ethical dilemmas. At the heart of these is the challenge of ensuring the most effective and least harmful means of anaesthetising the patient; and delegating this work to the most effective personnel to meet its challenges has been perceived as key. Anaesthetics have always been highly toxic substances; and their administration has always had to be very carefully calibrated. Employing the most appropriate personnel to handle these drugs has been a matter not only of status and professional identity, but also of ethical probity. For nurses to administer anaesthesia two dimensions of trust were crucial: firstly, the patient undergoing surgery had to trust the nurse's skills in order to consent to being put in a state of unconsciousness and lack of will, and to temporarily giving up his autonomy; secondly, the surgeon had to trust the professional expertise of the nurse who needed not only to know the technique of initiating anaesthesia perfectly but also to be

¹ In the US surgeons were initially not interested in this role, which they regarded as a lowly job. Nurses proved themselves to be fully capable of initiating and monitoring anaesthesia. In 1905, physicians founded the first expert association for anaesthesia but only in 1940 was the consultant/specialty for anaesthesia introduced. Nurses who had previously been engaged in developing the technique of inhalative anaesthesia had to accept now that they were assistants, cf. Bankert 1989. Yet, anaesthesiology did eventually emerge as an important specialism for nurses in the USA, Cf. Keeling 2007, *passim*.

able to judge the condition of the patient under anaesthesia correctly in order to act quickly and calmly in a case of emergency.²

In Germany for approximately one hundred years – from the mid nineteenth to the mid twentieth century – the “drip nurse” was part of every image showing surgeries. The nurse who personally initiated the inhalation anaesthesia and carefully monitored the condition of the patient under anaesthesia is a ubiquitous figure at the head of the operating table on these contemporary photographs. Nonetheless, today she has disappeared from collective memory.³ In Britain, even fewer such fleeting images are left – and all relate to wartime practice. Nurse-anaesthetists were introduced into British (and British Dominion) military hospitals only briefly from 1917 to 1918.⁴ After the First World War, these practitioners were obliged to return to their former roles as ‘theatre sisters’ or ‘scrub nurses’, only to emerge again – briefly and on an ad hoc (unofficial) basis – during the Second World War. This paper will examine the implications of the role of ‘nurse-anaesthetist’ in Germany and Britain from 1846 to 1954. In doing so, it will focus on the materiality of anaesthetic practice, considering the ways in which nurses adapted their peculiar ‘nursing’ skills, professional training and moral frameworks to the administration of hazardous medication and the use of equipment such as masks, drip bottles and complex apparatus. One of our foci is on the objects of anaesthesia and their role in arguments for or against nurse anaesthetists. What influence did the design and the handling of objects have on the perception of anaesthesia as a part of nurse competence in contrast to a doctor’s responsibility?

Drawing on the concept of a “material turn” in history⁵ the paper analyses on the one hand the link of nursing objects to practice and on the other hand their meaning in discussions relating to the tasks and competencies of nurses. The meaning of this issue has hardly been addressed in history of nursing because actual nursing practice has not been at the centre of historical research.⁶ Isabel Atzl has systematically analysed the stock of nursing objects in museums and other collections in the German-speaking area, thus bringing objects and material culture into the discipline of History of Nursing.⁷ Very little similar work has been done in the UK, although collaborations between university academics and museum curators are beginning to emerge.

This article focuses on several questions relating to the role of the nurse-anaesthetist in Germany and Britain: Why were nurses permitted to perform anaesthesia in Germany from the mid nineteenth century onwards? Why was nurse-led anaesthesia introduced in the UK only during the wartime emergency of the First World War? And why was this expansion of the nurse’s role reversed again after the war? Which developments in mid-twentieth-century

² On the ethics of trust in relation to the autonomy cf. Wiesemann 2016.

³ One year after introducing the specialisation of Consultant in Anaesthesia in West Germany, a text book on anaesthesia was published but the introduction with an overview of the history of anaesthesia did not mention nurse anaesthetists at all. Cf. Kilian, 1954.

⁴ Hallett, 2014, p. 246.

⁵ Programmatically on objects in history cf. Daston 2004; Ludwig 2015.

⁶ Atzl 2017 (forthcoming).

⁷ Cf. also Atzl 2011.

West Germany led to the changes from “old-fashioned” nurse anaesthesia to anaesthesia that could only be performed by physicians? What are the possible reasons for the wide variations in practice between the two countries?

2 Germany: The long era of nurse anaesthesia

A German textbook for nurses from the late 19th century emphasised how “responsible” the work of “chloroforming” was and stated furthermore that it could only be learned through “lots of practice under the supervision of a doctor.”⁸ This brief statement offers three insights: (1) during this time nurses performed anaesthesia with chloroform; (2) they received training in this activity, and (3) a physician was to supervise; that is, the initiation of anaesthesia was understood as providing the doctor assistance with his activities. The last insight here suggests how ambiguous the role of nurse anaesthetist was and helps us begin to uncover the gender specific conception of her work, her status during surgical procedures, and the link to objects involved in this work.

Initially the descriptions of the tasks of an anaesthesia nurse in textbooks for nurses between 1900-1954 show the large responsibility with which a nurse anaesthetist was entrusted during surgery. She constantly had to monitor the breathing and vital signs of the patient while also controlling the blink reflex through regular touches of the eye lid. This served to decide when the chloroform mask had to be taken away and when it had to be attached again. The nurse anaesthetist was the person who announced when resuscitation like artificial respiration had to be started. In the *Surgical Health Care Manual for Nurses and Theatre Nurses*⁹ from 1922¹⁰, the important position of the nurse anaesthetist in the theatre is emphasised in several instances. First, however, it was clarified that this nursing task required a high level of responsibility and served to support the doctor: “For all assisting nurses the rule applies that they only perform tasks that they were asked to perform. [...] The surgeon who must be the master in the operating room gives her a specific task.”¹¹ One nurse was charged with performing the anaesthesia, a second nurse had to hold the patient’s head and a third had to be ready to get or pass on objects which the disinfecting nurses at the operating table were not allowed to touch. Only the context provided in the subsequent description reveals that the decision as to which nurse was to perform the anaesthesia was not made spontaneously as this activity required special skills and experience. Of course, the nurse passing on the instruments also needed a qualification that exceeded the general training in nursing. Linguistically the nurse anaesthetist is described as seemingly on a par with the surgeon performing the operation as it is emphasised that the “nurse performing anaesthesia” did not have to pay attention to anything but the anaesthesia. She had to ensure that it was quiet in the operating theatre so that she and the surgeon could focus during their work. Also:

⁸ Rupprecht 1898, p. 252.

⁹ *Lehrbuch der Chirurgischen Krankenpflege für Pflegerinnen und Operationsschwwestern.*

¹⁰ Janssen 1922.

¹¹ Janssen 1922, p. 157. Cf. also Heller 1948.

“Nobody shall talk to her [...]” and “a person who talks to her nonetheless cannot expect to receive an answer.”¹² Because:

During the anaesthesia that is now following and which, in most cases, progresses evenly, the nurse anaesthetist must pay closest attention to a variety of things. If something is not right she has to speak in a clear voice to the surgeon and report this immediately, and he will base his next actions on this report.¹³

In the textbooks on nursing, the nurses’ task to strictly monitor the patient is particularly emphasised. Thus, the central idea of nursing is defined as observing the patient, which formed the key of the nursing training not only at the time but has continued to be central to this day.¹⁴

The following section considers the “implicit knowledge” of the central object of nurse anaesthesia: the chloroform dropper bottle.

The chloroform dropper bottle that can be seen in the medical historical collections in Würzburg has a drip faucet that looks like a teapot. The bottle is round and bulbous and reminds us of a perfume bottle (bottles with Cologne looked similar at this time, and indeed Cologne itself was also used during anaesthesia). The aesthetics of the dropper bottle recalls a household object and implicitly points to a female user.



Fig. 1: Chloroform bottle 1850, Medical historical collections of Würzburg, Photography: Karen Nolte

¹² Janssen 1922, p. 182.

¹³ Janssen 1922, p. 182.

¹⁴ Cf. here especially Salzwedel 1909, pp. 115-152. Other text books on nursing that are listed in the references equally provide many pages on the instructions on the professional observation of patients. We thank Isabel Atzl for her suggestion to investigate the relationship between observing patients and anaesthesia as part of nursing more closely.

In the text books on nursing there are detailed descriptions of how a nurse anaesthetist had to manage the chloroform cap and dropper bottle at the initiation and intensification of inhalation anaesthesia: At the beginning the methyl trichloride had to be combined with Eau de Cologne to give the narcotic a pleasant smell which ensured the patient's compliance. To avoid the feeling of choking, the chloroform mask had to be moved slowly towards the face and then carefully placed over mouth and nose. The text book continues that it was popular to let the patient count, but the continuous counting contained the risk that the patient did not breathe deeply enough. The nurse anaesthetist dripped the methyl trichloride continuously on the mask until the so called "excitation stage" had been overcome and the patient could be put into narcotic sleep – usually this was supposed to happen after approximately 1000 drops.¹⁵

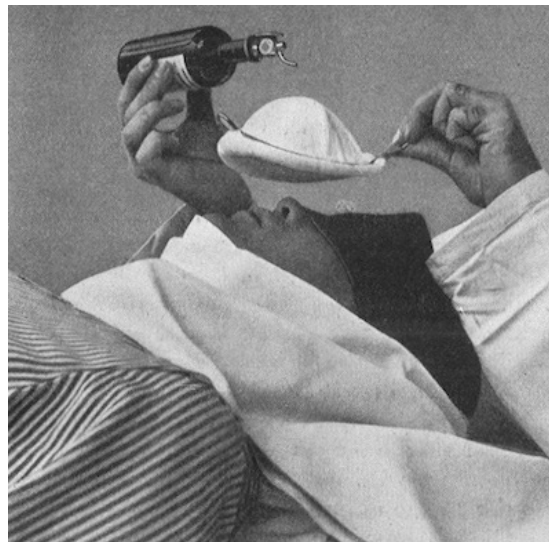


Fig. 2: Fischer/Gross/Venzmer 1940, p. 287: Dropper bottle and Schimmelbusch mask

The textbook for nurses contained further images of additional instruments with an explanation on their usage: a mouth-gag by Heister, a mouth mirror to examine the mouth for foreign objects or food leftovers, tongs to pull out the tongue - in case it blocked the respiratory tract – and a sick bowl.¹⁶

2.1 "Femininity" and the administration of anaesthesia

At the end of the 1940s an additional qualification of the nurse anaesthetist is emphasised that refers rather to her female "characteristics" rather than focussing on her ability to follow instructions and on her practical experience. The idea was to create a practitioner who could handle the technology in a professional manner while caring for the patient with the

¹⁵ Rupprecht 1898, pp. 251-254; Rupprecht 1902, pp. 257-261; Janssen 1922, pp. 173-178; Lindemann 1928, pp. 158-160; Fischer/Groß/Krick/Bauer 1949, pp. 438-440.

¹⁶ Rupprecht 1898, p. 253; Rupprecht 1902, p. 259; Janssen 1922, p. 178; Lindemann 1928, p. 162.

gentleness wanted and skill needed. The significance of emotional qualities in dealing with technology, i.e., especially the technical tools, as well as the patients was also emphasised for nurses performing X-rays, as Monika Dommann has shown in her study on the history of X-rays.¹⁷ In 1940 for instance the “Manual and Textbook of Nursing” by Fischer, Groß and Vezmer had the following to say on the tasks of a nurse anaesthetist:

Putting a patient under anaesthesia, which requires a lot of practice, experience, concentration, calmness, cold-bloodedness at a moment of danger, and comprehensive knowledge, is an art, albeit one that can be learned. In other words, just as it is with the doctors, the personality that also characterises a good nurse in general, is the crucial element because success does not only depend on technical ability but also on psychological factors, such as a relationship of mutual trust between the nurse and the patient, who, with the beginning of the anaesthesia, entrusted his life for better or worse to the nurse. The nurse must always be aware of that!¹⁸

The personal gift of a nurse chosen to be a nurse anaesthetist consisted in creating “the spiritual contact” to the male or female patient and provide “the patient with a feeling of security and comfort”. After she had created this atmosphere of peace and confidence in the operating theatre she was supposed to fully concentrate on the anaesthesia:

She only pays attention to the course of the anaesthesia, to reflexes, breathing, circulation, and after these observations she must set up the amount of the narcotic which must be administered. Upon request of the surgeon she must be able to immediately count the pulse, and share her observation of its nature, the look of the patient, his or her breathing etc.¹⁹

While nurses had been confident, since the introduction of the inhalation anaesthesia, to work with breathing masks, chloroform or ether, the 1950s saw the introduction of tracheal intubation anaesthesia. This new technique and the management of a complex anaesthesia machine would now require that the male physician anaesthetist would perform the anaesthesia – or so the opponents of the so called “nurse anaesthesia” claimed.

2.2 The chloroform bottle and chloroform mask as material traces of a forgotten history

Today chloroform masks and chloroform bottles are perceived as objects of medical intervention and have therefore survived only in some medical historical collections. These artefacts share the history of their tradition with many other items of nursing.²⁰ The “implicit

¹⁷ Dommann 2003, pp. 139-192.

¹⁸ Fischer et al. 1940, p. 280.

¹⁹ Fischer et al. 1949, p. 356.

²⁰ On the term nursing care objects cf. Atzl 2017.

knowledge”²¹ of these objects is no longer visible and must be reconstructed in conjunction with the history of anaesthesia and its agents. The forgetting of nurse anaesthetists is closely linked to the portrayal of the history of anaesthesia, which has usually been written by doctors and in particular anaesthetists. If nurse anaesthetists are mentioned at all in historical overviews, they are merely representatives of the “old-fashioned” method of anaesthesia through “breathing-in” which could, fortunately, be overcome through the establishment of the specialist for anaesthesia and the mechanisation of anaesthesia in 1953.²² In the meantime, of course the patients and surgeons in West Germany had confidence in the skills of the nurse anaesthetists, which was seemingly closely related to their ability to manipulate the objects used for anaesthesia.

3 Britain: the adaptable wartime nurse-anaesthetist

3.1 “Unlimited scope for resourcefulness”

In Britain anaesthesia had been regarded as a purely medical practice until well into the twentieth century.²³ The authors of influential nursing textbooks had emphasised how important it was for the professional nurse to understand the boundaries of her practice, and to avoid crossing those boundaries into the medical domain. Isla Stewart, Matron of St Bartholomew’s Hospital in London argued, in 1899, that the good nurse was one who recognised her limitations and was “averse to taking unnecessary responsibility on herself”.²⁴ She made it clear that “unnecessary responsibility” constituted anything that would normally be part of medical practice.

Historians of nursing have attempted to understand the nature of the profession’s boundaries, and the way in which these emerged during the nineteenth century. Historian, Brian Abel-Smith’s interest in nursing appears to have stemmed from his work on the history of British hospitals in the nineteenth and early twentieth centuries.²⁵ Abel-Smith argued that, in Britain, the more prestigious, voluntary hospitals, within which the earliest nurse training schools were founded, were driven both by medical technical advance, and by a need to demonstrate their worth to their wealthy subscribers. By the late nineteenth century they were taking fewer long-term chronic cases (who were more likely to be admitted to poor law

²¹ Reckwitz 2003, p. 291.

²² Cf. Weißbauer 2003, pp. 74-76. Nurse anaesthesia is completely omitted in the Festschrift of the Heidelberg Anaesthesiology, cf. Meister 2007. The website states: “Anaesthetising using old-fashioned methods and subordinate nursing staff was still practised up until the post-war period all over Germany. Only when it was recognised that in the Anglo-American countries huge progress was made during surgical procedures through the specialisation of anaesthesia, German surgeons began to rethink the issue and slowly accepted that specialists in anaesthesia with thorough training were inevitable.” cf. <https://www.klinikum.uni-heidelberg.de/Historie.135360.0.html>, 5/7/2017.

²³ On the history of anaesthesia as a medical practice, see: Snow 2008, *passim*.

²⁴ Stewart 1899, p.15. See also Luckes 1914, p. 10.

²⁵ Abel-Smith 1964, *passim*. See also Rivett, 1986, *passim*.

hospitals or nursed at home) and a greater number of acute and surgical cases, whose stay in hospital would be short-lived and would, potentially, result in a demonstrable cure. These developments increased pressure on medical men – especially surgeons – and led to the emergence of specialist surgical nurses. It did not, however, give rise in Britain, as it had in Germany, to the inception of the role ‘nurse-anaesthetist’. This appears to have been due to a greater vigilance over their boundaries among British medical-men, who were unwilling to relinquish roles appearing to require both technical skill and scientific knowledge.

Women’s historian, Sue Hawkins has argued that gender alone cannot explain such assiduous protection of professional boundaries. Nor can it enable us to understand the tensions that began to emerge between female nurses and male doctors in the late nineteenth century. Any historical analysis must consider the role of social class alongside that of gender. The assertive efforts of reforming “lady nurses” to carve out their own sphere of practice and develop their own moral code, appear to have aroused the anxieties of medical men. Hawkins suggests that the intensity of these anxieties was largely due to the fact that the ‘new nurses’ were of “at least equal status in society to their male colleagues”.²⁶ Very few historians of gender have paid attention to the emergence of the nursing profession in the late nineteenth century, though several notable works by women’s historians have explored the notion of separate male and female “social spheres” in nineteenth-century Britain, a notion that helps explain the rise of the nursing profession.²⁷ Social historian, Eva Gamarnikow has argued that nurses deliberately used their status as experts in the domestic sphere to forward their claims to an exclusively female profession,²⁸ while nurse historian, Anne Marie Rafferty has observed that male doctors permitted nurses to expand their sphere of practice because they required competent assistants and believed that they could easily exert control over what, at first, appeared to be a docile social group.²⁹ In relation to nursing, Hawkins has observed that nurses succeeded in negotiating a space within the male-dominated Victorian hospital by creating a “discrete feminine enclave at the heart of the male bastion”. She adds, however, that “socially elite women were challenging accepted social roles for women in Victorian society in a variety of settings, and lady nurses were bringing such challenges directly into the hospitals, which were bastions of male authority”.³⁰ Such observations can offer insights into the ways in which nurses’ pursuit of a “professionalising” project might have evoked anxiety in medical men, driving them to establish hard boundaries around technical and scientific domains of practice such as anaesthesia. The willingness of senior nurses to observe these boundaries illustrates the extent to which they recognised the value of arguing for a “separate

²⁶ Hawkins 2017, pp. 41-64; quotation on p. 42. Hawkins presents the example of Zepharina Veitch, a reforming matron at St Georges Hospital. See: Hawkins, 2010, *passim*.

²⁷ Vicinus 1985, *passim*; Vickery 1998, 294-322. On the role of gender in creating tension and conflict between nineteenth-century British nurses and doctors, see: Moore 1988, *passim*; Young 2008, 18-41; Tesseymann 2014, *passim*.

²⁸ Gamarnikow 1991, pp. 110-129.

²⁹ Rafferty 1996, *passim*.

³⁰ Hawkins 2017, p. 47.

sphere” for nurses within the hospital – a sphere that encompassed the domestic, practical and emotional elements of care.

When the First World War began in August 1914, professional nurses volunteered in their thousands for “war-service” in military hospitals – only to find themselves turned away by the military medical services, or refused “release” by their civilian hospitals. For many, their response was to enrol in volunteer hospitals many of which were financed and directed by wealthy patriots with no existing experience of hospital work. In these hospitals trained staff were scarce and the crossing of professional boundaries was frequent. The strictures of matrons such as Stewart not to cross the boundaries between nursing and medical practice appear to have held no sway in this new and challenging environment, in which professional boundaries seemed to have been becoming much less distinct. The lack of medical officers (M.O.s) meant that nurses began to perform procedures that would, previously, have been seen as unsuitable to their role and training. Among these was anaesthesia.

Fully-trained professional nurse, Violetta Thurstan, was funded by her employer the National Union of Trained Nurses to take a group of professionals to Belgium in September 1914. Thurstan was later to write that those early months of the war had provided unprecedented opportunities for professional nurses not only to demonstrate that women could perform valuable work during wartime, but also (and more importantly) to advance and expand their practice.³¹ Later in the war – in 1917 – Thurstan consolidated her ideas into her influential *A Text Book of War Nursing*, in which she wrote:

In many ways nursing was more interesting in the early days of the war, when everything had to be improvised or adapted, than later on when the excitement and the first rush were over, organisation brought to an undreamt-of pitch of perfection, and all necessities amply and even lavishly supplied. In those first months the individual had unlimited scope for resourcefulness and quickness of perception, and who shall say how many lives and limbs were saved by the nurses’ ready inventiveness and clever fingers?³²

As Thurstan’s words imply, the “inventiveness” of the early months of the war were soon replaced by a more controlled process by which medical men – from the commanding officers of casualty clearing stations to the most senior of consulting surgeons – began to recognise that the best solution to the problems posed by an acute shortage of M.O.s was to enable nurses to cross their previously rigidly-enforced boundaries into the fiercely-guarded medical domain of anaesthesia. By 1917, Thurstan was observing that nurses may “often have to give an anaesthetic themselves in an emergency where there is no anaesthetist available”.³³ As will be discussed later in this paper, however, this boundary-crossing behaviour by nurses was complicated (and, in many ways, compromised) by the development of innovative – and far more complex – anaesthetic equipment from 1916 onwards.

³¹ Thurstan 1915, *passim*.

³² Thurstan 1917, p. 11.

³³ Thurstan 1917, p. 142.

In the Spring of 1917 British journal, *The Nursing Times*, published a series of articles by A. De Prenderville, an anaesthetist at Charing Cross Hospital. There is no reference to the fact that, in some war-hospitals, nurses were administering anaesthetics. Instead, the series pays close attention to the many ways in which the nurse can support a patient prior to anaesthesia and assist a surgeon or anaesthetist during the operation. In his first article, dated 28 April, De Prenderville recognises the particular skill of the nurse in soothing and reassuring patients about to undergo anaesthesia:

Here there is a real chance for the nurse. She comes into close contact with the patient for some days before the operation and can naturally and easily comfort and reassure her charge, pointing out the need of taking healthy and optimistic views, banishing doubts and fears, and generally inspiring confidence and courage.³⁴

In a later paper, De Prenderville recognises that the total nursing care given to a patient can dramatically improve his chances of surviving anaesthesia and surgery. “It is just because [nurses] are so exact”, he comments, “that such good results are seen in our hospitals”. “Patients”, he adds, “must be subjected to a minute overhaul”, with nurses ensuring that nutrition is good, teeth and mouth are clean and bowels are empty prior to surgery.³⁵ The Remainder of De Prenderville’s series of articles offers nurses detailed information on the drugs and equipment used in anaesthesia, including information on how to diagnose and treat side-effects.³⁶ It does not, however, advocate the direct administration of anaesthesia by a nurse, leaving the reader uncertain about whether the editor of *The Nursing Times* is in favour of nurse-anaesthetists or not.

3.2 “On active service”

By November 1917 the Director Generals of the Army Medical Services, Sir Alfred Keogh and Sir Arthur Sloggett, were recognising that so many nurses were being asked to “step up” and give anaesthetics in the operating room that the practice needed to be regulated: nurses must receive a recognised anaesthetics training. This move was supported by Ethel Hope Becher, the Matron-in-Chief of the Queen Alexandra’s Imperial Military Nursing Service, and by her deputy on the Western Front, Maud McCarthy.³⁷ On 14 January 1918 a seven-month training was introduced. British and Dominion (Australian, New Zealand, Canadian and South African) nurses were carefully selected to become so-called “lady anaesthetists”. The training was “hands-on” with the nurses spending time in a base hospital operating theatre, working closely

³⁴ De Prenderville 1917, p. 508.

³⁵ De Prenderville, 1917, p. 534.

³⁶ De Prenderville, 1917, pp. 566-569; pp. 592-359; p. 620; pp. 650-651; pp. 681-682; pp. 711-712; pp. 740-743; pp. 767-768; p. 794.

³⁷ Hallett 2009, p. 99; Hallett, 2014, p. 246.

with experienced surgeons, followed by transfer to a casualty clearing station close to the front lines, where the work was more intense.³⁸

Sixty-three nurses successfully completed the training.³⁹ Most went on to practice as nurse-anaesthetists until well beyond the Armistice of 1918. But the efforts of one group were stymied by unwelcome medical intervention: Australian nurse-anaesthetists were never permitted to practice. Soon after they had completed their training, Sir Neville Howse, Assistant Medical Director of the Australian military medical service decided that nurses should not perform the work of anaesthetists, and they were never able to use their newly-acquired skills.⁴⁰ This professional ‘gate-keeping’ by a medical director perhaps illustrates the anxieties that could be evoked in the minds of medical men when nurses moved their practice across professional boundaries. Even though nurses had already proved themselves capable of administering anaesthetics when asked to do so in emergency situations by their surgical colleagues, some senior medical men still appear to have placed professional territoriality before clinical pragmatism – or it may be that they were concerned about the lack of anatomical and physiological knowledge, even amongst highly-trained professional nurses.

The experience of the Australian nurses contrasts markedly with that of US nurse-anaesthetists, who travelled to the Western Front, as part of several “base hospital” units in 1917. Many of these were already highly experienced in the administration of anaesthetics, and their expertise never appears to have been questioned.⁴¹ Not all British nurses shared the conviction of their US counterparts that the practice of the anaesthetists lay, rightly, in the domain of the professional nurse. Some appear to have shared the scepticism of many medical officers. One anonymous letter to the British Journal of Nursing illustrates the discomfort that could be experienced by nurses who found themselves, effectively, having to “give up” nursing, in order to become anaesthetists. This particular correspondent had clearly anticipated that as a “nurse anaesthetist” she would be a nurse first and an anaesthetist only second. Her dismay on discovering that the opposite was to be the case is palpable:

In a weak moment when the lists of Candidates for Training in the Giving of Anaesthetics came out, I put my name down never dreaming what it entailed. We were all dismayed on arriving here, when we were told that if considered suitable at the end of two months’ training we should then be sent up to C.C. Stations for one month and then be branded as anaesthetists, and not be allowed to do any more nursing! We have, therefore, decided to go through the training, and when we return to nursing we shall have the experience to help in case of emergency.⁴²

³⁸ Rawstron 2005, *passim*.

³⁹ McCarthy 1918, pp. 7-8.

⁴⁰ Bassett 1992, pp. 61-62; Harris, 2003, pp. 138-143; Harris, 2011, p. 199.

⁴¹ Telford 2007, pp. 134-135. On the role of the American nurse-anaesthetist, see also: Keeling 2007, *passim*. On US Army Nurse Corps anaesthetists during the First World War, see: Sarnecky, 1999, pp. 128-130.

⁴² Anonymous 1918, p. 92.

Clearly, this nurse, and it is implied, her colleagues – had a very clear sense of where the boundaries of their practice lay. Although they were willing to step across those boundaries “in case of emergency”, they anticipated that such “infringements” would be temporary.

Nurse-author, Violetta Thurstan, was direct in her instruction to nurse-anaesthetists. In her *A Text Book of War Nursing*, she makes it clear that the administration of anaesthetics required a range of nursing skills, from manual dexterity in administering the drug; through an ability to monitor and closely observe a patient’s condition; to emotional intelligence and skill in supporting and soothing an agitated patient. The following account of the process of administering chloroform – from Thurstan’s influential text – highlights these skills and abilities:

The patient is generally told to count in the first stage of an anaesthetic, this ensures his opening his mouth well to inhale it. After a few minutes, the second stage begins, the patient begins to get confused, stops counting for a minute, the muscles begin to contract, and he begins to get excited and to struggle. He may also at this stage turn a bad colour and breathe badly, this may be from attempts to vomit. On active service it is not always possible to carry out the ideal rule of giving an anaesthetic on an empty stomach, and a patient who has recently had a meal is likely to vomit. When this occurs, the head should be turned on one side, the tongue pulled forward with the tongue forceps, and the anaesthetic is pushed. In the next stage the muscles are relaxed, the breathing becomes easy and rhythmic and the patient is quite unconscious. The operation is begun after the deep unconsciousness has been tested by touching the patient’s eyeball with the tip of the finger, if he does not flinch, he is well “under” the anaesthetic. The sister must watch carefully (1) the respiration, (2) the pulse, (3) the state of the pupil of the eye.⁴³

As Thurstan’s text indicates, the Allied nurses of the First World War were, by 1918, becoming comfortable with the administration of anaesthetics – bringing this practice, it could be argued, to the level of an art-form, in which knowledge of the nature and actions of ether, chloroform and other potent chemicals, was combined with a dexterity in their administration and an understanding of how to ameliorate the physical and emotional distress they evoked in the patient. And yet, anaesthetic practice was removed from British nurses after the war. It, in fact, emerged as a medical specialty in 1918.⁴⁴ The innovations of the years 1917-18 along with recognition of the expanding knowledge-base of anaesthesiology induced the medical profession to give its practitioners much greater recognition as experts. Nevertheless, it is telling that the administration of anaesthetics by trained nurses re-emerged (although only in a purely ad hoc fashion) during the Second World War, when nurses, again, began to fill the gaps created by a shortage of medical practitioners.⁴⁵

⁴³ Thurstan 1917, p. 143.

⁴⁴ Smith 2015, p. 7.

⁴⁵ An article, published in the *British Medical Journal* in September 1940, recommended the training and employment of ‘nurse anaesthetists’ in civilian hospitals: Parsons 1940, p. 429. The proposal was, however,

3.3 Objects of anaesthesia on the Western Front: Allied nursing practice from 1914 to 1918

At the outbreak of the First World War, anaesthesia was not a specialist service. Techniques had changed very little since the 1870s but were always performed by a doctor. Ether and chloroform were delivered via a face mask (usually the Schimmelbusch mask). There were very few alternatives, although more complex processes adopting 'Clover's Ether Inhaler' and 'Junker's Chloroform Apparatus' were sometimes used. The use of masks and dropper bottles by nurses was prevalent in Britain and Dominion military hospitals – just as it had been in German hospitals since the mid nineteenth century. Extant dropper bottles, held at the Manchester Museum of Medicine and Health, UK, illustrate the apparently implicitly feminine qualities of the dropper bottles, which are reminiscent of teapots, evoking the culture of the drawing-room rather than that of the operating theatre.



Fig. 3: Chloroform dropper bottles of the type used in British military hospitals during the First World War (By permission: The University of Manchester Museum of Medicine & Health)

The side effects of chloroform and ether included myocardial depression and prolonged vomiting; hence it became clear that its administration was, potentially, a very dangerous process for patients who were being brought from the battlefields suffering from hypothermia and acute wound-shock.⁴⁶ Anaesthetic practice in the USA was more advanced, and was already, in some instances, being performed by specialist nurses. Oxygen and nitrous oxide was frequently used – delivered through the newly-invented Gwathmey apparatus.

Among Allied medical services, for the first three years of the so-called "Great War", anaesthesia was mostly administered by the "open drop" method. As we have seen, during the high-pressure, so-called "rushes" of casualties that followed large assaults on the front

vigorously opposed by other correspondents to the journal. See: Barford, 1940, p. 474; Stanley-Sykes, 1941, p. 339. We are indebted to Jane Brooks, who brought these source materials in the *British Medical Journal* to our attention. Brooks' book, *Negotiating Nursing*, will be published by Manchester University Press in 2018.

⁴⁶ Smith 2015, p. 6.

lines, ether or chloroform could be administered by personnel other than doctors.⁴⁷ In volunteer-hospitals run under the auspices of the Red Cross or Order of St John of Jerusalem it was sometimes handled by priests, or volunteer-nurses with very little training, under the supervision of the surgeon who attempted to monitor the condition of the patient and support the amateur-anaesthetist, whilst at the same time performing the surgery. Where trained nurses were available, they were the surgeons' preferred anaesthetists. Apart from their manual dexterity, they were seen – like the German nurse anaesthetists in the previous examples – to have the emotional skills needed to soothe patients, thus reducing the agitation in a patient during the process of anaesthetisation and ameliorate the risks of facial injury.

In her *A Text Book of War Nursing*, Violetta Thurstan devoted the last paragraph of her chapter on anaesthesia to a detailed explanation of the preparations for anaesthetic-administration, illustrating that, however much her role had shifted away from that of “doctor’s assistant” to that of “anaesthetist”, the nurse-anaesthetist was still responsible for the mundane task of preparing the materials to be used. Taking preparation for chloroform anaesthesia as her example, Thurstan advised that the nurse must first create a sterile field and then lay out the equipment:

The usual chloroform mask has a wire frame, but a small towel folded in the shape of a cone does equally well; measure glass; one or two bottles of chloroform; a bottle of ether; stethoscope and towel. (If the patient does not take chloroform well the anaesthetist may change to ether in the middle of the operation.) A few swabs for wiping out the mouth, and swab forceps; Vaseline to smear the face; tongue forceps; gag; a hypodermic injection of caffeine, strychnine, camphor or whatever stimulant the doctor prefers; pituitary extract; oxygen receiver and towel in case of vomiting; warm blanket to cover the patient after the operation.⁴⁸



Fig. 4: A Schimmelbusch Mask, of the type in use in British military hospitals during the First World War (by permission: The University of Manchester Museum of Medicine & Health)

⁴⁷ Hallett, 2014, p. 246.

⁴⁸ Thurstan 1917, pp. 145-146.

Intriguing here is the juxtaposition of drugs and pragmatic functional equipment designed to anaesthetise and revive the patient and ensure his safety, alongside more obviously care-related objects such as a towel and a warm blanket. Thurstan makes it clear that the nurse's vital role is still a caring one. She also emphasises the fact that the physician is still at the centre of proceedings in the operating theatre. He is still the senior and responsible clinician; the reference, for example, to ensuring the availability of "whatever stimulant the doctor prefers" is telling. The nurse may be administering the anaesthetic – but she is certainly not prescribing any of the drugs in the room. She is, nevertheless, responsible for ensuring the success and safety of the procedure, and the care and comfort of the patient. Her work is multi-faceted, requiring both operational precision, practical skill and emotional intelligence. Among her particular domains of practice are the ensuring of comfort and a sense of security in the patient.

In her vivid account of work at Mobile Surgical No. 1, a French field hospital in Flanders, author Ellen La Motte described how, during an operative procedure using a spinal anaesthetic, nurses, along with a priest-orderly soothed and reassured a patient:

A nurse held the sheet on one side of the table, and a priest-orderly held it at the other... and the Directrice and another nurse, answering the string of vapid remarks and trying to soothe him... the man babbled of his home, and of his wife. He said he wanted to see her again, very much... So, the man rambled on, gasping, and they replied to him in a soothing manner, and told him that there was a chance that he might see her again.⁴⁹

But Mary Borden – the Directrice mentioned in the above excerpt – was sceptical about nurses' involvement in technology. In her war-memoir, *The Forbidden Zone*, she included, the compelling short-story, 'Paraphernalia', which questions the nurses' use of technological equipment:

Here are cotton things and rubber things and steel things and things made of glass, all manner of things. What have so many things to do with the final adventure of this spirit? Here are blankets and pillows and tin boxes and needles and bottles and pots and basins and long rubber tubes and many little white squares of gauze. Here are bottles of all sizes filled with coloured liquids and basins of curious shapes and round shining boxes and square boxes marked with blue labels, and here you are busy among your things. Yes, I know you understand all these things... You have crowded the room with all manner of things. Why do you crowd all these things up to the edge of the great emptiness?⁵⁰

In this excerpt, Borden implicitly argues that the "things" of nursing – the equipment and apparatus – are not simply useless: they are actually obstructive to the real challenges of nursing a dying patient. Borden's arguments carry some weight in a case such as this, where there is clearly no hope for the patient's survival. Yet, her account also carries a larger message

⁴⁹ La Motte, 1916, pp. 161-162.

⁵⁰ Borden 1929, pp. 123-125.

– highlighting the proliferation of technologies during the early twentieth century – and the escalation of that process during the First World War. As the war progressed, nurses found themselves in charge of some highly sophisticated pieces of machinery. Yet articles in the nursing journals of the time indicate that attention to such apparatus was combined with a continuing focus on the holistic care of the patient. An article written by an anaesthetist (a medical doctor) and published in the *Nursing Times* for 5 May 1917 emphasises the nurse’s role in preparing the patient for surgery. The need to pay special attention to the bowels, the teeth and mouth and to “nutriment before operation” is emphasised.⁵¹

In 1916, the so-called ‘Shipway’s apparatus’ had been introduced. It could deliver both chloroform and ether at different points during the surgical operation and had several benefits. The incidence of bronchitis was much lower in patients anaesthetised using Shipway’s than in those anaesthetised by the open drop method. The technique used warm vapour and the anaesthetic was delivered, along with oxygen, through a mask as a steady flow. Because anaesthesia was induced using chloroform and then maintained by ether, the procedure induced less mucous production (a distinct problem with ether); hence, both prolonged vomiting and chest complications were less likely. In one military hospital, surgeon, Geoffrey Marshall, found that the incidence of bronchitis in a sample of patients with abdominal wounds was 54% when the open drop method was used – and 14.7% with the use of warm ether vapour.⁵² In an article published in the *British Medical Journal* on 2 June 1917, Surgeon-General, Sir Anthony Bowlby, along with co-author, Colonel Cuthbert Wallace, emphasised the value of the Shipway’s apparatus.⁵³ Its use transformed anaesthetic practice. The careful, slow process of dripping anaesthetic onto a mask – a process requiring individual judgement and manual dexterity – was replaced by the mechanised delivery of chemicals through a complex device.

⁵¹ De Prenderville 1917, p. 534.

⁵² Marshall 1917, *passim*. See also: Smith 2015, p. 6. On the surgical treatment of war wounds, see also Harrison, 2010, *passim*.

⁵³ Bowlby and Wallace 1917, pp. 705-721.



Fig. 5: Sir Francis Shipway (1875-1968) invented an apparatus that could deliver warm ether and/or chloroform vapours through an intra-tracheal tube. The apparatus consisted of two bottles of anaesthetic (one containing ether, the other chloroform) and a vacuum bottle that was used as a 'warming flask'. This photograph shows an example of the type of apparatus used in British military hospitals during the First World War (by permission: The University of Manchester Museum of Medicine & Health)

The 'Shipway's apparatus' was introduced just before the decision was taken to train nurses in anaesthetic practice, and, although there are no records to indicate which procedures were included in the training programme, it is highly likely that nurses were taught to apply both techniques. Hence, the practice of the nurse-anaesthetist was changing, even as her work was gaining recognition and becoming regularised. From the ad hoc application of an artistic – almost intuitive – process (the open drop method) to the need to maintain the functioning of a complex machine (the Shipway's), the attention of the anaesthetist was subtly shifting – her focus being drawn away from the patient's face towards the apparatus that was keeping him anaesthetised.

This was, perhaps, typical of so-called "advances" in nursing practice throughout the twentieth century, in which, as nurse-historian Margerete Sandelowski observes, there was perceived to be a growing danger that the nurse would lose her traditional focus and would spend more time nursing the machine than caring for the patient himself.⁵⁴ These fears, as Sandelowski herself observes, were largely unfounded. The highly focussed, careful, and, at times highly intuitive experiential knowledge that enabled the nurse to monitor the unconscious patient's condition, along with her physical and emotional abilities in enabling his subsequent recovery from the anaesthetics' more toxic effects continued to be a part of the repertoire of skills she deployed. In a catalogue produced by the medical equipment suppliers, Mayer and Phelps in

⁵⁴ Sandelowski 2000, *passim*; Barnard/Sandelowski 2001, pp. 367-375.

1931 – thirteen years after the removal of British and dominion nurses from anaesthetic practice – the authors refer to the operation of the hand-bellows on the Shipway's apparatus:

The hand-bellows is of such a size that it fills the hand comfortably, and continuous pumping is not wearisome. By squeezing it regularly with inspiration the anaesthetist soon acquires the habit of delivering a practically uniform dosage. He has two means of altering the strength of the vapour: one by regulation of the tap, the other by varying the vigour of the squeezing.⁵⁵

It is difficult to avoid the gendered tone of this excerpt. The instrument suppliers clearly anticipate that the apparatus will be used by a male practitioner. The distinction between the “vigour of squeezing” when using the Shipway's and the delicacy of the administration of chloroform drop-by-drop via a dropper bottle can be interpreted as marking a shift away from the implicitly feminine practice of administering anaesthetics via a dropper to the implicitly masculine use of the Shipway's and other complex devices.

Nurses did continue to administer anaesthetics in military hospitals until the end of the war, incorporating further innovations into their repertoire. The introduction of the so-called “Boyle's apparatus” from 1916 onwards began to overcome the problems association with administering chloroform and ether to patients with wound-shock. The apparatus was modelled on the American “Gwathmey's apparatus” and could deliver oxygen and nitrous oxide (and, when required, ether) via an endotracheal tube. This had an even more intricate mechanism – designed to carefully calibrate the doses of the chemical elements delivered. Its complexity (along with the increasing use of donated blood to treat shock) was one of the arguments used for the development of anaesthesia as a purely medical specialism in 1918.⁵⁶



Fig. 6: Photograph: A nurse using the Boyle's apparatus in a British army operating theatre at Wimereux, near Boulogne towards the end of the First World War: Wellcome Library L0008872

⁵⁵ Mayer and Phelps 1931, p. 504.

⁵⁶ Smith 2015, pp. 6-7.

4 Objects of Physician Anaesthesia

One of the main justifications for the development of anaesthesia as a specialist medical practice in Britain in 1918 was the increasing complexity of the apparatus used. A detailed knowledge of human physiology, along with an understanding of the actions of various chemicals on the human body was said to be fundamental to such practice. Alongside these arguments was an implicit assumption that the handling of machines was a masculine activity – just as the soothing of patients was a feminine one. Similar arguments (influenced by similar prejudices) can be found in West Germany in the mid twentieth century.⁵⁷ The Principal of the Association of German Nurses⁵⁸, Ruth Elster, pointed out in 1958 in the Doctors' Announcements⁵⁹ that "anaesthesia that requires operating machines" would not fall into the tasks of a nurse.⁶⁰ She thus defined the border between "nurse anaesthesia" and the physicians' anaesthesia through the object that had to be used to initiate the anaesthesia. While anaesthesia with the objects "chloroform cap" or ether mask respectively, dropper bottle, mouth mirror, tongs to pull out the tongue, and a sick bowl were acceptable for the work of a nurse, because they suggested a simple procedure. Operating a machine fell outside the scope of their area of expertise. Furthermore, intubation required an invasive procedure that the doctors wanted to keep to themselves. Yet, Dr. Fischer from Kiel suggested in 1960 in the journal "Der Chirurg" (The Surgeon) that the doctor could perform the intubation, but the nurse could still operate the anaesthesia machine and monitor the anaesthesia. He emphasised: "The way things are at the moment we will not get by without nurses as anaesthesia assistants."⁶¹

Again, the work of the nurse anaesthetist is characterised as an assistant job so that the line between the areas of expertise of a nurse and doctor respectively, did not get blurred. Fischer pointed out that there was a special training for nurse anaesthetists in Sweden and the USA and suggested the introduction of similar additional training of nurses in West Germany.⁶² The technical procedure of initiating anaesthesia moved to the centre of attention. Not even the nurses themselves address the actual expertise of the person performing the anaesthesia, namely keeping the patient under close observation through professional monitoring of the vital signs and his general condition.

⁵⁷ In the preface of the fourth edition of his "Kleines Narkosebuch" ("Little Book of Anaesthesia") from 1950, the surgeon and senior consultant in Saarbrücken still emphasised that the "duties and responsibilities of the doctors assistants – male and female nurses – [included] to perform anaesthesia of all types, Hesse 1950, p. III.

⁵⁸ Arbeitsgemeinschaft Deutscher Schwesternverbände und der Deutschen Schwesternschaft e.V. 1958.

⁵⁹ Ärztliche Mitteilungen, today Deutsches Ärzteblatt.

⁶⁰ Elster 1958, p. 1213.

⁶¹ Fischer 1960, p. 201.

⁶² Fischer 1959.

The dramatic shortage of nurses since the middle of the 1950s due to a lack of recruitment finally played into the hands of the anaesthetists in their efforts for professionalisation.⁶³ Furthermore, the professional organisation of nurses, the Agnes-Karll-Verband, rejected the idea of those proponents among doctors that anaesthesia should remain a responsibility of nurse anaesthetists, pointing to the lack of nurses. In addition, the German Hospital Federation⁶⁴ ascribed the legal responsibility of performing anaesthesia exclusively to the assistants (meaning nurses) whom the doctor had authorised. This guideline could have caused nurses who were willing to perform anaesthesia into big trouble, as nurses pointed out in 1959 in the German Journal for Nurses.⁶⁵

At this point, the nurses' task in the operating theatre was restricted to assisting and preparing the anaesthesia. In a text book on nursing from 1957 the transition of anaesthesia as an area of nursing expertise to an area of physicians' competence becomes very clear. The task of the nurse anaesthetist was now limited to the area of psychological and physical preparation of the patient and assistance during anaesthesia. The gender specific connotation of the work of the male anaesthetist was expressly emphasised. Initiating anaesthesia required technical expertise as did the handling of the technical equipment to monitor vital signs of the anaesthetised patient.⁶⁶

5 Closing remarks

The emergence and disappearance of the nurse anaesthetist in Germany and Britain during the nineteenth and twentieth centuries appears to have been linked to the adoption of new and increasingly complex technologies. With the introduction of inhalation anaesthesia nurses in Germany became experts in this field and enjoyed the trust of patients and surgeons for approximately one hundred years. Yet, in spite of (or perhaps because of) their higher social status, and their greater claims to professional independence, nurses in Britain, and in the self-governing Dominions of the former British Empire, were slow to cross the boundary to the adoption of anaesthetic practice. They only, eventually, made this move during a wartime emergency which occasioned an acute shortage of medical personnel. This paper has argued that, perhaps, because of the more entrenched boundaries between the male medical profession and the female nursing profession in Britain and its Dominions, nurses in these countries were not enabled to take on the role of anaesthetists until 1917. And their transition across the boundary from nurse to anaesthetic practitioner was short-lived, because, even as they were adopting the role of "lady anaesthetist", the invention of new technology – in the form of the "Boyle's Apparatus", a type of endotracheal anaesthesia – was creating a situation in which medical anaesthetists would be able to argue, at the end of the war (just one year later, in 1918) that only a trained doctor was competent to administer anaesthesia.

⁶³ On the scarcity of nurses at that time in West Germany, cf. Kreutzer 2005, pp. 164-274.

⁶⁴ Deutsche Krankenhausgesellschaft nicht im Verzeichnis

⁶⁵ Deutsche Schwesternzeitung 12/1959, p. 407.

⁶⁶ Fischer-Groß 1957, pp. 426-433. Cf. also Arbeitsgemeinschaft Deutscher Schwesternverbände 1958, pp. 458-479.

On the face of it, there were two reasons for the “demotion” of nurse anaesthetists: firstly, the wartime emergency – and its attendant shortage of surgeons – was over; and, secondly, equipment such as the “Boyle’s” was seen in terms of gender and profession as a purely medical area of competence. Yet, the situation was more complex than this. The role of the nurse- anaesthetist in wartime surgical practice was fleeting and transitory because both technological advance and medical prejudice were overtaking the burgeoning skill of the nurse. There is evidence that the new endotracheal technology appears to have been mastered by the nurse-anaesthetists (as indicated in Figure 5 in this paper). Yet, their medical colleagues still insisted on their removal from the role of anaesthetist after the war.

Hence, in Britain the emergence of new endotracheal technologies and their associated objects towards the end of the First World War served as an argument to return operating theatre nurses to the position of doctors’ assistants, working alongside surgeons and newly-recognised specialist anaesthetists. Anaesthesiology was an area in which technological advance was particularly rapid during the early twentieth century. The delivery of warm ether or chloroform vapour through a “Shipway’s” apparatus from 1916 in military hospitals, and the use of the “Boyle machine” to deliver nitrous oxide and oxygen from 1917 enabled the delivery of anaesthetics into patients’ bodies more effectively and with fewer side effects than the earlier open-drop methods. These innovations did not happen in isolation. They were heavily influenced by the arrival of US base hospital units on the Western Front; in the second decade of the twentieth century, US anaesthesia had already been using more advanced techniques than those current in European hospitals. Hence, in Britain (and the British self-governing Dominions) the nurse-anaesthetist was a fleeting figure who made a brief entrance into the military operating theatre, only to disappear again when peace was restored. But, during that brief period, her engagement with the apparatus – the “paraphernalia” - of anaesthesiology required a rapid process of learning and adaptation.

In West Germany, the practice of anaesthesia only began to change significantly in the middle of the 1950s, with the introduction of endotracheal or intubation anaesthesia. The introduction of the new technologies appears to have triggered the handover of anaesthesia from the nurse to the doctor. The delivery of anaesthetics became a ‘medical task’. The arguments for the change of responsibility focussed heavily on the material objects that were used to initiate and monitor anaesthesia. While handling the objects during inhalation anaesthesia was perceived as a simple technique that could be performed by women, the new demands of endotracheal anaesthesia gave rise to an argument, not only among (male) doctors but also within the organisation of nurses, that the skill to operate technically complex apparatuses could only be expected from a man.

The actual expertise that carers brought to the job as a nurse anaesthetist, namely the systematic observation of the patient, was addressed neither by the doctors nor by the nurses who participated in this debate. Indeed, with the increasing mechanisation of anaesthesia, machines took on part of the monitoring of patients’ vital signs. The close observation of skin colour, breathing, and quality and quantity of the pulse was previously the responsibility of experienced nurses who initiated action at the moment when the anaesthetised patient’s condition became critical.

‘Trust’ is an ethical issue. When surgeons gave their consent for nurses to perform anaesthesia – whether in the Germany of the nineteenth century or the Allied military hospitals of 1917 – it was because they believed that female nurses were not only competent to administer the drugs and monitor the patient’s condition but also that those nurses were peculiarly skilled in inspiring confidence. But the introduction of any new technology also raises new ethical issues. By 1918 in Britain and 1953 in West Germany, surgeons were arguing that nurses were not competent to handle technology such as endotracheal intubation – and could not, therefore be anaesthetists. Nurses, it was argued, were poorly equipped to handle complex machinery; so anaesthesiology was removed from their domain of practice. The interaction of care and technology⁶⁷ thus had first a “professionalising” and then, arguably, a “de-professionalising” effect on nurses.

With the replacement of the inhalation anaesthesia by endotracheal approaches, the initiation of anaesthesia was removed from the skill set of female nurses. The key competence of observing the patients was, subsequently, also transferred to technical apparatuses. Something that both the medical practitioners and the nurses’ organisations of the time, perhaps, failed to fully recognise was the nurse’s continuing ability to employ careful and systematic observation. Corporeality – the colour and temperature of the skin; the quality and rate of the respirations and pulse; the level of calm or agitation – was not measured by machines – nor could a machine soothe a distressed patient.

Acknowledgements

The authors would like to acknowledge the invaluable help of Isabel Atzl, (M.A. nurse by training & historian); Dr Peter Mohr BSc MB ChB PhD FRCP (retired neurologist & medical historian); and Dr. Tim, G.C. Smith FRCA, Curator, Berkshire Medical Heritage Centre, Reading, UK.

Karen Nolte (Prof Dr), Institute for History and Ethics of Medicine, University of Heidelberg, Germany

Christine E. Hallett (Prof Dr), School of Music, Humanities and Media, The University of Huddersfield, United Kingdom

⁶⁷ On the relationship of care practices and technology cf. also Mol/Moser/Pols 2010, pp. 7-26.

6 Bibliography

6.1 Manuscript Sources

McCarthy, Dame Maud: Reports on Nursing Services, 1918, Army Medical Services Museum Archives, Aldershot, UK; Box 10, 43/1985.

Mayer and Phelps: Catalogue of Medical Instruments, 1931, The University of Manchester Museum of Medicine and Health.

6.2 Books, Journal Articles and Theses

Abel-Smith, Brian: The Hospitals. 1800-1948. London 1964.

Anonymous: Letter, In: The British Journal of Nursing, 9 February, (1918), p. 92.

Arbeitsgemeinschaft Deutscher Schwesternverbände und der Deutschen Schwesternschaft e.V. (ed.): Die Pflege des kranken Menschen. Stuttgart 1958.

Atzl, Isabel (ed.): Who Cares? Geschichte und Alltag der Krankenpflege. Frankfurt am Main 2011.

Atzl, Isabel: Das materiale Erbe der Pflege. Historische Pflegedinge in Sammlungen und Museen und ihr Potential für die (pflege-)historische Forschung. In: Artner, Lucia/Atzl, Isabel (ed.): Pflegedinge. Materialitäten in Pflege und Care. Bielefeld 2017, pp. 51-86.

Bankert, Marianne: Watchful Care: A History of America's Nurse Anesthetists. New York 1989.

Barford, A. M.: Nurse Anaesthetists. In: British Medical Journal, 5 October, 1940, p. 474.

Barnard, Alan/Margarete Sandelowski: Technology and Humane Nursing Care: (Ir)reconcilable or Invented Difference? In: Journal of Advanced Nursing 34 (2001), 3, pp. 367-375.

Bassett, Jan: Guns and Brooches. Australian Army Nursing from the Boer War to the Gulf War. Melbourne 1992.

Borden, Mary: The Forbidden Zone. London 1929.

Bowlby, Sir Anthony/Colonel Cuthbert Wallace: The Development of British Surgery at the Front. In: British Medical Journal, 2 June, (1917), pp. 705-21.

Daston, Lorraine: Things That Talk: Object Lessons from Art and Science. New York 2004.

De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 28 April, p. 507.

De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 5 May, p. 534-535.

- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 12 May, pp. 566-569.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 19 May, pp. 592-593.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 26 May, p. 620.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 2 June, pp. 650-651.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 9 June, pp. 681-682.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 16 June, pp. 711-712.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 23 June, pp. 740-743.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 30 June, pp. 767-768.
- De Prenderville, A.: Anaesthesia and the Nurse's Duties. In: The Nursing Times (1917), 7 July, p. 794.
- Deutsche Krankenhausgesellschaft
- Deutsche Schwesternzeitung 12/1959, p. 407.
- Dommann, Monika: Durchsicht, Einsicht, Vorsicht: eine Geschichte der Röntgenstrahlen. 1896 – 1963. Zürich 2003.
- Elster, Ruth: Hinweis der Schwesternschaft. In: Ärztliche Mitteilungen 41 (1958), p. 1213.
- Fischer, A. W.: Wieweit können Schwestern und Pfleger an Narkosen beteiligt werden? In: Der Chirurg 297 (1959), pp. 236-254.
- Fischer, Ludolf; Groß, Fritz; Venzmer, Gerhard (ed.): Hand- und Lehrbuch der Krankenpflege. Band II: Praktische Krankenpflege. Stuttgart 1940.
- Fischer, Ludolf; Groß, Fritz; Venzmer, Gerhard (ed.): Hand- und Lehrbuch der Krankenpflege. Band I: Grundlagen. Stuttgart 1940.
- Fischer, Ludolf; Groß, Fritz (ed.): Hand- und Lehrbuch der Krankenpflege. Band II: Praktische Krankenpflege. Stuttgart 1957.
- Fischer, Ludolf; Groß, Fritz; Krick, Josef, Bauer, Robert (ed.): Hand- und Lehrbuch der Krankenpflege. Band II: Praktische Krankenpflege. Stuttgart 1949.
- Gamarnikow, Eva: Nurse or Woman: Gender and Professionalism in Reformed Nursing. 1860-1923. In: Holden, Pat/Jenny Littlewood (ed.): Nursing and Anthropology. London 1991.

- Hallett, Christine E.: *Containing Trauma: Nursing Work in the First World War*. Manchester 2009.
- Hallett, Christine E.: *Veiled Warriors: Allied Nurses of the First World War*. Oxford 2014.
- Harris, Kirsty: „Giving the dope“: Australian Army Nurse Anaesthetists during World War I. In: *Australian Journal of Military Medicine* 12 (2003), 3, pp. 138-143.
- Harris, Kirsty: *More than Bombs and Bandages: Australian Army Nurses at Work in World War I*. Newport, New South Wales, Australia 2011.
- Harrison, Mark: *The Medical War: British Military Medicine in the First World War*. Oxford 2010.
- Hawkins, Sue: 'I must remind you that the nurse is not the doctor; that she never can be': Gender and Hospital Nursing in 19th and 20th Century England". In: *Historia Hospitalium* 30 (2017), 17, pp. 41-64.
- Hawkins, Sue: *Nursing and Women's Labour in the Nineteenth Century*. Abingdon 2010.
- Heller, Ernst: *Das Handwerk des chirurgischen Stationsdienstes*. Leipzig 1948.
- Hesse, Fritz: *Kleines Narkosebuch. Eine Anleitung zur Erlernung der Allgemeinnarkose für Schwestern und Heilgehilfen*. Leipzig 1950.
- Janssen, P.: *Lehrbuch der Chirurgischen Krankenpflege für Pflegerinnen und Operationsschwestern*. Leipzig 1922.
- Keeling, Arlene: *Nursing and the Privilege of Prescription: 1893-2000*. Athens, Ohio 2007.
- Kilian, H.: Die Entwicklung der Narkose und Anästhesie im Laufe der Zeiten. In: Kilian, H./H. Weese (ed.): *Die Narkose. Ein Lehr- und Handbuch*. Stuttgart 1954, pp. 1-30.
- Kreutzer, Susanne: *Vom „Liebesdienst“ zum modernen Frauenberuf. Die Reform der Krankenpflege nach 1945*. New York/Frankfurt am Main 2005.
- La Motte, Ellen: *The Backwash of War*. New York 1916.
- Lindemann, Walter: *Schwestern-Lehrbuch für Schwestern und Krankenpfleger*. München 1928.
- Ludwig, Andreas: Geschichte ohne Dinge. Materielle Kultur zwischen Beiläufigkeit und Quelle. In: *Historische Anthropologie* 23 (2015), pp. 431-445.
- Luckes, Eva: *General Nursing, New and Revised (9th) Edition*, London 1914.
- Marshall, Geoffrey: „The Administration of Anaesthetics at the Front“. In: *British Medical Journal* (1917), 2 June, pp. 722-725.
- Medizinalabteilung des Königlich Preußischen Ministerium des Innern (ed.): *Krankenpflegelehrbuch*. Berlin 1913.
- Meister, Florian (ed.): *Klinik für Anaesthesiologie Universitätsklinikum Heidelberg. Festschrift anlässlich des 40-jährigen Jubiläums des Ordinariats für Anaesthesiologie an der Ruprecht-Karls-Universität Heidelberg* 2007. Heidelberg 2007.

- Mol, Annemarie/Ingunn Moser/Jeanette Pols: Care: Putting Practice into Theory. In: Mol, Annemarie/Ingunn Moser/Jeanette Pols (ed.): Care in Practice On Tinkering in Clinics, Homes and Farms. Bielefeld 2010, pp. 7-26.
- Moore, Judith: A Zeal For Responsibility: The Struggle for Professional Nursing in Victorian England, 1868-1883. Athens, Georgia, 1988.
- Parsons, F. B.: Nurse Anaesthetists. In: British Medical Journal (1940), 28 September, p. 429.
- Rafferty, Anne Marie: The Politics of Nursing Knowledge. London 1996.
- Rawstron, Richard E.: A Unique Nursing Group. New Zealand Army Nurse Anaesthetists of WWI. Christchurch 2005.
- Reckwitz, Andreas: Grundelemente einer Theorie sozialer Praktiken. In: Zeitschrift für Soziologie 32 (2003), pp. 282-301.
- Rivett, Geoffrey: The Development of the London Hospital System 1823-1982. Oxford 1986
- Rupprecht, Paul: Die Krankenpflege im Frieden und im Kriege zum Gebrauch für Jedermann insbesondere für Pflegerinnen, Pfleger und Ärzte. Leipzig 1898.
- Rupprecht, Paul: Die Krankenpflege im Frieden und im Kriege zum Gebrauch für Jedermann insbesondere für Pflegerinnen, Pfleger und Ärzte. Leipzig 1902.
- Rupprecht, Paul: Die Krankenpflege im Frieden und im Kriege zum Gebrauch für Jedermann insbesondere für Pflegerinnen, Pfleger und Ärzte. Leipzig 1914.
- Salzwedel, Rudolf: Handbuch der Krankenpflege. Zum Gebrauch für Krankenpflegeschulen sowie zum Selbstunterricht. Berlin 1909.
- Sandelowski, Margarete: Devices and Desires: Gender, Technology, and American Nursing. Chapel Hill, NC 2000.
- Sarnecky, Mary T.: A History of the US Army Nurse Corps. Philadelphia 1999.
- Smith, Tim: The Development of Anaesthesia during the First World War. In: Historical Medical Equipment Society Bulletin (2015), August, pp. 6-7.
- Snow, Stephanie J.: Blessed Days of Anaesthesia. How Anaesthetics Changed the World. Oxford 2008.
- Stewart, Isla and Cuff, Herbert E.: Practical Nursing. London 1899.
- Stanley-Sykes, W.: Nurse-anaesthetists. In: British Medical Journal (1941), 1 March, p. 339.
- Telford, Jennifer Casavant: American Red Cross Nursing during World War I: Opportunities and Obstacles, unpublished PhD thesis, The University of Virginia 2007.
- Tesseyman, Sheri: Complex Alliance: A Study of Relationships between Nursing and Medicine in Britain and the United States of America. 1860-1914, unpublished PhD thesis, The University of Manchester. Manchester 2014.

- Thurstan, Violetta: *Field Hospital and Flying Column. Being the Journal of an English Nursing Sister in Belgium and Russia*. London 1915.
- Thurstan, Violetta: *A Text Book of War Nursing*. London 1917.
- Vickery, Amanda: *From Golden Age to Separate Spheres: A Review of the Categories and Chronology of English Women's History*. In: Pamela Sharp (ed.): *Women's Work: The English Experience 1860-1914*. London, 1998, pp. 294-322.
- Vicinus, Martha: *Independent Woman: Work and Community for Single Women, 1850-1920*. London 1985.
- Weißauer, W.: *Die Entwicklung zu einem selbständigen Fachgebiet*. In: Jürgen Schüttler (ed.): *50 Jahre Deutsche Gesellschaft für Anästhesiologie und Intensivmedizin. Tradition & Innovation*. Berlin/Heidelberg/New York et al. 2003, pp. 68-78.
- Wiesemann, Claudia: *Vertrauen als moralische Basis – Bedeutung für Medizin und Ethik*. In: Steinfarth, Holmer/Claudia Wiesemann (ed.): *Autonomie und Vertrauen. Schlüsselbegriffe der modernen Medizin*. Wiesbaden 2016, pp. 69-80.
- Young, Arlene: *Entirely a Woman's Question? Class, Gender and the Victorian Nurse*. In: *Journal of Victorian Culture* 13 (2008), 1, pp.18-41.

The Fake Three-Sided Key

Patient-Fabricated Duplicate Keys in Psychiatry around 1900

Martina Wernli

Abstract

This paper analyses the historical importance of objects in psychiatry – particularly their use in the contemporary teaching and training of nurses – with reference to a collection of duplicate keys from the Waldau clinic near Berne. The collection consists of approximately 90 objects, made by patients with the aim of using them to escape. The psychiatrist Walter Morgenthaler (1882–1965) collected these keys at the beginning of the 20th century, attached them to plates, gave them patients' record numbers and used them for teaching. In these patient's records, stories of the keys can be found. For the first time, these records allow for an analysis of the keys in the context of material culture.

1 The “Key Problem”

In a passage about patients' attempts to escape in his 1900 *Guide for Nurses for Lunatics*, the Bremen psychiatrist Ludwig Scholz (1868–1918) wrote:

Escapes are only prevented by *sharp alertness!* Neither walls nor bars can replace attention, they in fact invite nurses to act negligently.

A lot of sin takes place during the *locking of the doors*. Key and hand of the nurses shall grow together, as it were, and the locking of the doors had to become a mechanical habit. Under no circumstances shall he leave the key anywhere; furthermore, he shall not make the common mistake of not locking the door on purpose, “because someone will come directly after him!” Moreover, he shall remember that sick people occasionally try to *snatch* or *steal* (at night!) keys.¹

This passage from his *Guide* steers the contemporary reader's attention in two directions: first, towards the person to be nursed and second, towards the object, in this case specifically keys, whose connections will be of concern in the following essay. Both groups, nurses and objects, were constitutive of psychiatry at that time. Whoever was in a mental institution was locked in or out of life outside by means of keys. This state of affairs had to be maintained by the institution's employees, since mental asylums were places of detention since the 19th century. Taking care or even curing patients was not a priority, and could not be, since asylums were overcrowded. Therefore, employees were mainly hired because of their physical strength, as they were often called upon to use it in their work. There were some attempts to professionalize nursing in the second half of the 19th century, leading psychiatrists to expect more than physical force from prospective employees. It was only at the beginning of the 20th century, however, that the expectations were expanded, thus increasing the potential for a

¹ Scholz 1900/1913, p. 104f., my translation. Italics are letterspaced in the original.

greater appreciation of the profession. This is especially striking in comparison with general nursing.²

In the following section, the “key problem”³ will be contextualised with regard to the training of nurses. Within the discussion, the relationship between training in the sense of pedagogical-normative specifications and the usage of keys as a practice will be examined. This will be followed by a consideration of the extraordinary collection of duplicate keys (around 90 objects) of the psychiatrist Walter Morgenthaler. These keys will then be analysed in the context of patient records – a connection of which research has not taken note of until now.

Methodologically, the keys will be regarded as components of a material culture, as has been done in recent productive analyses of the history of psychiatry and nursing.⁴ In keeping with such an approach, objects will be attributed *agency* in the sense of Bruno Latour’s actor-network-theory. Latour’s observations in *The Berlin Key or How to Do Words With Things* are particularly relevant for the topic at hand. He describes the Berlin Key as an “intermediary”⁵ within a network of things, signs and social relations. It is an extraordinary thing which appears quite powerful: it “authorizes me to re-enter my house and obliges me to bolt the door at night and forbids me to bolt it during the day”.⁶ A similar potential will also be attributed to the collected duplicate keys discussed here. Therefore, this paper will not follow the model of a more traditional history of psychiatry, which is only interested in famous psychiatrists and powerful institutions. With regard to keys however, it is not enough to describe them as mere (aesthetic) objects. Rather, their description is to be combined with an analysis of traditional sources like psychiatric textbooks and patient records. Only then can we gain an – at least partial – insight into asylums and their material practices.

To return to the 20th century: The handling of institutional keys was an issue in the training of nurses for psychiatry. In Switzerland, for instance, there were yearly examinations for “nursing staff for lunatics”⁷, which were executed by the Swiss Society for Psychiatry. Henri Bersot, the director of the Sanitarium Bellevue in Le Landeron described what was expected of candidates as follows:

good theoretical knowledge of anatomy, physiology, general nursing, furthermore nursing of lunatics, the study of asylums etc. In terms of practical skills, nursing,

² See Payk 2012, pp. 187–192 as well as Falkenstein 2000. On the history of nursing in general, see also Schweikardt 2008 as well the volume edited by Walter, Seidl, Kozon 2004 and especially the article by Braunschweig 2004, which discusses Swiss nursing.

³ This expression is Emil Kraepelin’s and will be discussed and quoted below. I want to thank Maria Böhmer for her feedback on a draft of this text. I would also like to thank Jermain Heidelberg for his help with the translation of this paper and Justin Mohler for proof reading this text.

⁴ See Artner et al. (ed.) 2017 as well as Majerus 2017. Regarding her biography, Majerus speaks of a threefold life, as objects, as “lifelike object” and as “aced objects’ [...] incorporated by actors.” Majerus 2017, p. 273.

⁵ Latour 1991, p. 18. I will not be able to discuss Latour’s almost anecdotic narrative style as well as his disconcerting gender-attributions (the clumsy female archaeologist) here.

⁶ Latour 1991, p. 19.

⁷ Bersot 1933, p. 4, my translation.

especially nursing of lunatics, observation of the sick, writing of reports as well as knowledge of the conduct in different wards is required.⁸

Between 1927 and 1932, “a total of 717 people, 291 male and 426 female nurses”⁹ had taken the exam, of whom six did not pass. In the whole of Switzerland, “25% of the male nurses and 21,7% of the female nurses”¹⁰ had been certified by 1933. Even though the numbers show that the profession’s target audience was changing to a more female orientated market rather than one of strong men, the percentages suggest that fewer women aspired to be certified.¹¹

In this new kind of training, objects like keys increasingly became a topic of interest. Previously, they were mentioned in the short normative descriptions of the profession for nurses. There is a passage in the *Official Regulations for Guards of the Mental Asylum Basel* from 1899 (the clinic was opened in 1886), which points out that doors must be locked and that keys must not be lost – *ex negativo* this means that open doors and lost keys were a problem.¹²

Forty years later, Walther Morgenthaller wrote to the director of the Swiss Public Health Department about the lack of progressive thinking by some doctors:

Even if the number is small, there are still doctors today, who believe that good character (which is often simply understood as good-heartedness sprinkled with indolence) and a short instruction of the chief guard about paying attention to keys and sick people, patience, etc. are enough.¹³

That (as well as how) Morgenthaller addresses the staff in addition to objects as topics of discussion is unusual for the time. Institutional changes can be pointed out paradigmatically with reference to keys, which have opened and closed the figurative doors of clinics.¹⁴ At that time, the former ‘guards’ became ‘nurses’ and the psychiatrists started paying attention to keys as technical things, since the sheer amount of them as well as the noise they were making began to disturb several actors.

In his *Memoirs* the German psychiatrist, Emil Kraepelin (1856–1926), also discussed keys. He writes:

⁸ Bersot 1933, p. 4, my translation.

⁹ Bersot 1933, p. 7, my translation.

¹⁰ Bersot 1933, p. 45, my translation. Bersot provides even more statistics, which are also of interest for an internal comparison of the clinics.

¹¹ Since female nurses were notably younger than male nurses on average, these figures should not only be considered with regard to the category of gender in order to provide meaningful explanations. Maybe women were not as much interested in certification as nursing was seen as a short-term job prior to marriage.

¹² Paragraph 26 reads as follows: “The guards always need to make sure that ward doors are closed and that keys are not forgotten or lost.” Hähner-Rombach 2008, my translation. The commentary by Braunschweig can also be found in Hähner-Rombach 2008, pp. 333–336.

¹³ Morgenthaller 1926, p. 456.

¹⁴ It would also be possible to analyze other things like beds or baths. See also the latest research by Monika Ankele (Hamburg) on beds and baths in psychiatry as well as the project by Maria Keil (Berlin) on hospital beds. This research shows a focus on objects in the history of psychiatry which adds to common approaches like the history of institutions or biographical as well as nosological research.

The need for a practical solution of the key problem was important. As I entered the clinic in Leipzig, before it was opened, I found a board with several hundred keys hanging on it, which had been supplied by the workmen for the various clinic doors. Whenever one wanted to go to a certain ward, one had to take a little basket full of the necessary keys. The clanking bunches of keys in some of the asylums reminded me of a prison. Furthermore, I did not like the three- and four-sided keys in use, not only because the corresponding locks emphasize that one is in some peculiar type of house, but also because the patients mistake them for tools for maltreatment. Therefore, I tried to make the locks and keys as uniform as possible, so the staff were only armed with one tiny key, which could be used to enter all rooms necessary for work.¹⁵

In his retrospective depiction, Kraepelin is disturbed by the amount (a “basket”) of keys, their loudness as well as their shape (their three- and four-sidedness), since they could also be used as weapons against patients, at least there seem to have existed complaints pointing towards this.

Textbooks from this time, however, did not only address keys, but also copies. The doctor Valentin Falthäuser (1876-1961)¹⁶ warned of duplicate keys in his work *Nursing of Lunatics*, initially published in 1923:

Almost countless are the attempts to make lock picks to open locks, or square keys, if they are qualified for their purpose, out of the most different materials that are passed on to them either by accident or deliberately. Lock picks, that is hooks bent in different ways depending on the respective lock, are made out of wire, convoluted pieces or strips of sheet metal, spoon handles, etc. It is not uncommon that previously some of the patients were canny burglars, metal workers, or from a similar profession. They make proper duplicate keys out of tinware, spoons, and pieces of sheet metal etc., after they have obtained imprints of the respective keys in unguarded moments in the most cunning way. These imprints are made out of wax or chewed bread. Or such imprints are given to visitors or a patient who is allowed to leave the premises or is released, and these then smuggle the subsequently manufactured keys on the premises, and possibly break into the asylum at an agreed time during the night and hand such duplicate keys to the waiting companion through a window, which was kept open with all kinds of tricks and dodges.¹⁷

¹⁵ Kraepelin wrote his *Memoirs* in the 1910s. Kraepelin 1987, p. 122.

¹⁶ Falthäuser, later, became a national socialist, who was involved in the euthanasia program as an ‘Action T4 expert’ and thus was jointly responsible for the murder of hundreds of children from the mental asylum Kaufbeuren. He was, however, given a lenient sentence and was even pardoned later. See also <https://www.pflege-wissenschaft.info/datenbanken/who-was-who-in-nursing-history/liste-aller-eintraege/104-datenbanken/who-was-who-in-nursing-history/11527-falthauser-valentin>, accessed August 20th, 2018.

¹⁷ Falthäuser 1925, p. 86, my translation.

Faltlhauser seems to have been virtually helpless against the uncontrollable number of attempts to copy keys. He found one group of internees especially suspicious – “the canny burglars or metal workers”. In the quoted passage, one can discern a basic mistrust of sick people. But not only patients were suspects – in relation to duplicate keys, everyday objects like dishes and spoons or materials like bread, which when chewed suddenly became a modelling compound rather than food, appeared in an altogether different light.

The quotes from Kraepelin, Faltlhauser, and Morgenthaler make clear: The “key problem” is one that worried psychiatrists. In addition to individual initiatives and reports like Kraepelin’s, keys were also turned into didactic items, which were stored, so they could be re-used in the training of staff members. From this perspective, large locks and their keys represented an old practice, which like means of coercion had to be overcome in ‘modern’ psychiatry.

2 Walter Morgenthaler’s Collection of Keys

In his 1930 work, *The Nursing of the Emotionally and Mentally Disturbed*, the Bernese psychiatrist, Walter Morgenthaler (1882–1965), features photographs of old and new keys.¹⁸



Fig. 1: Old set of keys. Morgenthaler 1930, Plate 17a.

¹⁸ The book was also published in French in the same year, in Italian in 1934, and in Spanish in 1936. For a general introduction to Morgenthaler, see Wernli 2014, pp. 152–160. On Morgenthaler as an art collector, see Luchsinger 2016, pp. 215–224 and pp. 282–300.



Fig. 2: Modern, combined keys. Morgenthaler 1930, Plate 17b and c.

Morgenthaler demanded the abolition of large sets of keys and a reduction to three keys: “An appropriately equipped asylum is supposed to get by with three keys for a nurse: a ward key for the doors, a special key for windows, light, signal bells, bath, etc. and a cabinet key.”¹⁹ In his opinion, the proper handling of keys was what made a good nurse. He wrote: “The right handling of the keys is very difficult and takes a long time to be learned. For an expert, nothing is a more appropriate measure to assess a nurse than the way he handles keys.”²⁰

The photographs show everyday objects, which had increasingly become a topic of scientific as well as museum interest: Similar to developments in prisons, collections of objects like keys were established in psychiatry. Keys were also exhibited in the 1914 Swiss National Exhibition in Berne, where the psychiatry exhibits occupied two rooms. What was exhibited, however, is not documented – theoretically, Morgenthaler’s collection of keys could already have been presented there, since he had also produced models of the old means of coercion for the exhibition. It has been established that copies of prison keys were displayed.²¹ Through these objects, a wider public as well as trainees were able to learn how an institution worked (and how it did not work). The latter was in particular the case, when the objects which were supposed to guarantee locking in and out were copied by those who were not intended to have power over the keys: the patients.

¹⁹ Morgenthaler 1930, p. 125, my translation.

²⁰ Morgenthaler 1930, p. 124, my translation. Morgenthaler’s use of the generic masculine does not reflect the actual proportion of male to female nurses in the Waldau clinic at the time – in the 1910s and 1920s the gender ratio of the employed nurses was almost equal.

²¹ In the report on the Swiss National Exhibition from 1914 (p. 61, my translation), group 44, VIII, the police and prison system are described as follows: “3. Crime Museum. From the Crime Museum of the Bernese cantonal police, a collection of murder weapons, burglary tools, duplicate keys, as well as a very substantial and interesting series of models for counterfeiting, forged stamps and signatures, were exhibited. The equipment of hotel thief was also exhibited as well as different images on gaming and fortune telling fraud. Following this, there was also an extensive collection of prohibited weapons, as used by poachers, and prohibited fishing equipment.” Until today, the Crime Museum of the Bernese cantonal police has preserved (uncommented) keys which are probably from this period.

2.1 The Material

A unique collection of duplicate keys is located in the psychiatry museum in Berne, i.e. keys made by patients and provided with reference numbers²² by Walter Morgenthaler. In these files, in turn, the respective history of a key can be found and it shows that most duplicate keys were produced for the purpose of escaping. By analyzing the files, these objects can be contextualised in a new way.

First, regarding the items: Morgenthaler's collection consists of three rectangular cardboard plates of the same size. On these plates there are two areas, which are both separated by two black horizontal lines and to which around 90 objects are attached.²³



²² I want to thank PD Dr. Andreas Altorfer for providing me with the files from Waldau in the psychiatry museum Berne. I will anonymize names and correct obvious misspellings. All mentioned files and objects may be found in the psychiatry museum Berne or in its archive.

²³ A plate with the title "Instruments constituting a public danger" does not seem to be part of inventory. Plate no. 114 is exhibited in the psychiatry museum Berne, the others are located in the archive. The tableaux no. 147 and no. 114 can be found in: Morgenthaler 1930, p. 187 (as plate 27). The instruments constituting a public danger can be found there too on p. 188 (plate 28). Plate 147 of the duplicate keys can be found in: Beretti, Heusser 1997, p. 127; Luchsinger 2008, plate 20. For an article on plate 578 with a focus the keys of an individual patient, Mr. B. (patient record no. 7505) see Wernli 2018. A plate by Morgenthaler with the title "Instruments for Suicide" only references two record numbers in its current condition. It has the inventory number 550. In Morgenthaler 1930, plate 26, we can find an image of the plate in its original condition – including more material and labels. On this plate, we can find three commentaries next to objects: "ribbon for hanging" or "no. 8912 15–VI.21 hung on the door handle of a bathroom in the barracks." Or: "No. 8911 hung himself on a pipe on 19.6.21."

Fig. 3: Morgenthaler: Duplicate keys. Inventory number 114.



Fig. 4: Morgenthaler: Duplicate keys. Inventory number 147.



Fig. 5: Morgenthaler: Duplicate keys. Inventory Number 578.

As the attached labels specify, most of them are duplicate keys. The plates also display individual parts of keys like bits or molds for the production of bits. All three plates have small holes at the top. One can thus assume that they hung in Morgenthaler's small asylum

museum, which he had set up in the attic of the new building constructed in 1913 (called ‘Old Clinic’ today). Further, there is a fourth, rather square plate, to which around 14 objects are attached freely and on which clear gaps can be identified, where things used to be.²⁴

The connection of object and number allows for contextualizing these things in the practice of documentation of psychiatry. The existence of reference numbers distinguishes the plates from Morgenthaler’s other efforts, on which there are instruments of suicide or generally dangerous tools and few if any reference numbers. For the files, this means that the objects add evidence to what is described: duplicate keys, as they are described in the patient records, can still be seen in the collection; they bear witness to escape attempts or at least attempts to prepare for them. For the patients, who are assigned a file number, this means the transmission of a work from their hand. What can be investigated with regard to the patients is thus not only the recorded psychiatric gaze, as stored in the medium of the file, but also a tool with specific material properties handcrafted by them.

Today, the keys themselves have several forms of presence. They are first, publicly viewable in the museum as well as haptically tangible on the tableaux. Second, they are available linguistically transformed in the files, when they were used for escape attempts, and third, they are printed as photographs and are furnished with explanations by doctors in teaching materials. In a section on so-called sick people who ‘constitute a public danger’, Morgenthaler writes that they are “particularly cunning; out of seemingly benign things” they can make “dangerous instruments”²⁵, among which he also ranks the duplicate keys. ‘Cunning’ is an expression, which is used repeatedly in the files – it also expresses a certain fascination with these objects, which manifest themselves in several textual forms.

First, however, the three plates need to be analyzed more precisely.²⁶ In general, it is difficult to discern a systematic order on the plates – visually, the objects are divided into horizontal lines, but further criteria of classification are not evident. All tableaux feature different materials, the objects are made out of wood, metal, bones, wire, or cardboard, many are composed of combinations of materials, which are held together by strings. The base materials are spoons, wire springs from mattresses, or nails. Such keys were not made from scratch, rather an everyday object was altered. It is also clear that the objects were not classified according to their creators, as there are objects by Mr. B (record number 7505) on all three as well as other record numbers on more than one plate. Hence Morgenthaler’s criteria for classification remain open.

More than half of the objects on the plate with the inventory number 114 (Fig. 3) are attributed to the patient record number 5682, Mr. J. Most of the objects by Mr. J. are made out of wood and seem professionally shaped in a lathe. They are, however, (and this we learn through the study of the patient record) not produced by a carpenter, as could be expected, but by a brewer. One single object (associated with record number 4635) is related to a full name. On

²⁴ Inventory number 562.

²⁵ Morgenthaler 1930, p. 188, my translation.

²⁶ The order, in which the plates appear in this paper, is arbitrary.

the fourth key from the top right, it says “Stalder Jakob NH 1920 19VIII”.²⁷ This key allows for dating, given that it was already attached to the plate when the collection was started. Thus, the collection could have come into being in 1920 at the earliest, even though older objects might also have been added, since the main term of employment for Morgenthaler in Berne was already before this time. That dating by means of the objects may, however, be problematic is revealed in a comparison with plate 114 from Morgenthaler’s teaching material.

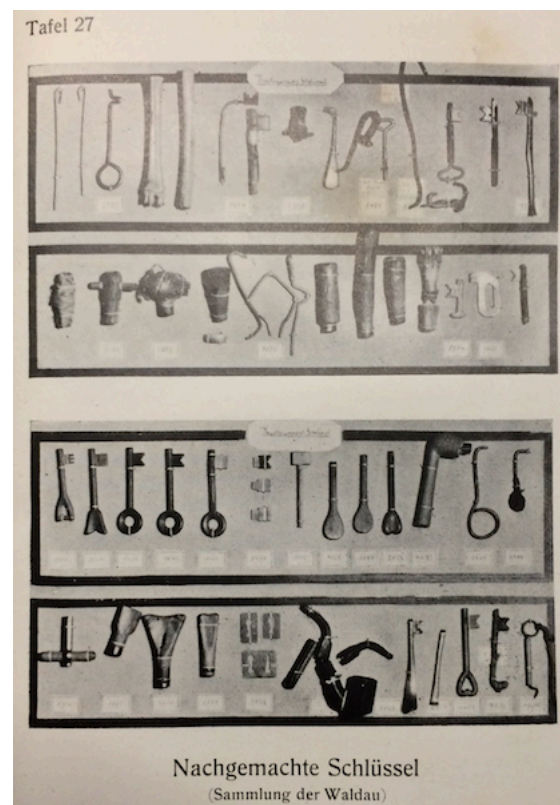


Fig. 6: Duplicate keys. Morgenthaler 1930, Plate 27.

It is striking that in the upper row of that plate, Stalder’s key is turned to the right, so that the name cannot be seen. Next to this key there are two more objects, while there are three objects on today’s plate 114. Thus, the metal key with the record number 12727 must have been attached to the plate after the teaching material’s year of publication (1930) – at a time when Morgenthaler had already stopped working at Waldau. In fact, Mr. R. (with record number 12727) had only come to the clinic in 1935. This one object then shows that while the plates and the arrangement trace back to Morgenthaler, the clinic continued collecting objects and presumably used the plates for teaching after he had left, since only this would explain that someone later attached the key of Mr. R. to the plate.

²⁷ Some objects made out of wood carry the same name. “NH” is sometimes spelled in full as Neuhaus. Most of his works are from the early 1920s. At the time of the composition of this text, the file with the number 4633 cannot be found. Neither can the name be found in Morgenthaler’s slip box.

In addition to the objects, the plate with the inventory number 114 (Fig. 3) includes two labels by Morgenthaler, which could be called micro-stories. The label for the pipe at the bottom which is made out of small pieces reads “the middle piece contains a three-sided key” and the label for the second object from the right reads “hidden in the mouth”. Here, the description and the history of the object intersect. This pipe trains the nursing gaze: it shows that a seemingly harmless everyday object may contain a tool for escape and that keys may not only be found in pockets, but also patients’ mouths. Through this, a history of the displayed object is hinted at, while at the same time the body of the patient is addressed. The corporeality of the patient is presented as potentially suspicious, since it can hide keys. Most of the objects on the plate with the inventory number 578 (Fig. 5) are attributed to Mr. B. In addition there are objects without record numbers. For instance left of the middle in the bottom row is an object that comprises a combination of a steel spring, other metal pieces and purple paper slips. This paper can also be found in the top row where the object on the left merely consists of (partly printed) paper and thus could most likely not be used as a key. It is the only object with a comment next to the record number, namely “psychopath”. Since the related record is missing from the archive, this trace cannot be followed further. By contrast, the third object from the left is clearly crafted from the handle of flatware. In addition, the object at the far right appears to have been forged. Lastly, the key with the number 7396 is three-sided. This can only be seen from the side. Thus, the precise nature of the objects as well as the patients’ ingenuity with respect to hiding them is only revealed when the keys are considered as three-dimensional things rather than illustrations. With numbers or records missing, however, it becomes clear that a scholarly engagement with these objects always needs to consider and find a way to handle such an incomplete transmission.

The plate with the inventory number 147 (Fig. 4) exhibits large bones as well as objects made from wire among other things. There, the micro-stories read: “used it to open windows” or “out of the box spring mattress of a bed” or “for opening the shutter”. In the upper row, a little left of the middle, there is also a key made out of cardboard, which the psychiatrist Theodor Spoerri depicted in a contribution for the 1972 documenta. It was, however, decontextualised and unrelated to the record missing today.²⁸

With regard to the plate with the inventory number 562, I can here only draw attention to two peculiarities: First, the plate documents the origin of the duplicate keys by using a range of comments. For example, one reads “inception of key manufacturing”, another “beginning of three-sided keys”. Others provide information on the material: “the sheet metal from cans serves as reinforcement”. Second, the origin of two three-sided keys is said to have been Münsingen, while it seems that for the other objects Waldau can be assumed to have been the place of origin. Thus, it can be concluded that the production of keys in different institutions was similar and that Morgenthaler had requested the keys from Münsingen, so he could add them to his collection.

²⁸ Spoerri 1972, pp. 11–4 (sic! page numbers). Against this backdrop, Spoerri’s sparse comment that it is “probably a symbol of power” remains a mere hypothesis.

3 The Records

There are 12 records on the key plates in the archive of the museum of psychiatry in Berne. They report on twelve men who were born between 1853 and 1896 and whom were all made to live for a short while at least in Waldau (with some having multiple lengthy stays). Since at that time there were as many women as men interned, it is striking that only men produced these objects. Most were so-called ‘cases for examination’, which were brought to the clinic from surrounding prisons for a psychiatric examination. Thus, many of these men were already familiar with the experience of being ‘behind bars’. Their patient records differ in terms of their length, but all include keys. Hence, the object has found its way into the medical description of the patients and their sickness. What Cornelia Vismann has explained with regard to files and law, may also be transferred to the psychiatric files, that is, files “act” by transforming and storing knowledge.²⁹ In this specific case, they act in a network in conjunction with objects as well as patients and doctors. As there are virtually no surviving qualitative records written by guards (it can be assumed that they simply were never made), an important group of observers is missing. Since only few doctors were employed in the clinic, it can be assumed that many of the observations on the production of keys and escape attempts found in the records are based on oral reports.

In the following section, I will present excerpts from the records alongside six theses.

3.1 Many different things are potential keys

As can be seen on the plate with the inventory number 147, Mr. E., a baker, born in 1896 in Belgium, is linked to a key made out of wire springs from a mattress. E. became a prisoner of war in Germany in 1916 and came to Switzerland due to an illness in 1917. Mr. E. was transferred from prison to Waldau at the end of June in 1917, after, according to his records, he had already tried to escape six times. The army doctor asked for prompt notification.³⁰ In Waldau, he was diagnosed with ‘epilepsy’. The psychiatric report was written on October 8 – at a time when the patient had already successfully escaped.³¹ In the patient record, Morgenthaler wrote:

Bolted last night around midnight in a quite ingenious way. Must have planned his escape for a long time, removed wire springs from the mattress & made duplicate keys, hid his clothes in the privy in the evening. Then said he had diarrhea & went

²⁹ Vismann writes: “Files can also be distinguished along the lines of how they act on specific legal regulations and institutions. The two basic forms in which files act are transmission and storage. In between there is room for several other actions, scriptural operations and record manipulations.” Vismann 2008, p. XIV.

³⁰ The military doctor wrote: „Ce jeune Belge ne semble pas pouvoir rester en place; il est à sa 5ème ou 6ème évasion et déclare lui-même vouloir s’évader de nouveau, s’il en a l’occasion. Il est donc indiqué de le mettre dans l’impossibilité de tenter une nouvelle évasion.” Copy of the interrogation protocol, in: Waldau, patient record no. 8067, p. 5.

³¹ According to the doctor’s expert report, it was probably the director of the clinic, Wilhelm von Speyr, who wrote: “As I have communicated via telegraph, E. was able to escape in a cunning way with the aid of a patient addicted to morphine in the night of September 25/26, even though he was closely watched. I, therefore, now send you the required report.” Supplement in: Waldau, patient record no. 8067, p. 1.

to the privy a few times, while a helper, the morphinist M., tried to keep the night guard busy, opened the window & lead himself down from the first floor using sheets twisted together. Was irritated during the last days, demanded his release, ranted, was threatening, but nevertheless worked on his Teneriffe lace.³²

The drafting of a profile closes the patient record of Mr. E. What remains are the wire springs. What can aid an escape is not only what one imagines to be a prototypical key, but also a wire spring which is used as a key. This example shows how attempts to escape by means of duplicate keys change our understanding of the furniture of an asylum. The material of the bed is no longer only the condition for a place to rest, but also the supplier of components for duplicate keys. The bed makes the key and thus the potential escape possible. Components of a normal patient bed are literally instrumentalised.

The already mentioned flatware is used similarly – for instance, spoons, which were already discussed in Faltlhauser’s textbook and constitute the source material for keys on some plates. Scholz thus demanded: “After every meal, knives and forks have to be counted.”³³ Faltlhauser, too, warned of further dangers: “The flatware, including the spoons have to be counted and stored carefully. A sick person may even do mischief with a broken spoon. He can swallow the spoon handle, he can turn it into a lock pick, or a weapon.”³⁴ Not only do objects appear in a new, suspicious light, but also the related work. The note that patient B. regularly helped with the dishes³⁵ makes clear that this activity also put him in the position of being close to the material source of new duplicate keys, and the patient record also provides information on exactly that: “Ten days ago, a dagger made out of a sharpened spoon handle a. a cudgel (enclosed) were found.”³⁶ Morgenthaler’s collection of duplicate keys thus materially exhibits the transformative potential of everyday objects from the clinic.

3.2 Keys and patient records lead through the clinic as a space

What the interior of clinics looked like can be gathered from construction plans and scattered photographs. However, in most cases the ways actors moved within them is not documented. For this, stories about keys provide an exceptional insight. Most escape routes aimed outside – there are, however, exceptions. Mr. B.,³⁷ for instance, used duplicate keys to break into the women’s section and steal dresses which he wanted to wear underneath his own clothes. And there is evidence that Mr. W., a former tailor’s apprentice with a penchant for animal abuse, who had been diagnosed with ‘dementia congenital’, broke into the staff room:

The next day, he [W.] sneaked into the room of the guards next to it with a quite skillfully self-made key; he “did not want to take a lot” from the guards, “only about one Fränkli [diminutive for Swiss Francs] or 2.” At first, he denied that he had made

³² Waldau, patient record no. 8067, p. 10, entry from September 26, 1917, my translation, (typewriting) signed with „mo“ by Walter Morgenthaler.

³³ Scholz 1900/1913, p. 105, my translation.

³⁴ Faltlhauser 1925, p. 56, my translation.

³⁵ Waldau, patient record no. 7507, p. 23, 27 and p. 28.

³⁶ Waldau, patient record no. 7507, p. 25, my translation.

³⁷ Waldau, patient record no. 7507. Keys primarily on plate with inventory no. 578.

the key; but then he admitted it, and also that he had made the one with which he had opened the door for pat. B[.] the night before.³⁸

Moreover, W. once disappeared from work in the fields and broke into the apartment of the director in the upper story of the clinic. There, he jumped from the bedroom down into the yard, remained unscathed, and apparently was delighted with his “successful prank”.³⁹

With regard to attempts to escape outside, the notes in the records allow the reader to participate in the transition of space, as in the record of Mr. V., a former hotelier diagnosed with ‘Dem. praec a. querulous paranoia’:

22. XII 17: “Escaped from the bedroom yesterday evening, when they went to bed: first covered the bed, left the clock in order to have the guards think that he was on the privy. With a key, he left the uppermost corridor, escaped out to the yard at the kitchen, tiptoed along the wall, saw a guard coming from the new building, when he wanted to change directions towards the forest, a. turned towards the main building, was outrun by the guard, fled into the garden in front of the men’s ward a. eventually hid in the privy of the Palin[?]building. There he was caught by the guards, was transferred to III.”⁴⁰

Through this description, the spatial arrangement of the clinic as well as its possible escape routes can be experienced from the inside. It is such excerpts from object stories which add a new inner perspective to traditional historical accounts of psychiatry. Analogous to Latour’s account of *The Berlin Key*, one can speak of a struggle⁴¹ for access or the attempt of denying escape – things as signs (the clock hung on the wall and pointed to the presence of the patient) and things which could act (the key made the escape from the corridor possible) as well as several guards, who ran, and the patient, Mr V., who moved through the monitored maze of the asylum and eventually ended up in another ward: all took part in this struggle.

3.3 Keys expand the functions of rooms and places

In clinics of this time, the bathroom has different meanings: First, a bath performs the transfer from the outside world into the asylum;⁴² second, a (continuous) bath served as a means to either calm or punish a patient.⁴³ With regard to duplicate keys, it is above all the two latter meanings that are of importance. In the bathroom, the patients were searched and after

³⁸ Waldau, patient record no.5892, entry from May 31, 1909, p. 11, my translation.

³⁹ Waldau, patient record no. 5892, entry from March, 20, 1919, p. 17, my translation.

⁴⁰ Waldau, patient record no.6812, entry from July 22, 1917, my translation.

⁴¹ Latour writes: „The Berlin key, the door and the concierge are engaged in a bitter struggle for control and access.“ Latour 1991, p. 18.

⁴² On the transfer of the patients, Scholz writes: “Once they have been led to the sick ward, every arrival is bathed; if he resists, even if reasoned with, the doctor is to be informed. Bathing does not only serve to *clean* the sick people, but also to *inspect* their body, to see if they for instance have wounds, rashes, bugs (hairy parts!), hernias etc. The *clothes*, too, are examined during the bath (valuables, weapons, bugs).” Scholz 1900/1913, p. 89, my translation. Italics are letterspaced in the original.

⁴³ Following an escape attempt, we can for instance find a note in the record of pat. J., saying “Came to the bath for the night.” Entry from September 2, 1922 in patient record no. 5682/7004, p. 21, my translation.

escape attempts, the doctors put them into continuous baths. An example for this is again a passage from the record of Mr. B.:

Guards lately presume that pat. has keys again, fellow patients reported B. had opened the faucet. Will be taken to the bathroom for a search today. We first find a three-sided key. Pat. again wears 2 chemises, one furnished with lace, about whose origin nothing is to be known.⁴⁴

In this case, the bathroom was not a place of therapy or penal custody, but a place of control and access to the body. With regard to Mr. B., two things were found: in addition to a three-sided key, the guards also found that he wore chemises. This circumstance seems to have confused the doctors for a long time – it, above all, makes clear that the doctors did not know how he came to possess these clothes. Thus, the bathroom was also the place of disclosure as well as new riddles.

3.4 In psychiatry, keys become apparent when they (do not) work

This thesis applies and it also does not. Openly, psychiatrists were disturbed by the noise of the staff's old set of keys. As discussed above, keys were noticed by psychiatrists, when they were disturbing. There was no place in 'modern' clinics for this overt symbol of power. The situation is, however, different with regard to duplicate keys, which became noticeable when they worked error-free, when they were made out of another thing like a spoon or a wire spring from a mattress or inconspicuous material like wood and used. This is how they eluded the controlling eyes of the employees. Hence, we can observe a reversal of Bill Brown's *Thing Theory*. When Brown writes: "We begin to confront the thingness of objects when they stop working for us",⁴⁵ it is the *non*-operability of a thing, which makes it noticeable. The problem of duplicate keys, however, was that their specific "thingness" remained unnoticed in day-to-day life, because they worked. Nurses and psychiatrists were unable to notice them – until an escape pointed to their existence. This applies to all objects which were used successfully, the ones with which male patients were able to break into the women's section and the ones with which dangerous patients were able to escape.⁴⁶ Through this, different relations between different actors and the objects also become apparent. While the (original) keys of nurses and doctors had to grant error-free access, duplicate keys were not supposed to be able to do this or supposed to do this even better. As far as possible, patients were supposed to be discouraged from producing such keys at all. The patients, in turn, tried to detract attention from the keys, while Morgenthaller's focus on these objects tried to contain their emergence and operability.

⁴⁴ Waldau, patient record no. 7507, entry from July 7, 1924, p. 27, my translation.

⁴⁵ Brown 2001, p. 4.

⁴⁶ The objects, which obviously do not work like the 'key' in the top left corner on plate no. 578, are an exception. In this case, only the (missing) record could tell us more. In comparison to other objects, it is, however, striking that there is a diagnosis ("Psychopath!") below the number – the key is thus pathologised.

3.5 Keys and patient records unveil collaborations

Opening files for each patient lead to a focus on individuals. The duplicate keys, however, show conspiratorial collaborations of patients. In this regard, Faltlhauser warned of “the possibility of a collective conspiracy”.⁴⁷ Morgenthauer simply noted: “A propensity for conspiracies is more frequent among these sick people [=the ones who constitute a public danger] than lunatics.”⁴⁸

In the record of Mr. B., we can find an example from Waldau:

Broke out of 260 with his buddy v. K[.] last night at 1. The two tied two sheets and a blanket together, attached them to a bed a. climbed down into yard IV. They wanted to steal shoes and clothes from fellow patients W[.] a. Sch[.] a. threatened with destruction when they wanted to make noise. In yard IV they looked for the wall to yard III on the corner of the house [?] v. K[.] was able to get over a. ran away, while B. got on top, but fell back into the yard and injured his l. foot.⁴⁹

In the record of v. K., a tailor diagnosed with ‘hypochondriac paranoia’, who spent four periods between 1902 and his death in 1919 in Waldau, one reads that he was out of prison for a month, but was transferred back from the prison in Langnau under suspicion of theft.⁵⁰ Already two years earlier, he apparently had attempted to escape together with another patient (Mr. St.), “this one reported that pat. had made a key, probably out of the sheet metal of an accordion; on that day, he was very excited, said now or never, he had just received wine for lunch from a guard (correct).”⁵¹ In addition to the collaboration of patients, the actions of the nurse are problematic in this case, since he supplied wine to a patient without being able to control the consequences.

3.6 Escape attempts with self-made duplicate keys leave psychiatry at a loss for an explanation

The plate with the number 147 (Fig. 4) includes an object by Mr. G whose record number was 6285.⁵² Mr. G. used to be a practicing doctor and had experience with prisons. At the age of 37, he was brought to Waldau for the first time due to paranoia, suicidal thoughts, and because he apparently heard voices and injected himself with a large dose of a morphine derivative. He entered the clinic voluntarily and was diagnosed with ‘catatonia’.⁵³ He stayed for

⁴⁷ Faltlhauser 1925, p. 85, my translation.

⁴⁸ Morgenthauer 1930, p. 189, my translation.

⁴⁹ Waldau, patient record no. 7507, entry from August 26 1917, p. 20f., my translation.

⁵⁰ Waldau, patient record no. 7406, entry from September 24 1917, p. 20, my translation. There is one key object by v. K. on the plate with the inventory no. 114. His further patient record numbers are: 5426, 6174, 6230.

⁵¹ Waldau, patient record no. 7406, entry from February 3, 1915, p. 18, my translation.

⁵² The record also has the number 6118, because Mr. G. was interned twice. The actual case history is 44 pages long. In addition, there is quantitative data.

⁵³ Diagnoses will be put in quotation marks, since they are contemporary attributions, which cannot be double-checked.

a half a year, was discharged, but interned again in the following year – subsequently he stayed until 1918, interrupted only by an attempted discharge, which failed.

His record reports that he worked as a bookbinder in the asylum, but was repeatedly in trouble with his fellow-patients or employees, resorted to violence, and was isolated in his cell. Following this, Mr. G. attempted to escape twice. The notes in his record show that due to such escapes, the employees came under pressure to offer an explanation if the patients did not offer an explanation themselves, for how such an undertaking was possible in the first place. While we can also read of errors by guards, it is above all their cluelessness which is noted: “How he opened this [window lock] is unclear.”⁵⁴ Later, the importance of patient accounts for psychiatric knowledge of the creation of duplicate keys and escapes is highlighted: “He does not want to tell us how he opened the window. Such precious secrets are not to be revealed.”⁵⁵ The object, which Morgenthaler preserved, was found in a search following an escape: “First he comes to the bathroom a. then back to his cell. When his clothing is examined, a metal [hook?] is found which the pt. seems to have let out of [the window?] on a string in order to unhinge the window hook.”⁵⁶

The story of Mr. G. has a tragic ending – after another escape, he took his own life. There is an urgency to protect a suicidal patient from actually committing suicide, which shows that keys and nursing staff were at the center of psychiatric attention. In this specific case, questions remained which the doctor noted:

This morning, the cell was found empty with the door locked three times a. the window bolted., the cap on the pillow. In the yard, a chair stood on a bench, a board leant against a wall. Proof that pat. escaped over the roof? Why was everything locked so accurately? Was he not even brought to his cell in the evening? The guards certainly deny this. It does, however, stand to reason.⁵⁷

Duplicate keys also point to the non-knowledge of the discipline at that time.⁵⁸ They generated uncertainty in the network of nurses-patient-key-doctor. As objects, duplicate keys governed observation practices and the psychiatric gaze as well as the modes of notation. This is also true for everything the object made possible. Duplicate keys cannot only open doors, but also lock them. What remained was a psychiatrist and his unanswered questions, only a chair on a bench could be used a clue.

In conclusion, it can be noted that in the same period in which nurses were increasingly professionalised in training courses, attention was increasingly devoted to objects. Good nursing staff needed to be able to correctly handle items like keys, as this would maintain the clinic’s control and power. Duplicate keys can serve to show that in addition to psychiatrists and nurses, other actors also acquired and used expert knowledge, namely the skillfully acting inmates. Keys thus not only decided who could open and lock doors, they also allow for a new

⁵⁴ Waldau, patient record no. 6285, p. 36, my translation.

⁵⁵ Waldau, patient record no. 6285, p. 42, my translation.

⁵⁶ Waldau, patient record no. 6285, entry from October 12, 1917, p. 42, my translation.

⁵⁷ Waldau, patient record no. 6285, entry from April 27 1918, p. 44, my translation.

⁵⁸ For the term ‘non-knowledge’, see Wernli 2012.

historicizing perspective on institutions. In the combined consideration of collected objects and records of actions as a psychiatric manifestation of the cultural technique writing, it becomes clear, how (duplicate) keys allowed for the experience of spatial arrangement and changed the function of spaces. Moreover, other objects in their function as material source as well as negligent nurses became suspicious due to keys. As everyday objects, keys have, moreover, already found their ways into metaphorical ways of speaking. There are ‘key figures’, ‘keywords’ as well as the ‘unlocking’ of secrets, which do not have to include a physical key.⁵⁹ How matter and metaphor interact becomes clear with reference to Morgenthaler’s collection. The collection brings together objects, which first may be perceived as signs because they refer to power – to quote Latour again. Second, the keys have a specific materiality, which is exhibited as such – the top view perspective is especially striking, which, for instance, obscures the three-sidedness of a key, but also aestheticizes the objects. Third, the keys are technical things, as it is often other items which are transformed and processed with recourse to knowledge of craftsmanship. Finally, the keys may act as an “intermediary”⁶⁰ by taking on an active role in a structure, for which Latour uses the metaphors “networks” and “chains of mediators”.⁶¹ Duplicate keys allowed patients to escape by opening doors, as *corpora delicti*, they convicted patients, and they deceived nurses and employees, when they were well-crafted. Once they were fixed to the plate, they instructed future nurses and turned the psychiatrist Morgenthaler into what he was: a teaching psychiatrist, an observing doctor, and a collector. Above all, these duplicate keys, however, give us access to an important part of the history of psychiatry, in the literal sense.

Martina Wernli (Dr), Institute for German Literature and Didactics, University of Frankfurt, Germany

4 List of Figures

Fig. 1, 2 and 6 out of Morgenthaler (1930): by courtesy of the Hogrefe Verlag Berne

Fig. 3: Sammlung Morgenthaler, Inv. Nr. 114 © Psychiatrie-Museum Berne

Fig. 4: Sammlung Morgenthaler, Inv. Nr. 147 © Psychiatrie-Museum Berne

Fig. 5: Sammlung Morgenthaler, Inv. Nr. 578 © Psychiatrie-Museum Berne

⁵⁹ Such metaphors can also be found in other languages. In French, ‘prendre la clef des champs’ refers to the escape object of an escape’. There are also more general usages of key metaphors like ‘mot-clé’ or ‘concept-clé’, which work similar to ‘Schlüsselbegriff’ or ‘parola chiave’. Due to lack of space, I will not be able to discuss literary keys, but want to call attention to Friedrich Glauser’s crime novel *In Matto’s Realm* (1936, English translation from 2005).

⁶⁰ Latour 1991, p. 18.

⁶¹ Latour 1991, p. 21.

5 Bibliography

- Artner, Lucia/Isabel Atzl/Anamaria Depner/André Heitmann-Möller/Carolin Kollwe (eds.): *Pflegedinge. Materialitäten in Pflege und Care*. Bielefeld 2017.
- Beretti, Michel/Armin Heusser (eds.): *Der letzte Kontinent. Bericht einer Reise zwischen Kunst und Wahn. Ein Bilder- und Lesebuch mit Materialien aus dem Waldau-Archiv*. Zürich 1997.
- Bersot, Henri: Statistik der Prüfungen des schweizerischen Irrenpflege-Personals von 1927–32. In: *Personal- und Anstaltsfragen. Beiträge zur Kranken- und Irrenpflege* (1933), 6.
- Braunschweig, Sabine: Die Entwicklung der Krankenpflege und der Psychiatriepflege in der Schweiz. In: Walter, Ilsemarie/Elisabeth Seidl/Vlastimil Kozol (eds.): *Wider die Geschichtslosigkeit der Pflege*. Wien 2004, pp. 113–122.
- Brown, Bill: *Thing Theory*. In: *Critical Inquiry* 28 (2001), 1: Things, p. 1–22.
- Falkenstein, Dorothe: „Ein guter Wärter ist das vorzüglichste Heilmittel...“. Zur Entwicklung der Irrenpflege vom Durchgangs- zum Ausbildungsberuf. Frankfurt a. M. 2000.
- Faltlhauser, Valentin: *Geisteskrankenpflege. Ein Lehr- und Handbuch zum Unterricht und Selbstunterricht für Irrenpfleger und zur Vorbereitung auf die Pflegerprüfung*. Halle a. d. Saale 1925.
- Hähner-Rombach (ed.): *Quellen zur Geschichte der Krankenpflege. Mit Einführungen und Kommentaren*. Frankfurt a. M. 2008.
- Kraepelin, Emil: *Memoirs*. Berlin et al. 1987.
- Latour, Bruno: The Berlin Key or How to Do things with Words. In: P.M. Graves-Brown Matter (ed.): *Materiality and Modern Culture*. London 1991, p. 10–21
- Luchsinger, Katrin (ed.): *Pläne: Werke aus psychiatrischen Kliniken in der Schweiz 1850 – 1920*. Zürich 2008.
- Luchsinger, Katrin: *Die Vergessenskurve. Werke aus psychiatrischen Kliniken in der Schweiz um 1900. Eine kulturanalytische Studie*. Zürich 2016.
- Majerus, Benoît: The Straitjacket, the Bed, and the Pill: Material Culture and Madness. In: Eghigian, Greg (ed.): *History of Madness and Mental Health*. London/New York 2017, pp. 263–276.
- Morgenthaler, Walter: Zur Ausbildung des Irrenpflegepersonals. In: *Schweizerische Aerztezeitung* 7 (1926), 52, pp. 456–457.
- Morgenthaler, Walter: *Die Pflege der Gemüts- und Geisteskranken. Im Auftrag der schweizerischen Gesellschaft für Psychiatrie*. Bern/Berlin 1930.
- Payk, Theo R.: *Psychiater und Psychotherapeuten. Berufsbilder in der medizinischen und psychologischen Heilkunde*. Stuttgart 2012.
- Scholz, Ludwig: *Leitfaden für Irrenpfleger*. Halle 1913.
- Schweikardt, Christoph: Berufliche Entwicklung der Krankenpflege in Deutschland, Österreich und der Schweiz im 19. und 20. Jahrhundert. In: Hähner-Rombach, Sylvelyn (ed.): *Quellen*

zur Geschichte der Krankenpflege. Mit Einführungen und Kommentaren. Frankfurt a. M. 2008, pp. 129–150.

Schweizerische Landesaustellung in Bern 1914. Fachberichte Band XIII. Zürich 1914.

Spoerri, Theodor: Identität von Abbildung und Abgebildetem in der Bildnerei der Geisteskranken. In: Documenta 5. Befragung der Realität. Bildwelten heute. Kassel 1972.

Vismann, Cornelia: Files. Law and Media Technology. Palo Alto, CA 2008.

Walter, Ilsemarie/Elisabeth Seidl/Vlastimil Kozol (eds.): Wider die Geschichtslosigkeit der Pflege. Wien 2004.

Wernli, Martina (ed.): Wissen und Nicht-Wissen in der Klinik. Dynamiken der Psychiatrie um 1900. Bielefeld 2012.

Wernli, Martina: Schreiben am Rand. Die ‚kantonale Irrenanstalt Waldau‘ und ihre Narrative (1895–1936). Bielefeld 2014.

Wernli, Martina: Key Stories: Walter Morgenthaler's Collection of Copies of Keys. In: Katrin Luchsinger/ Thomas Röske/ Helen Hirsch (eds.): Extraordinary! Unknown Works from Swiss Psychiatric Institution around 1900. (=Exhibition Catalogue in German and English) Zürich 2018, pp. 60–70 and 260–269.

The Quality of Time and Its Quantifications

Negotiations About the Feeding Tube at the End of Life

Jeannette Pols

Abstract

The measurement and calculations of quality of life have a huge impact on policy and treatment in Western countries and global health policies. The original motivation to develop these measurements was to bring in 'patient values'. However, it is far from clear what 'quality of life' comes to mean when it is quantified, and how it may correspond to things that patient value. In this paper I unravel what quantifications can and cannot make visible by ethnographically studying the different temporalities that are enfolded in different understandings of quality. To this end I analyse interviews and observations that relate how people with ALS who consider or live with a feeding tube encounter concerns with quality and temporality in their daily lives. I will show that the relevant temporalities change as qualities, rather than as quantities. Rather than 'gaining more time' by extending life through treatment, different types of times are added, fade away, or become lost. This can only be made visible through qualitative research.

1 Introduction

The measurement of quality of life has become a large-scale industry. Quality of life functions as an outcome measurement that is increasingly included in medical research. Quality of life outcomes are also used as a policy instrument to determine which treatments should be made available for patients. To this end, the expected extension of life is multiplied with a score that signifies quality of life, divided through the costs of a treatment. These QALY's (quality adjusted life years) are used in national policies and international studies that assess the 'Global Burden of Disease'.¹ These studies inform the funding and accessibility of treatments and shape health care policy nationally and globally. Next to its application in a medical context, various measurements of happiness and well-being are also used to 'take the temperature' of a nation or region outside the context of health concerns. This provides policy makers with instruments to detect and govern the wellbeing of the population.

The measurement and calculations of quality of life have a huge impact on policy and treatment in the Netherlands and other Western countries and global health policies.² All these calculations of quality are loosely linked by the aim to bring 'patient values' into the calculation to evaluate treatments. The history of quality of life measurements stems from oncology research.³ The quality of life measurements were a response to a too narrow focus on isolated medical outcomes, such as the decreased size of a tumor. The tumor could diminish spectacularly, but this may not show effects on patients' wellbeing. Patients may struggle with the effects of the treatment in daily life (e. g. fatigue, nausea, incapacity). Hence, attempts were made to include subjective experience into effect measurements – through objectifying it.

¹ See Moreira 2013. There is also the DALY, disability adjusted life years. This focuses on functioning rather than quality.

² Moreira 2013.

³ Willems 2010.

The desire for objectification, however, stands in sharp contrast to the murky understanding of what ‘quality of life’ could mean. Critics state that quality of life has become merely instrumental for the industry to sell particular treatments.⁴ Ways of defining quality in order to make it measurable, they claim, may not show any relation to people’s understandings of quality at all.⁵ In an earlier study we also found operationalisations of quality that were dubious or debatable. An example is quality understood as the impairment of (normal) functioning.⁶ Impairment of functioning may serve as an outcome measurement for the effect of a treatment concerning ‘health’ (one would not want treatments to lead to impairment of functioning), but it is dubious as a variable to measure quality. It assumes that the lives of people with disabilities and chronic disease are automatically of a lower quality than people who function ‘normally’, and belies the high scores on self-reported quality of life measurements by people with disabilities. This phenomenon became known as the ‘disability paradox’. Moreover, ‘functioning’ in these questionnaires is interpreted in terms of general physical impairment. They score if one is impaired to walk or not, rather than if one is able to, say, take one’s children to school. In this way, ‘functioning’ is detached from its relevance and value for daily life.⁷ In terms used by the World Health Organisation,⁸ the disability is ignored by foregrounding the impairment.

In our 2015 paper on quality of life we also argued that there are problems in approaching quality through modes of quantification.⁹ Such modes frame quality as general and generalizable outcomes that can be calculated, averaged, added up and subtracted as comparable scores. However, in the same study we saw that the distribution of values in a population could take the shape of nominal scales, establishing qualitative rather than quantitative differences (one person values X, whereas another is indifferent) rather than rational scales (one person values X more than another person). For instance, in the case of anticipating and living with feeding tubes, people with ALS would either see the aesthetic disruption of the body by the feeding tube as essential and ultimately unacceptable, or as a minor nuisance one just has to cope with. To add up and average these aesthetic values as an overall effect on a population would not make sense.

In the paper quoted, we made a start with unpacking the concept of quality of life and unravelling what quantifications can and cannot be made visible. In this paper I will continue with this extensive task by analysing the temporalities that are enfolded in different understandings of quality. This is one of the difficult puzzles for scientists who measure quality of life: people are not stable in their ratings of the quality of their life on questionnaires. Their

⁴ Hunt 1997.

⁵ Carr-Hill 1991; Carr/Higginson 2001.

⁶ An example is the EuroQol (EuroQol Group 2009) that establishes how well patients are functioning (‘I have no problems in walking about’).

⁷ See also Struhkamp et al. (2009), who compared the difference of quantified scores of ‘independence’ to the actual meaning of independence in daily life after spinal cord injury.

⁸ WHO 1980.

⁹ Pols/Limburg 2016.

responses to the same items tend to shift.¹⁰ It is unclear to the scientists whether these shifts refer to measurement errors, a change in peoples' values, or to something else. By qualitatively exploring the different temporalities at stake, I hope to shed more light on the phenomenon of 'quality', both as an attribute and valuation of daily life practices, as well as on the possibility of measuring it.

1.1 Empirical Ethics

I develop my analysis from the material semiotic approach of empirical ethics.¹¹ Empirical Ethics empirically studies values, or 'forms of the good',¹² that emerge in practices through the relationships between people, words and technologies. Hence, values are not predefined, but the analysis aims to uncover how forms of the good take shape in care practices and in the research practices that influence them. These goods may be as varied as tastes, norms, technological directives, regulations, research methods and daily activities.

Crucially, empirical ethics studies analyse how orientations toward some form of the good in practice are the result of the interactions between values dispersed over different actors. By closely analysing how the different human and non-human actors engage in care activities, it is possible to reconstruct what they take to be the problem that needs to be addressed, how they distribute the work among each other, and thus enact particular values. Comparing these to intended values may show interesting gaps. For example, in earlier studies we found that telecare technologies aimed at enhancing patients' autonomy through self-management could lead to increased professional control and patient passivity.¹³ This was not because the device dictated this, but because it emerged as a result of the relationships that developed between the professionals, patients and the technology. Such analyses lead to contextualised accounts where values can be seen to lead to particular effects. These may be compared to other situations to see what might fit there. Hence, the kind of normative 'recommendations' are not shrouded by principles, but by the actual workings of values in concrete situations.

1.2 New Nursing Studies

This discussion is relevant for nursing studies. With the academisation of nursing studies, as with medicine more generally, Evidence Based Nursing (EBN) has gained pride of place (see for instance the journal with the same title), next to a respectable tradition of qualitative research approaches. For EBN research, the randomized clinical trial and similar designs are adopted to study nursing interventions. Nurses are taught to collect 'evidence', so that they can ground their interventions on a solid knowledge base. However, this line of inquiry

¹⁰ Response shift is taken to be a shift in values (see the debate about this: Sprangers/Schwarz 2010; Ubel, Peeters/Smith 2010; Eton 2010). In our paper we could see that it can also be a shift in situations and real problems.

¹¹ Pols 2013a, b; Pols 2015; Sharon 2017; Willems and Pols 2010; Mol 2010; Thygesen and Moser 2010.

¹² Thévenot 2001.

¹³ Pols 2012, Ch 4.

struggles to capture the situatedness, processual nature and variety that is characteristic of nursing practices.¹⁴ Quantitative research aims to make generalizable claims on ‘what works’ in nursing care. It does not provide the tools to explore the variety of normative orientations in nursing practices. The recently proclaimed ‘new nursing studies’¹⁵ links to the qualitative research lines in nursing studies, with the aim to do just that: to analyse (historical) practices of nursing, including their materialities and values. By conducting theoretically informed ethnographic studies in nursing practices and in practices of nursing research, questions may be asked that are pertinent to these practices. This should lead to research that is useful to improve care practices,¹⁶ as well as to a critical exploration of what particular research methods can and cannot make visible.¹⁷

Studies on quality of life and its temporality fit this agenda because they show how quality and temporality become linked in attempts to both a) measure and quantify what is of value to patients and their families, and b) how ethnographic studies make these values visible. What can both methods, quantitative and qualitative, teach about quality and temporality, in a way that is relevant to nursing practices?

2 The Cases

My main case is the lives of people in the Netherlands suffering from ALS and PSMA (progressive spinal muscular atrophy). We studied these patients’ considerations for obtaining a feeding tube, and their experiences with living with a feeding tube over a period of time. ALS (in which we from now on include PSMA) is a severe progressive motor neurone disease. Because of the degeneration of nerve tissue that instructs the voluntary muscles, patients are progressively unable to move and the muscles waste away. The course of the disease is generally devastating: 50% of patients die from ALS within three years of diagnosis; most patients are dead after five years.

A feeding tube (gastrostomy) involves piercing the stomach wall to insert a plastic tube into the stomach. Fluid nutrition can be fed through the tube, either manually with a syringe, or through a motor-propelled drip. There are several methods for tube placement.¹⁸ In the hospital where we did the study, PEG (percutaneous endoscopic gastrostomy) was the most common procedure, as it is elsewhere. With PEG insertion, the patient has to swallow a scope that illuminates the stomach from within and the stomach wall is pierced from the inside out,

¹⁴ Ceci et al. 2017; Pols 2012.

¹⁵ New nursing studies are a specific type of care studies that are inspired by empirical ethics in care. Empirical ethics studies values and their workings empirically, before suggesting what is good to do, and for what reasons. See for instance: Pols 2015; 2017; Willems/Pols 2010, Mol 2010; 2008; Mol/Moser/Pols 2010. The study of practices aims to bridge the gap between the social sciences that study stories, narratives, culture, and meaning, and the life sciences, that study bodies, nature and materiality. At the time of writing the ‘Care Practices Research Network’ brings together this work. <https://www.ualberta.ca/Nursing/research/research-units/care-practice-research-network> (accessed February 2019).

¹⁶ Mol 2006; Moser 2010.

¹⁷ Pols 2012, Ch 8.

¹⁸ See Stavroulakis et al. 2013 for a clear description.

thereby minimizing potential damage to blood vessels. PEG can only be performed when patients have sufficient lung capacity and do not depend on breathing devices. PEG placement is done by a specialist, the gastroenterologist, who in our study was associated with the ALS team and knew the patients from earlier consultations on ways of dealing with dysphagia (swallowing problems due to the weakness of the tongue and mastication muscles). When a patients do not meet the requirements for PEG but can lie on their back, the radiologist inserts the tube: a procedure known as RIG (radiologically inserted gastrostomy). With RIG insertion, the stomach is inflated with air and the stomach wall is pierced from the outside. The diameter of the tube is smaller than for PEG, the tube is fixed less stably, and the wound needs to be stitched, increasing the risk of infection. The radiologist does not know the patient and this is one reason why PEG is preferred in the hospital where we conducted our study. The reasoning here is that as talking becomes difficult for the patient, and their body has lost much of its strength, a familiar doctor enhances communication and feelings of safety and trust (interview with the gastroenterologist).

We will build on the analysis made in Pols/Limburg quoted above,¹⁹ which identified different ways of understanding the feeding tube in patients' lives. It became a different object over time, for example, it could turn from a scary symbol of deterioration into a life saver. These different identities related to different variables, such as the presence of informal carers or not, the stage and character of the disease, or the particular values the patients either cherished or regarded with disinterest or dismay. The rapid progression and varied courses of the disease made time a prominent feature in the patients' stories. The identity of the feeding tube fluctuated over time. In this paper I am interested in these temporalities. These should be seen within a very particular and challenging temporality: the idea of a life ending.

For our study Sarah Limburg and I interviewed patients whom we met through the ALS Tertiary Care Centre in the academic hospital in the urbanized region of the Netherlands, through the ALS Stichting Nederland (a national funding agency for research into ALS), through social media and through personal connections. The theoretical design of the study aimed to find patients in different stages of relating to the feeding tube, varying from anticipation to experienced use. We interviewed 11 ALS patients anticipating (3) or living with a feeding tube (8) or at both times (2). In total we recorded and/or transcribed 15 new interviews for this study. We collaborated closely with our colleague who worked with the same patient group for her study on advanced care planning.²⁰ We do not quote the latter material here, but it gave us background to test our findings.

Interviewing ALS patients took particular patience from both the interviewed and the interviewer, as muscle weakening made talking difficult for informants. Partners and children supported the interviewee by explaining things to the interviewer. Some informants used a speech computer. Others could not speak at all, and delivered their story to us in writing or through the spouse. According to Dutch law and research codes we did not need the approval of an ethics committee for this study, but with this particularly vulnerable patient group we

¹⁹ Pols/Limburg 2016.

²⁰ Seeber 2016, which gave us extra material on 28 people with ALS.

took special care to let people know they could always opt out of an interview or cancel an appointment, which they sometimes did. We carefully anonymized the material.

We also interviewed the professionals in the hospital who at different points in time has been concerned with tube feeding the gastroenterologist, the neurologist concerned with diagnosing ALS patients, the nurse specialized in coaching patients with feeding tubes, and the rehabilitation doctor, who was the central carer for ALS patients and our main point of contact. The rehabilitation doctor helped us to approach patients by handing out our information letter to them. If patients wished to volunteer to participate, they could tell the doctor or nurse, who would then give us their contact details. We discussed our results with the rehabilitation doctor to check our findings and interpretations. When possible, we observed patients using the feeding tube and consultations about this, or asked them detailed questions about using it, turning the patients into ethnographers of their own situation.

Next to the ALS study I use some insights gained about temporality from interviews with palliative oncology care patients in a rural hospital in the North of the Netherlands.²¹ I was studying a telecare device they were using, to learn if it led to an improvement of their care. The device is used to support patients in the period of life when they are being treated palliatively, and know they will not get better. The telecare device is a white box with a screen and every day patients receive a list of questions that they answer by pressing buttons. There is an extensive check of symptoms, followed by questions on psychosocial wellbeing, spiritual questions on coping with imminent death, information about diet, and so on. The session ends with a 'quote of the day', offering wisdom borrowed from classic and popular philosophers. These patients revealed some interesting temporalities they encountered while facing the end of their lives. I visited 16 patients at their home, and interviewed 14 of them. 6 of the interviews also included their partner, who were sometimes key users of the device. One of the team of 4 oncology nurses was my central informant at the hospital, and I spoke to her several times. I was also present at project group meetings.

2.1 Quality

Much like we did in the first paper on quality and in the discussion on quality of life as a way to bring in patient values, I use quality, and also temporality, as 'loose concepts' to guide the analysis.²² Quality refers to a characteristic in life (a certain state of the world, or presence of certain features, as with qualitative research that denotes a type of research rather than an appreciation) and the normative understanding of this quality (quality as something good, the way it is often used in everyday language). Temporality refers to both time as it is experienced and narrated by patients and their loved ones, but also to quantified and objectified forms of time, such as linear clock time. As the reader will see, the various understandings of time in specific situations do not 'add up' to a coherent picture or theory on time, but form a colourful

²¹ Pols 2012, Ch 2.

²² A loose concept is a concept that is to be empirically substantiated in order to get more precise meanings (Pols 2015).

bouquet. It forms a first exploration of what quality related to time might mean when studying it ethnographically, both in patient's practices, as well as in quantitative research.

Our earlier analysis of the feeding tube²³ was motivated by the lack of knowledge about what the feeding tube meant to patients. To the clinicians it was clear that patients did not like the feeding tube at all, were reluctant to think about it, and postponed its placement as long as they possibly could. Biomedical studies attempted to measure the effects of the tube on quality of life, and also on nutritional status and survival, but these studies were indecisive; no effect on quality of life could be established.²⁴ Through our ethnographic study we showed that the reason for this was the extreme heterogeneity of the patient group, the variation in local treatment regimens, the impact of contextual factors, and the changing identity of the tube over time. State of the art randomized clinical trials could not be performed for ethical reasons. The prominence of time, in the rapidly progressing condition of the patients as well as in their valuating of the feeding tube, lead to the questions of this paper. What temporalities are relevant to quality of life as we can observe it ethnographically, and hear in the stories people tell? How can we think about the relation between quality and temporality, and what does this imply for attempts to quantify quality of life in general terms?

2.2 A Time for Living

The specific temporality of the QALY measure will serve as an entry point. The QALY corrects calendar time according to the quality of this time. If one has, say, 5 years to live, but only with severe treatments that reduce quality, the number of 5 (for the years) can be corrected with a factor between 1 (full health) and zero (death). Hypothetically, there can be a minus score for a situation that is 'worse than being dead', but I have never seen this being reported in medical research. Quality here is related to a temporality that is marked by a clear start (the intervention) and endpoint: the end of biological life. The quality of this time is framed as stable once the intervention takes effect. It is one score that stands for a stable outcome, effect or end result of a particular treatment. Transient inconveniences of the treatment and fluctuations are hence not represented in the outcomes, unless repeated over time. This focus on end results fits with a general orientation of medical research that studies interventions that cure particular conditions.²⁵ A relatively short period of suffering from the administration of the treatment is bracketed to establish the eventual outcome, which would be 'a return to health', or a loss of quality when this is not achieved. This framing and shaping of quality fits less well with chronic or terminal conditions, for which different temporalities are at stake. The disease cannot be cured and will stay with the patients, who will eventually deteriorate rather than regain 'health'. They will persistently need support and treatment, which increases these interventions' impact on people's lives and substantially changes its quality.²⁶

²³ Pols/Limburg 2016.

²⁴ Benatar/Katzberg 2011; Langmore et al. 2006.

²⁵ Weisz (2014) calls this the infection model of disease.

²⁶ See Pols (2013).

3 The End of Life

The first ethnographically observed temporality related to the ALS patients' quality of daily life resembles the temporality built into the QALY measurements in some ways. It is the temporality that emerges when people get their diagnosis and realise that their life will end prematurely. As a nurse in palliative care once explained to me: 'We are all immortal, until we get a life-threatening disease.' This means that we generally live without a clear sense of an ending. We all know that life has an ending, and some actively desire for this ending to come. In general, however, it is not a type of knowledge that is relevant to our daily activities, nor is it in the foreground when we plan our lives.

This idea of a final ending and people's neglect or lack of understanding of this is food for thoughts for existentialists and phenomenologists. They write about Death as the Eternal Black Nothingness and negation of life. We can only tolerate this by showing 'bad faith', i.e. through denying this truth.²⁷ We negate nothingness. However, the patients to whom we talked, who were confronted with a near ending of their lives, had to be much more pragmatic about life's ending. Rather than denying death, they had to, somehow, live with a shortened life expectancy.²⁸

As Seeber et al. show,²⁹ for the ALS patients this meant, first of all, a concern for this new life span or a first consideration of lives' temporality. After recovering from the initial shock, they generally wanted to learn first about the way they would die.³⁰ They discussed and organised will statements with their general practitioners, in which they formulated their wishes for (non-) resuscitation, palliative sedation, or situations in which they would opt for euthanasia if suffering would become unbearable.³¹

The relevant temporality here is, much like that of the QALY, one's total life span. This life span emerged at the time of diagnosis, and made patients' lives acquire an ending that was closer than anticipated. It demanded new perspectives and planning. Interestingly, an anticipation of living with a feeding tube was not part of this temporality. Living with a feeding tube was so repulsive to patients that they used the proverbial mantra 'If I have reached that stage [to need a feeding tube], I'd rather be dead'. At that point in time they saw the feeding tube as a symbol of a gruesome and unacceptable deterioration. At the time of diagnosis and directly after, the feeding tube represented a life that is not worth living. The quality of a time to live

²⁷ See for example Nolan (2011), who discusses the work of existentialist Gabriël Marcel and Sartre (2001).

²⁸ One of the oncology patients in palliative care said to me: "It is a gradual difference. We all die, I may go a bit earlier than you. That is, if you are not run over by a bus. But for both of us it is unclear *when* we will go. So it is not all that different." Future time is hard to predict.

²⁹ Seeber et al. 2015.

³⁰ Seeber et al. 2015.

³¹ Seeber et al. 2015. This is a possibility in the Netherlands. Veldink et al. (2002) show that 17% of ALS patients use the possibility for euthanasia in a late state of the disease. It was clear to all participants that these were provisory determinations, and the rehabilitation doctor warned people that they might change their ideas along the way and that this was perfectly fine; Seeber et al. 2016.

with a feeding tube was a time they did not want, and they did not want to consider it. It was bad enough to consider an early death.

Here we already see a difference with the quantifiable QALY-time (calendar time corrected for quality): a perspective that includes a life that is ending in the near future is in itself a change of the quality of that life (as it has gained an ending). When this 'life with an ending' can be lived in an acceptable way, this could be thought of as a life of good quality. However, the time in between diagnosis and death differs from the QALY-time. The patients did not see it as a time that is corrected for sadness, and stable thereafter. They also did not anticipate deterioration and 'reduced functioning' that will inevitably follow. The 'in between' time had yet to emerge. It was not there at the time of diagnosis and in the concerns for the last parts of life. It only emerged by living it.

3.1 The Time of Getting Through the Day

There was another temporality in this anticipation of life's ending. This was the temporality of life each day. I first learned this from the oncology patients in palliative care. They were brave enough or found it inevitable to consider their approaching death, and some even anticipated and organized their funeral when they were still fit.

Mrs Veronica: I'd looked at the questions [on the screen of the telecare device] with a friend, and she told me later that she found it puts you in confrontation with reality so terribly. It said so clearly: you won't get better, asking questions like 'How do you see this, how do you deal with that, and are you sad about that?' She thought that was making you face unwanted facts. But I said to her: 'Yes, but I have this disease. And I live with it.' So, to me, it's very different. I know I can't get better. They're doing lots to slow down the disease. But they can't stop it. So you know what the situation is. This is the way it is, I don't have a choice. I have to take it from there.

Dying became part of living, but the patients insisted they could not and did not want to do this 24 hours a day. They could not be dying persons for the whole day. They could take a certain amount of time to consider the end of their life and what came with that. But they also needed time to live life on a daily basis. Mr Jansen worked in a shop and his customers were very concerned about his condition.

Mr Jansen: They [the customers] constantly wanted to know what was going on, how you are, really, right down to the bone. But if you tell that story 10, 20, 30 times a day, you get sick of being ill. That's really heavy, psychologically speaking. So I said: 'If you want to visit a patient, come when I'm in hospital having chemo.' With a tube stuck into my hand, me lying flat out on a bed, a nurse in the vicinity. Then I'm sick. Not on other days. Outside the hospital I don't want to be confronted with this. Then it'd rule your life. I don't want to be just someone sick. That's not how I want to live my life. [...] [About the telecare device]: It makes you aware of certain things. Have I got fever, did I throw up, have I weighed myself? I always do what the [telecare device] tells me to do. It says: 'Did you step on the scales today?'

so I go to the scales and check my weight. I do the questions, and when I am done with the [device] for the day, I concentrate on the rest of my day.

Mr Jansen pointed to the temporal intensity or duration of being confronted with his fatal disease. When using the device he remarked that it took him 5 minutes a day to answer the questions, and that was just enough time for death. 'Living' the patients explained, consisted of the small things of everyday life. They wanted to be involved in how their children were getting on at school, the colour of the new curtains, and to have a cup of coffee and a chat with the neighbour. They valued things more, because they knew they would end.

Mrs Franken: Well you see, we say: he is not in pain, and that is great. Because you often hear about people who are always in pain, and that is awful. And, well, we are here, and we live here so beautifully. And then he is pottering about outside, fiddling in the garden. That is really wonderful. You can complain 'we cannot go on holidays anymore!' But well, just look at what you still have. It is a lot.

Important relationships and moments of intimacy were cherished by the patients and their families, showing a remarkable appreciation of life. Rather than devising 'bucket lists' of great things still to achieve, they became more aware of the 'small events' and relationships they valued and enjoyed. The time scale here was that of everyday life. Mr. Jansen separated a small part of the day for dying by using clock time, but the rest of the time in the day related to many small pleasures, as well as neutralities and necessities such as brushing one's teeth or getting dressed. It is the more fluid time of getting up in the morning and getting through the day. It is the here-and-now-time. It is lived, but little reflected upon.

3.2 Every Day Time and Swallowing

This every day time also emerged in the life of people with ALS when it concerned their problems with swallowing, and hence, with eating. When swallowing became difficult due to decreasing muscle power, patients became more and more occupied with the activity of making food move from their mouth to their stomach. Even if doable at first, the task could slowly become an obsession, taking several hours in the day. Patients also worried about weight loss and there was the real danger of an inflammation of the lungs when food strayed and got stuck there. This could mean intensive care treatment and a near ending of life.

Partner: Eating was very difficult, and it took a lot of time.

Jenita: I was busy eating the whole day.

Partner: And obsessively, eh, because it is also a fight against losing weight. It was really tense. And now, with the feeding tube, she wins lots of time and energy that does not go into eating and worrying about food. She eats soup, custard, whipped cream, all the things she really likes. And it's no longer the main thing, or a necessity.

Obsessive eating had an abstract temporality. There was no discrete point in time in which it could be pinpointed as 'too much'. Limits slid all the time anyway, slowly, as bodies changed. It was hard to establish when 'enough was enough' and the feeding tube could be considered

as a solution rather than a threat. The rehabilitation doctor would keep an eye on this relative time of weight loss, as a gate keeper. But until a limit was recognized, time was fluid. It was not clearly evaluated for 'quality', in a positive or a negative sense. Things were as they unfolded, they emerged slowly as events that came with the disease. Not as things to act upon to change life for the better.

This fluid temporality changed when concerned doctors or spouses intervened, or when swallowing problems became acute problems for the patients. This happened when people experienced choking on their food. Difficulties swallowing meant that food could get stuck in the oesophagus. The lack of muscle power and lung capacity made it difficult to cough, which caused people to have near-death experiences or the real risk of dying. This choking caused a lot of immediate fear and extended anxiety. One of our informants even dubbed this 'swallowing anxiety' as if it were a diagnosis in itself ('slikangst'). Time lost its fluidity here and closed in on the patients. There was a problem *now* and they were confronted with the need for acting on it soon. The fluid everyday time was breached by a discrete urgency. At this point the feeding tube could solve a problem the patients did not have before, one which they were anxious to get rid of.³²

Interviewer: Can you tell me what happened to make you need a feeding tube?

Mr Klaasen: I had problems swallowing, and I choked. And eating took a very long time... One month, two months ago, eating dinner took the whole evening. I couldn't swallow food. So that's why, really. [...] And then it takes you more than an hour to eat. It takes so much energy. And you leave lots of food on your plate, because you give up trying. So then I lost weight, I was underfed. And I lost more and more weight. So at a certain moment... We have a very good doctor and she wanted to do it [the placement] before she retired. So we had to think about it a lot, before we accepted the feeding tube.

Interviewer: What did you have to think about?

Mr Klaasen: Well, of course, the fact that you have such a thing in your stomach wall!

Mrs Klaasen: Yes, you considered the down side, eh? But then, this explanation [by the doctor], that was really nice. She told us everything about it. And then we knew it just had to be done. We [the family] decided immediately. But Hans [Klaasen] said: I don't want it. So we took a leaflet home, deliberated, considered. That was Wednesday. And then, the other day, [to husband:] you choked terribly, [to interviewer:] he chokes every day, but this time we thought: "This is the end". And the boys [sons] were there and we said to Hans: "What do you want? Do you want

³² This is not a shift in values or responses, but in problems and needs. It is a change of the situation, not a shift in response (Pols & Limburg 2016). For people with a bulbar onset of complaints, their trouble started with swallowing. For them, the trajectory was different, as they took into account that the feeding tube would give them more time to do things they found important.

to choke?" And then he said: "You've convinced me." And he sent an email on Friday, straight away. [To Hans:] And you even looked forward to it!

At this point Mr Klaasen submitted to a treatment which he had not wanted to consider before. Suddenly, the quality of his life, in the normative sense, breached the fluidity of everyday time and things that are-as-they-are. The feeding tube held promise to improve this.

3.3 A Time for the Tube

The placement procedure for the feeding tube was as bad as patients had feared it to be. It implied hospitalization, which in turn meant being away from the supportive technologies that had started to fill their homes. They felt helpless, with bodies they were unable to move and control. Many had difficulties breathing, and none of the patients considered the placement to be a 'minor intervention', as the literature labels it (from the perspective of the doctors and the technical procedure).³³ Their time in the hospital for the placement was a time to endure, but they also understood it as being of limited duration and serving the larger aim of choke prevention, which enabled them to continue with the intervention.

Mr Frederiks: I was afraid of the operation. They, well, they move into your body. I had to think about that! And yes, it is another thing on your body. And it was exhausting, also because the nurses didn't know my devices. So I had to explain all the time [while speaking was difficult and cost a lot of energy]. And I noticed my hands had deteriorated. So that was very demanding.

After this bad time there came a bifurcation in temporalities and qualities. Having solved the immediate problem of choking, the feeding tube could lead to an improved life, or it could lead to a change of the type of misery to endure. With respect to improved life, what the patients gained with the feeding tube we could dub 'quality time'. Instead of having to be occupied with feeding oneself through the mouth, one way in which the new quality time could be spent was, paradoxically, by enjoying eating again. There were, however, limits to what the patients could swallow. Too liquid fluids were difficult. When thickened, they could be swallowed, even though this did not work for all fluids. Many patients regretted that they could no longer taste coffee. One of our informants told us he had found a way to experience some taste of coffee, by inserting coffee through the feeding tube with enough air to produce a 'burp with coffee taste'. This would certainly sit uneasily with standards of decency of most patients, but shows creative ways in which people could regain the taste of food and the pleasure of tasting things. Where tasting and calories had become separated with the loss of taste, tasting was regained with the loss of worries about calories.

Mrs Velds: You really like yoghurt, Greek yoghurt. And we put fruit in it, a mashed banana, that's what we did.

³³ Hossein et al. (2011); Mazzini et al. (1995).

Mr Velds: Or a mergpijpje [a meringue coated in marzipan and chocolate] every now and then.

Mrs Velds: [laughs] Yes, a mergpijpje, something sweet, he likes that. It's soft.

Mr Velds: And yesterday we had chicken tandoori.

Mrs Velds: Yes, just for the taste. We mashed it, really crushed it because the bits of it are really hard. But he likes it anyway, so we put a little on his plate with something.

Mr Velds: With asparagus, yes. [laughs]

Interviewer: Also mashed?

Mrs Velds: Yes, yes! [...] And now and then an alcohol-free lager, or just a beer. Like yesterday.

Mr Velds: Two! [smiles broadly. Mrs Velds and interviewer laugh too]

Clearly the couple had great pleasure in helping Mr Velds re-enjoy the taste of food. The feeding tube made patients gain time to eat what they enjoyed, even if it could not restore all affective relations to food. Eating out for instance, eventually became too much of a burden. It was one more quality to be crossed off the list of possible activities.

The temporality of this quality time here is a relative temporality; it is changing a (bad) time of obsessively absorbing calories with a good time for tasting and eating as an enjoyable activity. This was a gain if eating had always been a pleasure for the person. Some people, in contrast, thought that not having to eat meant 'good riddance'. No need to spend time on what one does not enjoy. And this points to the second way in which the feeding tube could lead to quality time: if one had the possibility to do things one enjoyed, the feeding tube could change time for obsessive eating into time used for activities to enjoy.

Gastroenterologist: The tube does not give quality of life in the sense that it cures a patient, because they cannot be cured. The only quality it gives is that people say that they did not enjoy the social aspects of eating so much, 'because it takes me hours to eat, my food gets cold'. Well, we give them plate-warmers, we do everything possible to facilitate eating. But at a certain point people say: 'Oh, I'm so tired of it.' I had one patient, he was an artist, a painter, who because of his ALS could only draw dots. He'd go to the zoo, and he would make dots with his pencil, make drawings just out of dots. And he said to me: "Thanks to the tube I have won so many hours in a day. I have only a couple of hours in the day when I am fit enough to draw my dots. Before, I used those hours for eating, and now I don't have to do that anymore!"

The example shows that the feeding tube might allow for positive characteristics that do not in themselves relate to the tube, but are facilitated by it. Then the tube is not a positive characteristic in itself. It delivered 'free time'. Patients had to find out what they could do with the time won by obtaining a tube.

3.4 Changing Bad Times for Bad Times

The example of the artist who gained time for enjoyable expression, is in sharp contrast to the bad time gained by others. Mr Gonders had to administer fluid food constantly, because his stomach could not bear too much fluid at a time.

Interviewer: Is there anything else you'd like to mention about the tube?

Mrs Gonders: well, if I may say this for him, the worst was that he couldn't move. When he had to go to the loo for instance. First he had to detach the power cord for the motor of the feeding drip. Then the oxygen... he could take the oxygen with him. And then he had to bring the whole circus with him. He couldn't just get up to get something, or go to the door when somebody rung the bell, or to go to the toilet. He couldn't do this, and this put him totally in the doldrums. Not going to the computer, or moving to the table, because it was so much fuss!

Mr Gonders was shackled by his drip machine. Even if he was physically able to walk, he could not do it easily because of the machines attached to him. He could not do the things that he liked. Other informants said this could also involve time spent waiting for the nurse to come to switch bags of fluid food. A lack of possibilities to do other things, or a lack of possibilities to do things one could enjoy, could make the life of ALS patients with a feeding tube miserable again. Rather than working to stuff oneself with calories through the mouth, which was caught in the fluid temporality of everyday life, their life turned into a life fixed to the motor drip with their eyes on the clock ticking, wasting time away. In this bad quality time, the everyday time changed into a time of emptiness. It promised no pleasurable events but turned the everyday into a time devoid of order, activities and meaning.

3.5 The Last Bit of Time

A last temporality I would like to discuss returns to the QALY-time in the sense that it relates a discrete linear calendar time to an ending. This is the retrospectively observed time of patients who had opted for the feeding tube, when it turned out they only survived after the placement for 3 months. Here, a calculation between quality and length of life seems to be in order. The difficulty patients experienced with the placement procedure, as well as their bad condition, could be compensated for by the extra time won (if there was any), that may or may not get filled with meaningful activities. Yet there is again a fluidity, a tragic one: who may predict the time of dying? In the really terminal stages this may be more obvious. In the time span of 3 months, the end is apparently hard to foretell. We have not spoken to these patients, or we do not know if some of the patients we talked to died. It was a group of patients we could only identify through the literature.³⁴

³⁴ See for instance the study by Stavroulakis and colleagues (2013), quoted in Pols/Limburg (2016): 27 patients volunteered to be interviewed about their tube three months after placement. Five of them died before the interview could be conducted, and the condition of eight patients had deteriorated so severely that they had to withdraw. Nearly half of the patients dropped out within three months after placement.

4 Discussion

In the analysis of temporalities and their relation to quality, it became clear quality may not always be about time, but that time is indeed always about quality. At first it was a temporality that related to an idea of a life span, much like a QALY that connects people with a total span of life left. But, unlike the QALY, for the patients contemplating this time, there was no 'in between' time to consider yet. The in-between temporalities only became palpable later.

Then there was the bad time of the feeding tube placement. This could be a relatively short time to endure, and gained in significance when the end was near. Once this bad time ended, everyday temporalities became important again: the time of getting through the day, filled with some preparations for dying, but which mostly pertained to the everyday trivialities and (small) pleasures that made up daily life. Matters of brushing one's teeth were important next to concerns about 'what life is all about' or what one really values. This everyday life time was characterized by a fluid 'this is how it is', of fiddling with food, of concerns with homecare nurses who might prepare a sandwich for lunch, or who were only allowed to feed the patient ready-made food. It is a fluid temporality of what has to be done on a day. As one's action radius for 'larger' assignments diminished, such as going to school or work, these smaller things became the things that 'living' was all about, and where life could gain its quality. Quality here was not so much about what can be done, but about if and how things could be done.

This fluid every day temporality stopped when a 'big issue' emerged that needed immediate evaluation and action: the fear of choking on food. Then time would solidify and become dense. Action was demanded at short notice. Due to its acuteness, this was not always related to the time one would gain by the placement of a tube. To some, the time gained was quality time for tasting, eating and other enjoyable activities. For others a dense time for troublesome eating and occasional choking was swapped for the endless emptiness of waiting for the next administration of fluid food to take place. Finally, there was a return to the QALY-like time when death approached. In this final phase, however, the time of ending was not of a phenomenological nature, as patients did not experience it. It could only be established retrospectively. Yet it is relevant for clinical care, as a short survival period may not outweigh the cost of the placement procedure.

A last temporality to consider when regarding these different temporalities is their 'addition'. Contrary to the addition of abstract numbers, the addition of temporalities and qualities in daily life is one of fractures, discontinuities and partial connections. There are different times to live, but they do not add up to a 'whole' or a clear linear time with a beginning and an ending. The different temporalities are folded into one another. For example, the lived time of the total life span may encompass every day times, but not automatically. Meanwhile, 'the total life span' also changed shape, depending on the closeness of the ending or the nearness of this ending as the patients experienced it.

The relevant temporalities change as qualities, rather than as quantities. Foregrounding one temporality rather than another re-sets, so to speak, the axes within which time gets its meaning. This may not be measurable at all. Rather than 'gaining more time' by extending life through treatment, different times are added, fade away, or become lost. These complex and discontinuous temporalities that are so strongly related to quality make a general

quantification difficult. As temporalities fluctuate, the ‘effect’ of the tube could vary from the bad times of hospitalization and being tied to the motor drip, to finding time to spend on reading books or making art. Rather than one stable ‘average’ quality factor or QALY-time, different temporalities are gained and lost. One way of capturing these fluctuations in temporalities would be to repeatedly measure them. Yet these repeated measurements cannot capture the different qualities related to time and the differences for different people. One cannot add up Mrs Jansen’s bad time of hospitalization with Mr Franken’s good time of being able to potter about in the garden. The temporality of a ‘total life span’ interferes with the temporality of everyday-ness.

5 Finale: Nursing Nudies

What does this analysis teach for nursing studies? Our ethnographic analysis does not show obvious generalisations, except to say that for every person different temporalities fluctuate in different ways. It is a generalization that insists on particularity. Yet the foregrounding of the situatedness of findings does other, more interesting things.

First, the findings can be made clinically relevant. The analysis shows what kind of concerns might emerge around the complex situation of anticipating a feeding tube. It shows why and when patients are reluctant to think about it. It also shows what are the relevant questions to ask when the question about tube placement becomes pertinent. Is the time won by the feeding tube quality time for the patient? And if not, how may that change the prospect of having a tube placed at all? Patients and clinicians may learn from the situated lessons learned by others, and they may exchange ‘tips and tricks’ (‘How to go to the beach with a feeding tube without getting stared at?’). Where guidelines may suggest a general applicability to any case at hand, such an analysis demands explication of what can be learned from specific situations. How may the specificities of a case differ from the situation I am involved in with this patient? The work to analyse what can be transported from one situation to another and what needs adaptation is explicitly demanded, it asks for a comparison of specificities.³⁵ In this way, there is much more to say about feeding tubes to patients other than: ‘there is no evidence that it influences quality of life’.³⁶ It invites us to explore what quality and temporality mean in their particular situations.

Second, a commitment to the situatedness of treatment procedures and effects opens up new areas for research, by paying close attention to everyday practices of (nursing) research. It shows how methods, quantifications and conceptualizations make some things visible and others invisible. Scientific methods are not mirrors of nature, but tools that co-shape the object of inquiry. In the case of quality and temporality it showed that common quantifications

³⁵ These specificities are often missing in quantitative studies, where ‘the intervention’ is often briefly described in the methods section. For new technologies, for example, this black boxes the way these technologies transform practices and are used in ways nobody had expected (see Pols 2012).

³⁶ A friend pointed out that the general ‘reassurance’ that ‘this treatment enhances quality of life!’ did not mean much anyway in the situation where she was engaged with thinking about an intrusive cancer treatment for her partner. That still would not answer the question if it might help her partner or not, and how.

of quality, such as the QALY, imply certain assumptions about relevant temporalities and qualities that hide many temporal complexities in daily life. It hence also questioned the relevance of these quantifications for clinical practice, while simultaneously providing insight in the processes pertinent in a life with ALS in relation to feeding tubes. Also, such studies provide building blocks for further studies on 'big concepts' like quality and temporality. This in turn may provide interesting theoretical lenses to the study of practices. A worthy challenge for nursing studies indeed!

Jeannette Pols, Socrates Professor for Social Theory, Humanism & Materialities, Department of Anthropology, Section of Medical Ethics, University of Amsterdam Medical Centre, The Netherlands

6 Biography

- Albrecht, Gary L/Devlieger, Patrick J: The Disability Paradox: High Quality of Life Against All Odds. In: Social Science & Medicine 48 (1999), pp. 977-988.
- Carr, Alison J/Higginson, Irene J: Measuring Quality of Life: Are Quality of Life Measures Patient Centred? In: BMJ: British Medical Journal 322 (2001), p. 1357.
- Carr-Hill, Roy A: Allocating Resources to Health Care: Is the QALY (Quality Adjusted Life Year) a Technical Solution to a Political Problem? In: International Journal of Health Services 21 (1991), pp. 351-363.
- Ceci, Christine/Pols, Jeannette /Purkis, Mary Ellen: Chapter Two: Privileging Practices: Manifesto for "New Nursing Studies". In: Critical Approaches in Nursing Theory and Nursing Research: Implications for Nursing Practice 14 (2017), p. 51.
- Eton, David T: Why We Need Response Shift: An Appeal to Functionalism. In: Quality of Life Research 19 (2010), pp. 929-930.
- Hosseini, Somi Mohammad/ Leili, Maghbouli/Hosseini, Antikchi Mohammad: Acceptability and Outcomes of Percutaneous Endoscopic Gastrostomy (PEG) Tube Placement and Patient Quality of Life. In: Turk Journal of Gastroenterology 22 (2011), pp. 128-133.
- Hunt, Sonja: Quality of Life Claims in Trials of Anti-Hypertensive Therapy. In: Quality of Life Research 6 (1997), 6: 0. <https://doi.org/10.1023/A:1026498318938>
- Katzberg, Hans Dieter/Benatar, Michael: Enteral Tube Feeding for Amyotrophic Lateral Sclerosis/Motor Neuron Disease. Cochrane Database of Systematic Reviews 2011, Issue 1. Art. No.: CD004030. DOI: 10.1002/14651858.CD004030.pub3.
- Langmore, Susan E/Kasarskis, Edward J/Manca, Maria Laura /Olney, Richard K: Enteral Tube Feeding for Amyotrophic Lateral Sclerosis, Motor Neuron Disease. In: Cochrane Database Syst Rev 4 (2006), DOI: 10.1002/14651858.CD004030.pub3
- Mazzini, L/ Corra, T/ Zaccala, M/ Mora, G/ Del Piano, M/ Galante, M: Percutaneous Endoscopic Gastrostomy and Enteral Nutrition in Amyotrophic Lateral Sclerosis. In: Journal of Neurology 242 (1995), pp. 695-698.

- Mol, Annemarie: Proving or Improving: on Health Care Research as a Form of Self-Reflection. In: Qualitative Health Research 16 (2006), pp. 405-414.
- Mol, Annemarie: The Logic of Care: Health and the Problem of Patient Choice. London 2008.
- Mol, Annemarie: Care and its Values. Good Food in the Nursing Home. In: Mol, A., Moser, I and Pols (eds) Care in Practice: On Tinkering in Clinics, Homes and Farms (2010), pp. 215-34.
- Mol, A., Moser, I and Pols (eds) Care in Practice: On Tinkering in Clinics, Homes and Farms Bielefeld 2010.
- Mol, Annemarie/Moser, Ingunn/ Piras, Enrico Maria/Turrini, Mauro/ Pols, Jeannette/Zanutto, Alberto: Care in Practice. On Normativity, Concepts, and Boundaries. In: TECNOSCIENZA: Italian Journal of Science & Technology Studies 2 (2011), pp. 73-86.
- Moreira, Tiago: The Transformation of Contemporary Health Care: The Market, the Laboratory, and the Forum. London 2013.
- Moser, Ingunn: Perhaps Tears Should not Be Counted but Wiped Away: On Quality and Improvement in Dementia Care. In: Mol, A. Moser, I and Pols, J. (eds) Care in Practice: On Tinkering in Clinics, Homes and Farms. Bielefeld 2010, pp. 277-300.
- Nolan, Steve: Spiritual Care at the End of Life: The Chaplain as a 'Hopeful Presence'. London, Philadelphia 2011.
- Pols, Jeannette: Care at a Distance: On the Closeness of Technology. Amsterdam 2012.
- Pols, Jeannette: The Chronification of Illness. In: An empirical Ethics in Care (2013). www.oratiereeks.nl.
- Pols, Jeannette, & Limburg, Sarah. A Matter of Taste? Quality of Life in Day-to-Day Living with ALS and a Feeding Tube. In: Culture, Medicine and Psychiatry, 40 (2016), pp. 361-382. <http://doi.org/10.1007/s11013-015-9479-y>
- Pols, Jeannette: Good Relations with Technology: Empirical Ethics and Aesthetics in Care. In: Nursing Philosophy 18 (2017) 1, E12-154 DOI: [10.1111/nup.12154](https://doi.org/10.1111/nup.12154)
- Pols, Jeannette: Towards an Empirical Ethics in Care: Relations with Technologies in Health Care Medicine, Health Care and Philosophy, 18 (2015), 1, pp. 81-90.
- Sartre, Jean-Paul: Being and Nothingness: An Essay on Phenomenological Ontology. London 1958 (1969).
- Seeber, Antje A/ Pols, A Jeannette/ Hijdra, Albert/ Grupstra, Hepke F/ Willems, Dick L/De Visser, Marianne: Experiences and Reflections of Patients with Motor Neuron Disease on Breaking the News in a Two-Tiered Appointment: A Qualitative Study. In: BMJ Supportive & Palliative Care Online First 2 february (2016), [bmjcare-2015-000977](https://doi.org/10.1136/bmjspcare-2015-000977).
- Sharon, Tamar.: Self-Tracking for Health and the Quantified Self: Re-Articulating Autonomy, Solidarity, and Authenticity in an Age of Personalized Healthcare. In: Philosophy & Technology, 30 (2017), 1, pp. 93-121.

- Sprangers, Mirjam/Schwartz, Carolyn E: Do not Throw out the Baby with the Bath Water: Build on Current Approaches to Realize Conceptual Clarity. Response to Ubel, Peeters, and Smith. In: *Quality of Life Research* 19 (2010), pp. 477-479.
- Stavroulakis, Theocharis/ Walsh, Theresa/ Shaw, Pamela J/Mcdermott, Christopher J: Gastrostomy Use in Motor Neurone Disease (MND): A Review, Meta-Analysis and Survey of Current Practice. In: *Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration* 14 (2013), pp. 96-104.
- Struhkamp, Rita/ Mol, Annemarie/Swierstra, Tsjalling: Dealing with Independence: Doctoring in Physical Rehabilitation Practice. In: *Science, Technology, & Human Values* 34 (2009), pp. 55-76.
- Thévenot, L. "Pragmatic Regimes Governing the Engagement with the World". In T. R. Schatzki, K. Knorr-Cetina & E. von Savigny (Eds.), *The practice turn in contemporary theory*. London 2005, pp. 56-73
- Routledge, 2001. Thygesen, Hilde/Moser, Ingunn. : Technology and Good Dementia Care: An Argument for an Ethics-in-Practice Approach. *New Technologies and Emerging Spaces of Care*. Farnham 2010, pp. 129-147.
- Ubel, Peter A/ Peeters, Yvette/Smith, Dylan: Abandoning the Language of "Response Shift": a Plea for Conceptual Clarity in Distinguishing Scale Recalibration from True Changes in Quality of Life. In: *Quality of Life Research* 19 (2010), pp. 465-471.
- Veldink, Jan H/ Wokke, John HJ/Van Der Wal, Gerrit/ Vianney De Jong, JMB/Van Den Berg, Leonard H: Euthanasia and Physician-Assisted Suicide Among Patients with Amyotrophic Lateral Sclerosis in the Netherlands. In: *New England Journal of Medicine* 346 (2002), pp. 1638-1644.
- Weisz, George: *Chronic Disease in the Twentieth Century: A History*. Baltimore, John Hopkins University Press 2014.
- Willems, Dick: Quality of life: Measure or Listen. A Reflection for Disability Studies. In: *Medische Antropologie*, 22 (2010), 2, pp. 289-91.
- Willems, Dick: Varieties of Goodness in High-Tech Home Care. In: Mol, A, Moser, I, and Pols, J. (eds) *Care in Practice: On Tinkering in Clinics, Homes and Farms* (2010), pp. 257-276.
- Willems, Dick/Pols, Jeannette: Goodness! The Empirical Turn in Health Care Ethics. In: *Issues* 1 (2010), p. 1.
- World Health Organisation: *International Classification of Impairments, Disabilities, and Handicaps: A Manual of Classification Relating to the Consequences of Disease*, Published in Accordance with Resolution WHA29. 35 of the Twenty-ninth World Health Assembly, May 1976 (1980).

European Nursing Traditions and Global Experiences

An Entangled History

Susanne Kreutzer

Abstract

The article draws on the currently intense debate on a transnationally conceived history and discusses the specificity of a European history of nursing. Using deaconess motherhouses as an example the article reveals that nursing organisations, nursing concepts and practices in Europe developed mutually in transnational exchanges. To analyse these, comparative approaches and also approaches from transfer and entangled history are required. An entangled history of nursing can address the mutual exchange processes and illustrate how similarities developed in the various countries, despite the differences. European nursing traditions can thus also be made visible as shared traditions which evolved in exchange with non-European countries. With regard to ethical questions we can show on the one hand the establishment of common value systems and explain on the other hand that these must be interpreted differently depending on the region, time and context. The article illustrates furthermore, that a European nursing history can question well-kept hegemonic discourses on the history of nursing – informed by US-American norms of secular-professional standards. A decidedly European perspective will therefore make the history of nursing more complex and contradictory but also significantly more interesting in many respects.

1 Introduction

Beginning in the 1980s, the history of nursing has been very strongly promoted in North America, mainly in the US. The first professional organisations, departments and journals for nursing history were founded here and have dominated the research area internationally for a long time. If scholars working on European nursing traditions wanted to be understood in this context, they had to adapt their analysis to the norms of secular-professional nursing of the colleagues working in the US. Thus, US nursing history was in danger of becoming the standard against which everything else in a teleological perspective could be classified as progressive or regressive. Changing this imbalance was an important goal for nursing historians from various European countries when they came together in 2012 to found the European Association for the History of Nursing.

Yet, what exactly could be regarded as a European history of nursing? Since the 1990s, history as a discipline has been increasingly pursuing this question regarding the specificity of a European self-understanding – as it were as concomitant research alongside the European unification process. This highly funded search for the European illustrates, however, that the recourse to a European identity that has evolved over time is extremely difficult. Even as an idea Europe only seems to exist as the diversity of its concepts and the self-description as a “European” is just one of many identity-building narratives.¹ Arnd Bauernkämper suggested to understand Europe as a space of action, experience and discourse with flexible borders that constitutes and repeatedly reconstitutes transgressive entanglements and mutual delimitation processes at the same time.² This methodological understanding of Europe based on social practice is the framework of the following reflections on a European history of nursing.

¹ Arndt/Häberlen/Reinecke 2011, p. 26; Raphael 2012.

² Bauernkämper 2011.

The project for a European Nursing History and the exchange between nursing historians between various European countries is still at an early stage.³ For that reason a systematic overview of European nursing traditions cannot be provided. Due to the disparate state of research it makes little sense to introduce selected countries or regions to analyse similarities and differences. While there are many interesting studies on various aspects of nursing history, comparative studies from other countries are missing which would allow a substantial comparison. The question of how the different developments in the European countries can be characterised and explained has rarely been asked in the context of nursing history.

For that reason, the focus of the following article will be on another aspect: Even though Europe is characterised by a large number of different nursing traditions, these did not develop independently of each other. In the nineteenth century nurses were closely transnationally linked. Sioban Nelson has provided an impressive study in this regard that investigated Anglo-American countries of the nineteenth century.⁴

Drawing on the considerations on networks within the nursing history of the nineteenth and twentieth century, this article contributes to the currently intense debate on a transnationally conceived history that has been negotiated under various terms.⁵ Transnational history describes a border-crossing historiography that can be conceptualised as comparative history, transfer history, or interwoven history. While a comparative history requires separate objects of investigation that either hardly influence each other or not at all, transfer research emphasises the “movement of people, material objects, concepts and cultural sign systems”⁶ as well as their modification and adaptation during the transition from one cultural context to another. These transfer processes can also be analysed as a simple transfer into one direction.

Interwoven history that has been named *histoire croisée*, shared history or entangled history is interested in the wide range of mutual interconnections between cultures and societies. While the *histoire croisée* is situated more within a European context, shared history or entangled history focus in particular on the close links between European and non-European societies.⁷ The temporarily hardened fronts between comparative, transfer and interwoven history have been by now resolved and made space for the insight that comparisons can usually not take place without transfers and interconnections and vice versa.⁸

Subsequently this article similarly argues that a European history of nursing must consist of multiple elements – comparison, transfer and interplay – that can be weighted differently depending on the subject matter and topic. Entangled history must be particularly emphasised in this regard to make clear that a European history of nursing does not end at the (already flexible) borders of Europe. That a European nursing history must also be written as an entangled history is illustrated through the Iberian-American Federation for the History of Nursing that was founded in 2009 by nursing historians from Spain, Portugal and Brazil.⁹ Due to the large research gaps within transnational nursing history such connections can only be sketched out with some initial findings. The following article aims at providing ideas for further

³ Rafferty 2014.

⁴ Nelson 2001.

⁵ Budde 2006; Conrad 2007; Kaelble 1998 and 1999; Kaelble/Schriewer 2003; Osterhammel 2008; cf. also the articles in *H-Soz-and-Kult-Forum* on “Transnational History”.

⁶ Middell 2000, p. 18.

⁷ Conrad/Randeria 2013; Werner/Zimmermann 2002 and 2006.

⁸ Arndt/Häberlen/Reinecke 2011; Bauernkämper 2011.

⁹ Oguisso/de Freitas 2015.

discussion about research perspectives, research questions and methodological approaches to a European history of nursing.

2 The History of Nursing as Entangled History

The central protagonists of an entangled history of nursing are denominational nurses – Catholic congregations and Protestant deaconesses. There are many implications that suggest that nurses – just like missionaries – were one of the professional groups that were most intertwined in the 19th century.¹⁰ Often departing from France, Catholic nurses settled in many European and non-European countries. During the 1880s in England, more than half of the Apostolic Congregations had come from France, others had moved from Belgium, Ireland, Italy, Germany, the Netherlands and Austria. Pure English branches were a minority.¹¹

What happens then when nursing organisations and the concepts of nursing that they represent begin to wander around? The Mother General of a congregation which was originally French but had settled in England commented on this question as follows:

„you will go forth and pitch our tents from one end of the earth to the other ... As for me, I do not wish any longer to be called French: I am Italian, English, German, Spanish; I am American, African, Indian.“¹²

The panache with which the Mother Superior claims that national identities are dissipated through transfer processes is impressive. Yet, some doubts are in order. Does a French order not remain French to a certain degree, even if it moves to England or does it really become English? What does each scenario actually mean? In each case an adaptation to the new national context would be necessary. Because of these adaptation processes communities of nurses are an excellent focal point for an international comparative history and a history of transfers. Simultaneously, only the transfer – that is the contact with the new culture – enables us to see what the specifics of French or English nursing traditions had been.¹³

The transnational history of the associations of nurses (Sisterhoods) is also highly relevant from a nursing ethical point of view because the women became experts in the cultural exchange and helped shape the relationships between intra-European and European and non-European societies. Their history clearly reveals that dealings with the “strange other” and questions of an intercultural ethics of nursing have a long tradition.¹⁴

In the following, the cultural encounters in the field of nursing will be addressed using the example of deaconesses – the Protestant counterpart to the Catholic congregations. Thus there is a nursing organisation at the centre that was founded in the 1830s in Germany, but was subsequently exported to many European and non-European countries. This method is only one of many options to approach a European history of nursing. The shift of the geographical and/or time focus for instance of French congregations of the premodern period would result in a different sort of picture.

¹⁰ Habermas 2008, p. 641.

¹¹ O'Brien 1997, p. 154–156.

¹² Euphrasia Pelletier, cited after O'Brien 1997, p. 159.

¹³ Habermas 2008, p. 660.

¹⁴ Coors/Grützmann/Peters 2014.

2.1 Deaconesses as Protagonists of an Entangled History of Nursing

The first deaconess motherhouse was founded in 1836 by the pastor Theodor Fliedner in Kaiserswerth near Düsseldorf. From the beginning this was not a genuinely German project because before founding the deaconess motherhouse Fliedner did what all leading protagonists of Christian welfare did in the 19th century: He went on a “social tour,” a journey through the Netherlands and England that not only served to raise funds but also to study the structures of Christian charity services. Intrigued, he noticed that in the countries he visited, very often women, driven by their Christian faith, committed themselves to social issues. Fliedner wanted to build something similar in Prussia after his return. Another model for him were the Catholic Sisters of Mercy – originally a French order that had been founded as early as the 17th century. The founding of the deaconess motherhouse in Kaiserswerth was thus a transnationally linked building process during which Fliedner borrowed widely from neighbouring European countries.¹⁵ In reverse, Kaiserswerth later developed into an internationally popular travel destination that protagonists of Christian welfare from numerous countries visited and that helped shape their ideas and concepts.

Like the Catholic congregations the deaconess motherhouses were based on a simple exchange principle: The young women received thorough training and the security of lifelong provision for retirement, if they in return were willing to dedicate their life completely to the service of charity. The motherhouse sent the deaconesses to work in hospitals and parishes to serve there, mainly in the impoverished areas, as “local missionaries.” Nursing was thus a major part of the Inner Mission. This concept was based on the idea that both poverty and disease were mainly caused by a lack of faith.¹⁶

For that reason, the deaconesses had to address not only the physical but also the spiritual well-being of the patients. In the 19th century, deaconesses proceeded to action with the well-meaning intention of rescuing the patients by leading them to salvation. At times they were quite vehement in their evangelisation. Towards the end of the 19th century these practices were increasingly criticised as “spiritual bombardments.” In the 20th century the targeted evangelisation at sickbeds gradually lost in meaning. Nonetheless, the basic idea that the care for the physical and spiritual well-being are inextricably linked remained. For the deaconesses this union of physical and spiritual care was central to their understanding of their task as nurses and it shaped the history of nursing in Germany until the second half of the 20th century.¹⁷

The Christian concept of disease as both a physical and spiritual event secured a very high position for the deaconesses within the health care system. Physicians and nurses were seen as professions that complemented each other. While the starting point for the physicians was the symptoms of the disease which they diagnosed and for which they found a treatment, for the nurses the whole personality of the patient was of professional interest. In particular, care for the soul was the domain of the nurses in which doctors had no authority. Considering the historical everyday practice of Christian nursing, the image of the nurse who was always obedient and subservient to the doctor quickly dissolves.

¹⁵ Habermas 2008, p. 655; Köser 2006, pp. 55–60 and pp. 86–87.

¹⁶ Nolte 2016, p. 74.

¹⁷ Kreutzer/Nolte 2010.

In the context of Protestant health care, the high status of nursing had another quite obvious reason, in that the institutions had usually been established by communities of deaconesses in the 19th century. Hence, the sisterhoods owned the hospitals. Until the second half of the 20th century, physicians had no chance to make a claim to leadership.¹⁸

An example for the quite impressive power of persuasion the deaconesses displayed was in 1907/08 when one of the big names in the history of surgery in Germany – Ferdinand Sauerbruch – applied for the position of head physician at the hospital in Kaiserswerth, which was led by deaconesses. From a professional point of view, he was probably the first choice. However, he was not hired for a simple reason, in that the condition for employment was a letter of recommendation by a deaconess and he was unable to produce that. Even the best university certificates were merely one criterion among others. The good evaluation by a deaconess who confirmed the personal qualities of the doctor and – very importantly – his ability to work well in a team was the most important document.¹⁹ There are also similar examples for the time after World War II. Until well into the 1950s, the “love for the sisterhood” – the ability to work co-operatively with the nursing staff – was one of the central selection criteria in hospitals run by deaconesses in West Germany when they hired doctors.²⁰

The model of the deaconess motherhouse became one of the German “export hits” of the 19th century. There were two versions of this: Firstly, the motherhouses sent their sisters not only to places within Germany but also, as part of the External Mission, to many other countries. In this case the sisters remained members of their motherhouse in Germany but worked far away in hospitals or parishes abroad. At times, subsidiaries of the motherhouses were founded in these countries, including hospitals and numerous training facilities. Already in the second half of the 19th century, deaconesses from Kaiserswerth worked in Italy, in Florence, Rome and San Remo, but also in Jerusalem, Constantinople, Smyrna, Bucharest, Beirut, Alexandria and Cairo.²¹

Secondly, in many other countries institutions for deaconesses were founded that followed the model of Kaiserswerth. These deaconess motherhouses were not subsidiaries of a German house but independent institutions. At times, the initiative for founding these institutions came from the German motherhouses directly. In general, however, these institutions were built by the women on site following the Kaiserswerth model. What follows reviews both versions of the transfer.²²

2.2 Deaconesses in the Outer Mission

The involvement of German deaconesses abroad has been studied particularly for the motherhouse in Kaiserswerth, although studies on the history of nursing and ethics in the numerous different areas of work are still to come. The questions of whom the deaconesses took care of, how they adapted their understanding of caring for both body and soul to the new cultural contexts, what kind of ethical conflicts emerged and how the deaconesses and their

¹⁸ Schmuhl 2003.

¹⁹ Dross 2008, p. 177.

²⁰ Kreutzer 2014, pp. 90–91.

²¹ Kaminsky 2010, p. 14 and pp. 27–36.

²² Cf. also the anthology on the transfer history of the deaconesses, Kreutzer/Nolte 2016.

patients dealt with them, have so far not been investigated. The current studies on the deaconesses working abroad paint a heterogeneous picture.

Most of the recent studies assume that the deaconesses' sites abroad were conceptualised as a kind of "Germany abroad".²³ The argument is that the deaconesses were mainly responsible for the care of German citizens and not for the so-called "Gentile mission" in the respective countries.²⁴ In Italy the deaconesses were supposed to mainly provide the nursing care of German protestant parishes and not push the conversion of the largely Catholic population. In San Remo the main target group of the deaconesses were Germans who would fall ill during their holidays on the Riviera. Similarly, in other foreign stations the work of the deaconesses was closely linked to the local German communities.²⁵

Apart from German citizens, the deaconesses abroad took care of affluent local patients and international clients mainly, for example members of the English embassy. For that reason, the nurses' relationship to the local population was presumably rather selective. The deaconesses from Kaiserswerth were much less available for the impoverished parts of the population than intended. Thus, they departed from the ideal of a deaconess that the motherhouse preached and that they were to represent.²⁶

However, there are also counterexamples: The Moravian deaconesses in Jerusalem cared mainly for Muslim patients with leprosy from different social backgrounds. While the conversion of Muslims was strictly forbidden in the Ottoman Empire the deaconesses tried nonetheless to assert their Christian influence. They read to the patients from the New Testament, taught them Christian songs and tried to motivate them to attend the Sunday service – though with very little success.²⁷ Especially when caring for dying or severely ill patients it seems unlikely that the deaconesses ignored their task to care for the soul, since they regarded the conversion to the Christian faith as an essential prerequisite for a blissful death.²⁸ The example of the Moravian deaconesses illustrates that the activities of the deaconesses in the Outer Mission were not limited to the German enclaves. The sisters gained experiences as nurses of patients with different cultural and religious influences and it would indeed be worthwhile to reconstruct these as part of a history of intercultural nursing.

In addition, as studies on social missions internationally reveal, the nurses were supposed to take care of white Europeans mainly at the beginning. However, this changed in many places when the devastating effects of colonialism – such as the results of urbanisation and labour migration – on the local population and its health became apparent. Even if one goal was to protect one's own European population on site, a Public Health Programme for the local population was established to protect it from problems that had only arisen through colonisation.

²³ Lissner 2005, p. 243.

²⁴ In the German-speaking Protestant missionary unmarried women such as deaconesses were only hesitatingly sent to do missionary service. Specific missionary orders for women were founded from the middle of the 19th century particularly in the Catholic church. At the beginning of the 20th century they formed the largest group of women in the missionary service. Cf. Gugglberger 2014, p. 35.

²⁵ Kaminsky 2016, p. 14 and pp. 27–36.

²⁶ Lissner 2005, pp. 254–256.

²⁷ Wexler 2016, pp. 101–107; Löffler 2011. In her study on deaconesses working as teachers in Beirut Hauser emphasises that one should not underestimate the missionary character of their work. Cf. Hauser 2014.

²⁸ Nolte 2016, p. 205.

²⁹ Nurses played a central role in the worldwide endeavour to push forward Western standards of hygiene, nursing, and medicine.

Numerous references to questions of culturally sensitive ethics of nursing could be evoked here, which address not only culturally different concepts of illness and nursing and their negotiation in power-bearing relationships, but would also take transnational, ethical issues of social justice into account. How did the sisters manage divergent understandings of health, illness, the body, pain, the process of dying and death and different boundaries of shame and practices of personal hygiene? What kind of values were embedded in these? How and with what degree of success did they attempt to enforce their self-understandings? How did their perspective of the “foreign” change – both due to the duration of their stay abroad and the course of history? The established principles of medical ethics claim universal validity even though they have to be interpreted depending on the context and the situation.³⁰ An ethically oriented entangled history of nursing could result in a better understanding of how this claim was put into practice historically, which conflicts it entailed, and which role nurses played in this context.

2.3 Working Abroad and the Communities of Deaconesses

At the foreign posts the rules and regulations of service applied which the motherhouse in Kaiserswerth had established. The deaconesses were requested not to mingle outside their own circles. This is one of the reasons why the sisters were sent abroad without sufficient knowledge of the language. This way the new local community of deaconesses was supposed to get stronger as was their connection to the motherhouse. The principals in Kaiserswerth sought to stay in close contact with the deaconesses abroad by implementing both a detailed and regulated reporting system and by regular personal visits.³¹

In the course of the 19th century, the motherhouse in Kaiserswerth was able to create a tight international network, as the deaconesses' descriptions of their journeys reveal.³² While the sisters usually travelled by themselves to their posts, which was still highly unusual for women at the beginning of the 20th century, they were then met and supported by supporters of the motherhouse system or fellow deaconesses at the harbours or train stations they passed during their journey.³³

Despite the wide network the influence of the motherhouse abroad was limited. During an oral history project with deaconesses from Kaiserswerth that took place from 2001 to 2004, many sisters remembered a new freedom and an increase in status and responsibility at the stations abroad. So far away from the motherhouse, the superiors of the stations in particular were able to establish their own centres of power. Yet, many of the nurses who were interviewed also reported that they had felt overwhelmed in the new situation, especially because

²⁹ Schweig 2012, pp. 93–101; Sweet/Hawkins 2015, pp. 4–6.

³⁰ Beauchamp/Childress 2013, pp. 17–19 and Coors 2014, pp. 9–10.

³¹ Hauser 2011; Köser 2006, pp. 300–302; Lissner 2005, pp. 249–252 and pp. 259–264. On the deaconesses of the Moravian Church in Jerusalem cf. Wexler 2016.

³² This was also true for the secular nurses who were sent to the German colonies. In contrast to other migrants of the time, nurses did not follow other family members who had travelled ahead but had their own dedicated networks available because of their profession and gender. Cf. Schweig 2012, p. 14, see also: Loosen 2014, pp. 98–132.

³³ Köser 2006, p. 474.

none of the women had learned the respective language – as previously mentioned. The desperate attempts to make do with little notes in the pocket of the apron and with learning vocabulary at night were an integral part of the biographical narrations of the deaconesses.³⁴

Even more difficult than departing from the home country and arriving in a new one seems to have been the return to the old structures of the motherhouse with which the deaconesses struggled after their long years of absence. During the Oral History Interviews they reported that in Kaiserswerth it was not welcome when they shared their new experiences and increased knowledge. At times the returning deaconesses were explicitly prohibited from talking about their experiences abroad. Apparently, the deaconesses who had stayed home were to learn as little as possible about the temptations of a different life. The Kaiserswerth institution thus tried to ignore the experiences the sisters had had abroad to avoid changing its own profile.³⁵

However, the ability to work abroad still had repercussions on the community of deaconesses in Germany. Foreign assignments became particularly powerful for the motherhouses with regard to the public. They were effectively used in numerous publications and, since the 1920s, also in advertisements and commercials. The principals emphasised again and again the broad sphere of activity and the internationality of the deaconesses' work. The nurses' work in Jerusalem – the central place of the Christian tradition and the "land of the bible" – was particularly prestigious. The commitment abroad the Kaiserswerthian deaconesses showed boosted both the population's willingness to donate money and the attraction of becoming a deaconess among women in Germany. Becoming a deaconess was one of the few options for women to travel to foreign countries. The prospect of working abroad, in particular in Palestine, was quite an efficient advertisement.³⁶

The internal life of the community was also affected by the service abroad. The first deaconesses that began to write down their story during the nineteenth century were so-called "Sisters of the Orient". They had worked in the countries of the Levante and proudly reported on their professional performances, their adventures, dangers and tests they had to master abroad. They created female heroes of deaconship who broke with the image of the quiet and modest Sister who subordinated herself in the community.³⁷

In addition, the internationalisation of labour not only put the deaconesses abroad under new pressure, but also the deaconesses in leading roles in Germany required new qualifications. Thus, in 1913, the newly appointed Mother Superior in Kaiserswerth, Elisabeth von Buttlar, spoke English, French and Italian. She had gained these language skills during her 14-yearlong appointment as Matron in Rome and Cairo. This way, the image of a German Mother Superior changed, meaning that at least in Kaiserswerth she represented a sense of cosmopolitanism.³⁸ Hence the work the deaconesses performed in other European and non-European countries contributed to changing the community of deaconesses in Germany.

These repercussions illustrate the importance of considering a European history of nursing also as an interwoven history. The deaconesses did not only transfer their understanding of nurses into other cultural contexts but had also changed themselves when they returned.

³⁴ Lissner 2005, pp. 256–258 and pp. 269–271.

³⁵ Lissner 2005, pp. 271–273.

³⁶ Kaminsky 2010, pp. 47–50; Kaminsky 2016, pp. 86–87.

³⁷ Kaminsky 2010, p. 48; Köser 2006, p. 472.

³⁸ Kaminsky 2010, p. 51.

While working abroad, deaconesses acquired an understanding for local social situations, different biographical backgrounds and life experiences. The example of Sumaya Farhat-Naser illustrates this vividly: as a Christian Palestinian in the 1950s she visited the school Talitha Kumi in Beit Jala (today West Bank) that was run by deaconesses. Subsequently she received the opportunity to study in Germany to be able to become the head of the school later on. In her autobiography she tells of the difficulties living in the Germany of the 1960s as a Palestinian woman; she had the impression that nobody was really interested in her experiences as a Palestinian because of the strong solidarity with the state of Israel. Often conversations stopped when she admitted where she was from. To avoid embarrassing situations she then had often pretended to be from India. Her large number of siblings were often perceived as a shame which is why she tried for a long time to hide it. In this situation the deaconesses who had meanwhile returned from Palestine were an important haven for her. The Sisters understood her conflicts since they were familiar with her background and became important partners for conversation.³⁹ While this example comes from the field of education in which deaconesses also worked but it would be worthwhile to analyse such mutual learning process also within the history of nursing.⁴⁰

3 New Founding of Deaconess Motherhouses Abroad: Sweden

The temporary professional migration of nurses was only one variant in which the life and work concept of deaconesses was internationally exported. In addition, women in other countries founded institutions for deaconesses that followed the German model. This international transfer was, however, only more or less successful. In some countries, like the United States and Great Britain, they barely managed to establish themselves.⁴¹ In contrast, in the Scandinavian countries that had been influenced by Lutheran Protestantism, the concept of a deaconess motherhouse was very successful and it sustainably influenced the history of nursing in the individual countries.⁴² The following illuminates this through the example of Sweden.

The first Swedish deaconess motherhouse was established in 1851 in Stockholm – only 15 years after the foundation of the motherhouse in Kaiserswerth. The “Society for the Preparation of a Deaconess Institution” in Stockholm drew heavily on the German programme of the Inner Mission and considered nursing care as an essential vehicle for converting the population. For this reason, the nurses were to be trained both in physical and spiritual care.⁴³

The first Mother Superior of the Deaconess Institute, Marie Cederschiöld, had spent a year in Germany before its foundation, largely in Kaiserswerth. As the daughter of a pastor and a member of the Swedish upper class, Cederschiöld was evidently deeply shocked when she arrived in Kaiserswerth. Sharing the bedroom with twelve probationary nurses was deeply humiliating for her. She bitterly complained in her diary that she even had to share the bed with a probationary nurse who came across to her like a maidservant. Marie Cederschiöld also

³⁹ Farhat-Naser 2013, pp. 52–56.

⁴⁰ Armstrong-Reid 2015.

⁴¹ Mangion 2016; Riemann 2016 and Zerull 2010.

⁴² For Denmark, see: Malchau Dietz 2013 and 2016, for Finland see: Markkola 2016, for Norway see: Martinsen 1984 and Okkenhaug 2013. In Scandinavia, the deaconess motherhouses were so successful that their example can serve to analyse a double transfer. The Scandinavian immigrant communities founded their own deaconess motherhouses in the United States. Thus, in the US there were German, Norwegian, Swedish and Danish deaconess motherhouses, cf. Malchau Dietz 2016, p. 124.

⁴³ Green 2011, pp. 38–39.

had mixed feelings about the consecration of the deaconesses, i.e. the ceremony in which the women were accepted into the community as full members. The Swedish lady apparently took issue with the fact that women from all classes were given a nominally equal position in the sisterhood. The institution in Kaiserswerth clearly did not correspond to her idea of the necessity of social hierarchy.⁴⁴

This experience had consequences for the conceptualisation of the institution in Stockholm. While Cederschiöld set up the institution for deaconesses in Stockholm following the German model of the motherhouse system, she was not consecrated as a deaconess. Furthermore, in contrast to the tradition in Kaiserswerth she did not let the sisters address her as mother but as Miss (*Fröken*).⁴⁵ In contrast to the model in Kaiserswerth, Cederschiöld decidedly distanced herself from the target to recruit daughters from the upper classes because she regarded it as too difficult for this group to adjust to the everyday working life in the community of deaconesses.⁴⁶ This was clearly the lesson she had painfully learned herself in Kaiserswerth. Furthermore, Cederschiöld shifted the focus of the training – autonomously and against the mission statement of the foundation – from nursing care to education, i.e. to the training and the work placement of teachers. Private schools especially in rural areas reported the need for teachers which Cederschiöld met with suitably trained deaconesses. However, one might also assume that her commitment to education was closer to Marie Cederschiöld's heart because of her own family background. Only after Cederschiöld left her post, in the 1860s did the professional emphasis of the institution shift to nursing and the welfare for children and poor people.⁴⁷

The motherhouse developed into a significant agent for expanding the healthcare system and professionalising nursing care in Sweden. The deaconess institution was the first institution in Sweden that offered any kind of systematic training in nursing, even though it was conceptualised more as an all-round programme for all tasks linked to nursing and social work. Such a broad, non-specialised qualification was important for enabling the sisters to work as flexibly as possible after their graduation, in any area of the larger institution for deaconesses. Some deaconesses worked locally in Stockholm. Most sisters, however, were sent to hospitals, parishes, orphanages or other social institutions all over Sweden. Usually they took on a leading role there and thus were highly influential in the everyday life of these houses.⁴⁸

4 Christian and Secular Care Traditions: A Comparison of Germany and Sweden

In the middle of the nineteenth century, the institution for deaconesses in Stockholm occupied a pioneering position in the training of nurses in Sweden. However, it subsequently lost this significant function. From around 1870 onwards, the institution faced competition. New training facilities emerged that drew on English nursing traditions and Florence Nightingale. One of these was the nursing school of the Red Cross in Uppsala and another the Sophia Home (*Sophiahemmet*) in Stockholm. Both schools offered a more secular training in nursing. Especially the Sophiahemmet managed successfully to recruit daughters of the upper classes and

⁴⁴ Andersson 2002, pp. 65–67 and p. 71; Christiansson 2006, p. 72; Green 2011, pp. 39–40.

⁴⁵ Christiansson 2006, p. 71; Green 2011, p. 40.

⁴⁶ Christiansson 2006, pp. 71–72.

⁴⁷ Green 2011, pp. 41–48.

⁴⁸ Green 2011, p. 123 and pp. 128–138.

train them specifically for management functions in nursing. Already during the 1890s the Sophiahemmet offered a two-year training programme that was extended to three years ten years later.⁴⁹

Nonetheless, the English model was not completely adopted here either. Elements of the tradition of deaconry were also kept. Like in the motherhouse system, the Sophiahemmet organised the working assignments for the nurses, negotiated the working conditions and salaries and secured benefits for the nurses when they grew old.⁵⁰ The Sophiahemmet was thus a Swedish interpretation of German and English nursing traditions even though one should keep in mind that the nursing traditions that were perceived as either German and English had evolved through the examination of nursing concepts in other countries.

Similar mixed organisations such as in Sweden can also be observed in Germany. For example, while some Red Cross Matrons were inspired by the writings of Florence Nightingale they would organise their community of nurses following the concept of the motherhouse – against the beliefs of Nightingale.⁵¹ Even in Switzerland – the “mother country” of the Red Cross – secular Red Cross nurses adopted the system of the motherhouse.⁵² The reason for this are not only contemporary notions of an appropriate female lifestyle. Apart from the restrictive-controlling aspects that had been perceived as painful, a motherhouse also fulfilled an important protective function by regulated working conditions for the sisters and providing social security. In the 1950s the Federal Ministry for Employment in West Germany noted that nurses who belonged to a motherhouse received significantly better pensions than the so-called free nurses.⁵³ The motherhouse indeed offered an attractive organisational structure, also from an economic point of view.

Overall, Florence Nightingale’s influence in Germany remained marginal. The success story of the “Nightingale System”⁵⁴ must be put in a new perspective if we look beyond the United Kingdom, the United States and the British colonies. Besides, the “Nightingale System” was most popular in Germany among the physicians, which might be quite surprising.⁵⁵ However, the Christian nurses were very inconvenient for the doctors. The physicians repeatedly complained about the unwillingness of Christian nurses to subordinate themselves to the doctors’ medical expertise. The central authority for the deaconesses and nuns was the management of the motherhouse and not the doctors. For the deaconesses this meant in particular: the Matron and the theological supervisor. Especially when the women felt that their task to care for the soul was threatened they showed considerable stubbornness towards the doctors.⁵⁶ The doctors hoped to finally gain recognition of their claim for leadership if nursing care was organised in a secular and professional manner. Similar trends can also be observed in France.

⁴⁹ Andersson 2002, pp. 78–102; Bohm 1972, p. 37.

⁵⁰ Bohm 1972, pp. 153–154.

⁵¹ Weber-Reich 2003.

⁵² Fritschi 1990, p. 58.

⁵³ Kreutzer 2005, p. 207.

⁵⁴ The “Nightingale System” allowed for two types of training: in addition to the training for practical nursing women from the upper classes could qualify for leading positions. The nursing school was supposed to be run independent of the hospital.

⁵⁵ Schweikardt 2008, pp. 76–78.

⁵⁶ Nolte 2016, pp. 30–31.

Here, the physicians argued for a professionalisation and secularisation of nursing with a nod to Nightingale, anticipating that they would gain better medical assistants in the end.⁵⁷

In Germany such a secular notion of nursing care faced enormous difficulties in becoming recognised. There had been newly created “free” communities of nurses that had been founded at the end of the 19th century, offering their members more independence. Yet the position of the motherhouses remained largely untouched until the second half of the 20th century.⁵⁸ A complicating factor in West Germany was that the image of denominational nursing care significantly rose after the Second World War. In contrast to secular nurses, after 1945 Christian nurses were not suspected to have been actively involved in the National Socialist policy of extermination. A Christian ethos was hence regarded as a guarantee in West Germany for a “good” caring type of nursing care. Even public hospitals were very interested in delegating nursing care to Christian nurses because such a move had a positive effect on the reputation of the hospital.

In this German context, independent self-employed nurses also adopted the denominational concepts. In principle we can say that until the 1950s there was no organisational structure apart from the sisterhood model for nurses in West Germany. Even nurses who had organised themselves into a trade union founded a sisterhood that lasted until 1968.⁵⁹ Because of the dominance of the sisterhood principle the term “Sister” – which was originally reserved for religious communities – became the general term for nurses in Germany.

By contrast, around the turn of the century in Sweden, a more secular understanding of the profession gained acceptance. The Swedish Society of Nursing (*Svensk Sjuksköterskeförening*), founded in 1910, departed from the principle of sisterhood – in contrast to the German counterpart. Nonetheless the concept of vocation that had been passed down continued to be effective in Sweden. For instance, the Swedish Society of Nursing argued vehemently at the beginning of the 1920s against shortening the working hours in nursing because on the one hand the care for the patient would suffer and on the other hand nursing would lose its special status that separated it from other gainful occupations.⁶⁰

This position changed severely during the 1930s when, after fierce internal conflicts, the Swedish Society of Nursing was extended into a trade union. The commitment to fight for wage increases and a shortening of the working hours was now part of the everyday business of the organisation. In 1945, more than ninety percent of all nursing staff in Sweden belonged to a trade union. This illustrates the enormously high acceptance of the view of nursing care as a job (rather than a vocation) in Sweden.⁶¹

This slowly terminated the justification for the work and life model of a deaconess. Matters were complicated further by the fact that the Swedish welfare state in its social-democratic spirit was generally sceptical towards Christian welfare as it was regarded as non-professional. The conflicts between diaconal nursing traditions and the more scientifically oriented state social policy ignited dramatically in the area of community nursing, as Pirjo Markkola has illustrated.

⁵⁷ Schultheiss 2001, pp. 85–95.

⁵⁸ Kreutzer 2005, pp. 33–34; Schmidbaur 2002.

⁵⁹ Kreutzer 2005, pp. 46–57.

⁶⁰ Emanuelsson 1990, p. 98.

⁶¹ Bohm 1972, p. 213.

Since the 1920s the Swedish councils employed more and more public health nurses who threatened to supersede the deaconesses. At the end of the 1930s the whole country was divided into districts. Each district had to hire a public health nurse who had undergone special training. Deaconesses without appropriate training were no longer employed. This regulation put the deaconesses under immense pressure for professionalisation and many sisters were sent for further training. This is just one example of how the Swedish welfare state began to influence the training and nursing practice of deaconesses.⁶²

A similar influence would have been unthinkable in West Germany well until the 1960s because the position of the motherhouses was much stronger here. Unlike in Sweden denominational welfare had a privileged status in West Germany. The reason for that is the so-called subsidiarity principle of the West German welfare state. According to this principle Christian institutions must generally take precedence over public institutions. Thus, it rewarded a specific denominational proliferation of the hospitals and promoted the Christian nursing tradition.⁶³

In contrast the Swedish welfare state that was rapidly established after 1945 defined social tasks primarily as state tasks. Denominational welfare, as a final resort, was supposed to be restricted in Sweden to the church. For that reason Christian nursing traditions had a fundamentally different position in Germany and Sweden. This illustrates again how closely nursing history and the history of the welfare state are linked. It would be worthwhile to investigate these connections more closely from a transnational perspective.

5 Perspectives of a European History of Nursing

The ideas introduced here on a European history of nursing reveal that nursing organisations, nursing concepts and nursing practices developed mutually in transnational ex-changes. To analyse them comparative approaches alongside approaches from transfer and entangled history are required. Comparisons are important to identify similarities and differences (e.g. the implementation and development of various nursing organisations) and influencing factors. Similarly, in transfer history studies comparisons are necessary to determine the effects of transfers. To reveal the numerous interdependencies, we need a methodology based on transfer and interwoven history that can address the mutual exchange processes and illustrate *how* similarities developed in the various countries, despite some differences, with regard to the conceptualisation, organisation and practice of nursing. European nursing traditions can thus also be made visible as shared traditions which evolved in exchange with non-European countries. With regard to ethical questions we can show on the one hand the establishment of common value systems and explain on the other hand that these must be interpreted differently depending on the region, time and context.

The research results outlined here illustrate furthermore that a European nursing history can question well-kept hegemonic discourses on the history of nursing. This includes the possibly overestimated importance of Florence Nightingale in an international context. In many countries Nightingale clearly played an inferior role, as for instance in Germany. In addition, the meaning of Nightingale's ideas changed with their transfer into different soci-etal contexts. In Germany and France, it was mainly physicians who referred positively to Nightingale. They assumed that they would finally receive the recognition of their claim for leadership in the

⁶² Markkola 2000, pp. 113–114.

⁶³ Schmuhl 2010, p. 162.

domain of health care if nursing was organised in a secular and professional way. The denominational sisters had always refused to grant them this authority. This aspect shows the international perception of Nightingale in a very different light with respect to nursing.

The same is true for the other hegemonic argument, namely the assumption that professionalisation and scientification formed *the only* path to further the respect for nurses in society. In Germany and many other European countries in the 19th and 20th centuries, denominational sisterhoods were very successful in ensuring that the nursing staff gained respect and significant independence. The secularisation and professionalisation would have had a very different effect in these countries, in that it would not have necessarily resulted in an increase in status and prestige but possibly in the opposite: Here professionalisation and the devaluation of nursing were intertwined.

Through the project of a European nursing history other protagonists will come into focus. The example of Sweden shows that the trade union gained important power and that it was also transnationally connected. However, in the international research this fact has been so far neglected. A decidedly European perspective will therefore make the history of nursing more complex and contradictory but also significantly more interesting in many respects.

Yet, we should not omit the challenges and problems that are associated with such a project: A European history of nursing must address the inner plurality that is inherent to Europe – it means to write European nursing *histories*. So far, however, nursing historical research has developed mostly in Western European countries. A nursing history that integrates both Western and Eastern European countries is not yet on the horizon. Most studies to date have focussed primarily on the situation in individual states. Transnationally conceptualised research that address the cultural context with its learning processes, translation work and ethical tensions are an exception, possibly because such an analysis involves a number of prerequisites. It demands from the researchers a very good knowledge of languages in addition to their native language, detailed knowledge of the different socio-historical contexts and a high level of methodological competence. The foundation of the European Journal for Nursing History and Ethics can be regarded as an opportunity to communicate transnationally about topics, points of view, insights and methodological challenges of an ethically informed European history of nursing that takes into account both the diversity, differences and connections within Europe but also the demarcations and complex relationships with non-European countries.

Susanne Kreutzer (Prof Dr), Muenster School of Health, Muenster University of Applied Sciences, Germany

6 Bibliography

Andersson, Åsa: Ett högt och ädelt kall. Kalltankens betydelse för sjuksköterskeyrkets formering 1850–1930. Umeå 2002.

Arndt, Agnes/Joachim C. Häberlen/Christiane Reinecke: Europäische Geschichtsschreibung zwischen Theorie und Praxis. In: Arndt, Agnes/Joachim C. Häberlen/Christiane Reinecke (eds.): Vergleichen, Verflechten, Verwirren? Europäische Geschichtsschreibung zwischen Theorie und Praxis. Göttingen 2011, pp. 11–30.

- Armstrong-Reid, Susan: Two China ,Gadabouts'. Guerilla Nursing With The Friends Ambulance Unit, 1946–48. In: Sweet, Helen/Sue Hawkins (eds.): Colonial Caring. A History of Colonial and Post-Colonial Nursing. Manchester 2015, pp. 208–231.
- Bauernkämper, Arnd: Wege zur europäischen Geschichte. Erträge und Perspektiven der vergleichs- und transfergeschichtlichen Forschung. In: Arndt, Agnes/Joachim C. Häberlen/Christiane Reinecke (eds.): Vergleichen, Verflechten, Verwirren? Europäische Geschichtsschreibung zwischen Theorie und Praxis. Göttingen 2011, pp. 33–60.
- Beauchamp, Tom L./James F. Childress: Principles of Biomedical Ethics. New York, Oxford 2013.
- Bohm, Eva. Okänd, godkänd, legitimerad. Svensk Sjuksköterskeföreningens fösta 50 År. Stockholm 1972.
- Budde, Gunilla/Sebastian Conrad/Oliver Janz (eds.): Transnationale Geschichte. Themen, Tendenzen und Theorien. Göttingen 2006.
- Christiansson, Elisabeth: Kyrklig och social reform. Motiveringar till diakoni 1845–1965. Skellefteå 2006.
- Conrad, Sebastian et al. (eds.): Globalgeschichte. Theorien, Ansätze, Themen. Frankfurt a. Main, New York 2007.
- Conrad, Sebastian/Shalini Randeria: Einleitung. Geteilte Geschichten – Europa in einer postkolonialen Welt. In: Conrad, Sebastian/Shalini Randeria (eds.): Jenseits des Eurozentrismus. Postkoloniale Perspektiven in den Geschichte- und Kulturwissenschaften. Frankfurt a. M. 2013, pp. 32–70.
- Coors, Michael: Die Ethik und das Fremde. Einleitende Beobachtungen zum (kulturell) Fremden als Thema der Medizinethik. In: Coors, Michael/Tatjana Grützmann/Tim Peters (eds.): Interkulturelle Ethik. Der Umgang mit Fremdheit in Medizin und Pflege. Göttingen 2014, pp. 7–19.
- Coors, Michael/Tatjana Grützmann/Tim Peters (eds.): Interkulturelle Ethik. Der Umgang mit Fremdheit in Medizin und Pflege. Göttingen 2014.
- Dross, Fritz: „Der Kampfplatz der Liebe“. Das Fronberg-Krankenhaus der Kaiserswerther Diakonie. In: Medizinhistorisches Journal 43 (2008), pp. 149–182.
- Emanuelsson, Agneta: Pionjärer i vitt. Professionella och fackliga strategier bland svenska sjuksköterskor och sjukvårdsbiträden, 1851–1939. Huddinge 1990.
- Farhat-Naser, Sumaya: Thymian und Steine. Eine palästinensische Lebensgeschichte. 10th Edition Basel 2013.
- Fleischmann, Ellen/Sony Grypma/Michael Marten/Inger Marie Okkenhaug (eds.): Transnational and Historical Perspectives on Global Health, Welfare and Humanitarianism. Kristiansand 2013.
- Fritschi, Alfred: Schwesterntum. Zur Sozialgeschichte der weiblichen Berufsrankenpflege in der Schweiz. Zürich 1990.
- Green, Todd H.: Responding to Secularization. The Deaconess Movement in Nineteenth-Century Sweden. Leiden, Boston 2011.

- Gugglberger, Martina: Reguliertes Abenteuer. Missionarinnen in Südafrika nach 1945. Wien et al. 2014.
- Habermas, Rebekka: Mission im 19. Jahrhundert. Globale Netze des Religiösen. In: Historische Zeitschrift 287 (2008), pp. 629–679.
- Hauser, Julia: Waisen gewinnen. Mission zwischen Programmatik und Praxis in der Erziehungsarbeit der Kaiserswerther Diakonissen in Beirut seit 1860. In: WerkstattGeschichte 57 (2011), pp. 9–30.
- Hauser, Julia: Mind the Gap! Raum, Geschlecht und die Zirkulation von Wissen in der Mission am Beispiel der Kaiserswerther Diakonissen in Beirut. In: Habermas, Rebekka/Richard Hölzl (eds.): Mission global. Eine Verflechtungsgeschichte seit dem 19. Jahrhundert. Köln et al. 2014, pp. 137–157.
- Hüwelmeier, Gertrud: Negotiating Diversity. Catholics Nuns as Cosmopolitans. In: Schweizerische Zeitschrift für Religions- und Kulturgeschichte 102 (2008), pp. 105–117.
- Kaelble, Hartmut: Gesellschaften im Vergleich. Forschungen aus Sozial- und Geschichtswissenschaften. Frankfurt a. M. 1998.
- Kaelble, Hartmut: Der historische Vergleich. Eine Einführung zum 19. und 20. Jahrhundert. Frankfurt a. M., New York 1999.
- Kaelble, Hartmut/Jürgen Schriewer (eds.): Vergleich und Transfer. Komparatistik in den Sozial-, Geschichts- und Kulturwissenschaften. Frankfurt a. M., New York 2003.
- Kaminsky, Uwe: Innere Mission im Ausland. Der Aufbau religiöser und sozialer Infrastruktur am Beispiel der Kaiserswerther Diakonie (1851–1975). Stuttgart 2010.
- Kaminsky, Uwe: The Establishment of Nursing Care in the Parish. Kaiserswerth Deaconesses in Jerusalem. In: Kreutzer, Susanne/Karen Nolte (eds.): Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016, pp. 81–95.
- Köser, Silke: Denn eine Diakonisse darf kein Alltagsmensch sein. Kollektive Identitäten Kaiserswerther Diakonissen 1836–1914. Leipzig 2006.
- Kreutzer, Susanne: Vom „Liebesdienst“ zum modernen Frauenberuf. Die Reform der Krankenpflege nach 1945. Frankfurt a. M., New York 2005.
- Kreutzer, Susanne: Arbeits- und Lebensalltag evangelischer Krankenpflege. Organisation, soziale Praxis und biographische Erfahrungen, 1945–1980. Göttingen 2014.
- Kreutzer, Susanne/Karen Nolte: Seelsorgerin „im Kleinen“. Krankenseelsorge durch Diakonissen im 19. und 20. Jahrhundert. In: Zeitschrift für medizinische Ethik 56 (2010), 1, pp. 45–56.
- Kreutzer, Susanne/Karen Nolte (eds.): Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016.
- Lissner, Cordula: Arbeitsmigration ohne Migrationserfahrung? Kaiserswerther Schwestern im Auslandseinsatz. In: Gause, Ute/Cordula Lissner (eds.): Kosmos Diakonissenmutterhaus. Geschichte und Gedächtnis einer protestantischen Frauengemeinschaft. Leipzig 2005, pp. 243–274.

- Löffler, Roland: Westliche Frauen im Umgang mit kranken orientalischen Männern. Aspekte der Geschichte des mährischen Aussätzigenasyls in Jerusalem. In: Goren, Haim/Jakob Eisler (eds.): Deutschland und Deutsche in Jerusalem. Jerusalem 2011, pp. 261–278.
- Loosen, Livia: Deutsche Frauen in den Südsee-Kolonien des Kaiserreichs. Alltag und Beziehungen zur indigenen Bevölkerung, 1884–1919. Bielefeld 2014.
- Malchau Dietz, Susanne: Køn, kald og kompetencer. Diakonissestiftelsens kvindefællesskab og omsorgsuddannelser 1863–1955. Kopenhagen 2013.
- Malchau Dietz, Susanne: The Deaconess Movement and Professional Nursing. International Demographics and Danish Deaconess Settlements at Home and Abroad 1836–1914. In: Kreutzer, Susanne/Karen Nolte (eds.): Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016, pp. 117–134.
- Mangion, Carmen M.: „No Nurses Like the Deaconesses?” Protestant Deaconesses and the Medical Marketplace in Late-nineteenth-century England. In: Kreutzer, Susanne/Karen Nolte (eds.): Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016, pp. 161–184.
- Markkola, Pirjo: Promoting Faith and Welfare. The Deaconess Movement in Finland and Sweden, 1850–1930. In: Scandinavian Journal of History 25 (2000), 1–2, pp. 101–118.
- Markkola, Pirjo: Deaconesses in the History of Nursing in Finland, 1890s to 1960s. In: Kreutzer, Susanne/Karen Nolte (eds.): Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century. Stuttgart 2016, pp. 135–158.
- Martinsen, Kari: Freidige og uforsagte diakonisser. Et omsorgsykke vokser fram 1860–1905. Aschehoug 1984.
- Middell, Matthias: Kulturtransfer und Historische Komparatistik. Thesen zu ihrem Verhältnis. In: Comparativ. Zeitschrift für Globalgeschichte und vergleichende Gesellschaftsforschung 10 (2000), pp. 7–41.
- Nelson, Sioban: Say Little, Do Much. Nursing, Nuns, and Hospitals in the Nineteenth Century. Philadelphia 2001.
- Nolte, Karen: Todkrank. Sterbebegleitung im 19. Jahrhundert. Medizin, Krankenpflege und Religion. Göttingen 2016.
- O’Brien, Susan: French Nuns in Nineteenth-Century England. In: Past & Present 154 (1997), pp. 142–180.
- Oguisso, Taka/Genival Fernandes de Freitas: English as a Barrier. In: Nursing History Review 23 (2015), pp. 9–10.
- Okkenhaug, Inger Marie: Norwegian Nurses, Relief and Welfare in the United States and Middle East, ca. 1880–1915. In: Fleischmann, Ellen/Sonya Grypma/Michael Marten/Inger Marie Okkenhaug (eds.): Transnational and Historical Perspectives on Global Health, Welfare and Humanitarianism. Kristiansand 2013, pp. 41–69.
- Osterhammel, Jürgen (ed.): Weltgeschichte. Stuttgart 2008.
- Rafferty, Anne-Marie: Tiptoeing Towards a History of Nursing in Europe. In: Nursing History Review 22 (2014), pp. 107–113.

- Riemann, Doris: ‚How to Meet the Needs of the Church‘. On the History of Deaconesses in the Lutheran Motherhouse in Baltimore, Maryland, USA, in the Twentieth Century. In: Kreutzer, Susanne/Karen Nolte (eds.): *Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century*. Stuttgart 2016, pp. 185–210.
- Raphael, Lutz: Ordnungsmuster und Selbstbeschreibungen europäischer Gesellschaften im 20. Jahrhundert. In: Raphael, Lutz (ed.): *Theorien und Experimente der Moderne. Europas Gesellschaften im 20. Jahrhundert*. Köln et al. 2012, pp. 9–20.
- Schmidbaur, Marianne: *Vom Lazarskrenz zur Pflege aktuell. Professionalisierungsdiskurse in der deutschen Krankenpflege 1903–2000*. Königstein i. Taunus 2002.
- Schmuhl, Hans-Walter: Ärzte in konfessionellen Kranken- und Pflegeanstalten 1908–1957. In: Kuhleemann, Frank-Michael/Hans-Walter Schmuhl (eds.): *Beruf und Religion im 19. und 20. Jahrhundert*. Stuttgart 2003, pp. 176–194.
- Schmuhl, Hans-Walter: Der Neubeginn sozialer Staatlichkeit nach 1945. In: Kaiser, Jochen-Christoph/Rajah Scheepers (eds.): *Dienerinnen des Herrn. Beiträge zur weiblichen Diakonie im 19. und 20. Jahrhundert*. Leipzig 2010, pp. 148–163.
- Schultheiss, Katrin: *Bodies and Souls. Politics and the Professionalization of Nursing in France, 1880–1922*. Cambridge, Mass. et al. 2001.
- Schweig, Nicole: *Weltliche Krankenpflege in den deutschen Kolonien Afrikas 1884–1918*. Frankfurt a. M. 2012.
- Schweikardt, Christoph: *Die Entwicklung der Krankenpflege zur staatlich anerkannten Tätigkeit im 19. und frühen 20. Jahrhundert. Das Zusammenwirken von Modernisierungsbestrebungen, ärztlicher Dominanz, konfessioneller Selbstbehauptung und Vorgaben preußischer Regierungspolitik*. München 2008.
- Sweet, Helen/Sue Hawkins: Introduction. Contextualising Colonial and Post-Colonial Nursing. In: Sweet, Helen/Sue Hawkins (eds.): *Colonial Caring. A History of Colonial and Post-Colonial Nursing*. Manchester 2015, pp. 1–17.
- Weber-Reich, Traudel: „Wir sind die Pionierinnen der Pflege ...“. Krankenschwestern und ihre Pflegestätten im 19. Jahrhundert am Beispiel Göttingen. Bern et al. 2003.
- Werner, Michael/Bénédicte Zimmermann: Vergleich, Transfer, Verflechtung. Der Ansatz der *Histoire croisée* und die Herausforderung des Transnationalen. In: *Geschichte und Gesellschaft* 28 (2002), pp. 607–636.
- Werner, Michael/Bénédicte Zimmermann: Beyond Comparison. *Histoire Croisée* and the Challenge of Reflexivity. In: *History and Theory* 45 (2006), pp. 30–50.
- Wexler, Ruth: Deaconesses at the Leper Home in Jerusalem, 1874–1950. In: Kreutzer, Susanne/Karen Nolte (eds.): *Deaconesses in Nursing Care. International Transfer of a Female Model of Life and Work in the 19th and 20th Century*. Stuttgart 2016, pp. 97–113.
- Zerull, Lisa: *Nursing Out of the Parish. A History of the Baltimore Lutheran Deaconesses 1893–1911*. Charlottesville 2010.

History of Public Health Nursing in Spain and the International Context

María Eugenia Galiana-Sánchez

Abstract

The aim of this study was to analyse the international factors that influenced the professionalisation of public health nursing in Spain. The sources consulted included the archives of the League of Nations, the World Health Organisation and the Rockefeller Foundation, as well as articles and reports drawn up by health authorities, public health doctors and nurses. The results show that Rockefeller Foundation and international European organisations contributed to the professionalisation of public health nursing in Spain, but that this process was interrupted by the outbreak of the Spanish Civil War and the subsequent Franco dictatorship. The Francoist regime rebuffed the efforts made by national and international institutions, reoriented health policies deploying nurses as an ideological vehicle and exacerbated the gender gap. Whereas public health nursing became increasingly consolidated in other countries over the course of the twentieth century, the field of nursing suffered a significant deterioration in Spain, where emphasis was placed on an auxiliary role carried out almost exclusively in hospitals, heightening the discipline's isolation and hindering its professionalisation.

1 Introduction

The professionalisation of public health nursing in Europe dates back to the last third of the 19th century and first decades of the 20th century.¹ At that time, and especially in the inter-war period, Europe witnessed the formation of what has been called the “international health movement”, which helped establish a social and political context conducive to attaining higher levels of health and well-being. This was fostered by achievements such as the creation of public health authorities in Europe,² the development of public health driven by the Rockefeller Foundation³ and the League of Nations,⁴ and a structured, collective effort based on the work of experts. Ultimately, the aim was to establish a central frame of reference for the exchange of healthcare knowledge and practices.⁵

In this context and especially following the First World War, international organisations and agencies promoted a healthcare model based on improving public health, implementing models of care that would first meet the immediate needs of refugees and would subsequently consolidate national and international public health services.⁶ Consequently, it was necessary to develop a new type of health professional and attempt to provide them with satisfactory training and working conditions.⁷ The professionalisation of nursing had begun in England in the second half of the 19th century, and nurses, who became indispensable in the post-war period to carry out the

¹ Dingwall/Rafferty/Webster 1993; Baly 1995.

² Barona/Bernabeu-Mestre 2008.

³ Weindling 1997; Farley 2004; Barona 2015.

⁴ Borowy 2009; Weindling 1995; Dubin 1995.

⁵ Andresen/Groenlie 2007; Barona 2012.

⁶ Weindling 1995; Andresen/Groenlie 2007.

⁷ McGann 2008, p. 29.

humanitarian work of organisations such as the International Red Cross, formed one of the professional groups that aroused most interest among health institutions and organisations. Public health nurses slotted perfectly into the new healthcare model developed in the fields of hygiene and social medicine.⁸

In the final decades of the 19th century, Spain lagged behind its neighbouring countries in many respects in all social spheres. In terms of health, communicable diseases and especially the so-called social diseases (e.g. tuberculosis, cholera, syphilis, trachoma and diphtheria) caused high rates of mortality and morbidity. However, at the turn of the century, a slow but steady change began in demography and health, generating a widespread desire for modernisation in accordance with the criteria and structures of other Western European countries. This laid the groundwork for the hygiene and social medicine movement, and public policies began to reflect a growing concern for public health. There were also early attempts at health service reform and a more outward-looking attitude emerged, embodied in an agreement on scientific and health collaboration with the Rockefeller Foundation.⁹ It was at this time that the first steps were taken towards the professionalisation of public health nursing in Spain.

The international literature includes studies on the history of public health nursing in the international arena.¹⁰ Our research group has explored the history of public health nursing in Spain.¹¹ On this occasion, our goal has been to highlight the relationship between the international and Spanish contexts, analysing factors in the former that exerted influence on the process of professionalisation of public health nursing in Spain.¹² To this end, we will first examine the initiatives implemented by European institutions aimed at consolidating public health nursing in Europe, in comparison with the case of Spain. Then, we will describe the transformation in health and demography witnessed in Spain and discuss how this led to the inception of public health nursing, analysing those elements of the international context that were decisive in the process of nursing professionalisation in Spain.

2 Institutional Initiatives to Establish Public Health Nursing in Europe

After the First World War, the alarming epidemiological situation combined with the need for nurses in countries devastated by the war generated a climate of international cooperation promoted by the League of Red Cross Societies, which held its first meeting in Cannes in 1919. This meeting was attended by the nursing delegation, which advised

⁸ Dingwall/Rafferty/Webster 1993.

⁹ Pérez-Moreda/Reher/Sanz-Gimeno 2015.

¹⁰ Davies 2007; Rafferty 2014; Mortimer/McGann 2005; Boschma 2008, 2014.

¹¹ Bernabeu-Mestre/Gascón-Pérez 1999; Gascón-Pérez/Galiana-Sánchez/Bernabeu-Mestre 2002; Galiana-Sánchez/Bernabeu-Mestre 2011; Bernabeu-Mestre/Galiana-Sánchez 2012b; Bernabeu-Mestre/Galiana-Sánchez/Cremades-Monerris 2013.

¹² Previous studies in this area of research include: Bernabeu-Mestre/Galiana-Sánchez 2011b; Galiana-Sánchez 2015, 2017.

the League to prioritise the professional development of public health nursing and suggested that this could be achieved by organising international public health courses to train groups of nurses in this field.¹³ The courses were successfully created, generated a high level of interest and were delivered for eighteen years, training a total of 350 nurses from 47 countries.¹⁴ The students were subsequently responsible for directing public health nursing programmes in their respective countries, although such training was adapted to the social, political and health profile of each country, as in the case of Spain.¹⁵

Following its creation in 1919, the League of Nations also prioritised the need to combat and prevent the most prevalent diseases and carry out urgent health interventions. In consequence, the League created a Hygiene Committee in 1923, charged with establishing the League's health policy guidelines.¹⁶ Its director, Dr. Hazeman, and the technical adviser and nursing expert for the Hygiene Section, the American nurse Hazel Avis Goff,¹⁷ together coordinated the debate on the situation and perspectives of public health nursing in Europe. Goff collaborated regularly with the Rockefeller Foundation's International Health Board, exemplifying the Rockefeller Foundation's involvement in the League of Nations Hygiene Committee. Through the incorporation of health experts, in this case an expert in public health nursing, the Foundation's principles and guidelines were disseminated among international organisations such as the League of Nations.¹⁸ Goff contributed to the debate on nursing education and analysed public health nursing in Europe, producing reports on ten European countries: Austria,¹⁹ Bulgaria,²⁰ Greece,²¹ Finland,²² Hungary,²³ Yugoslavia,²⁴ Norway,²⁵ Poland,²⁶ Czechoslovakia²⁷ and Romania.²⁸

¹³ When the League of Cross Red Societies was founded, it incorporated a large delegation of nurses who played an important role in establishing the public health agenda, see McGann 2008, pp. 29-31.

¹⁴ These countries included Spain, which in 1928-29 sent a Catalan nurse who on her return to Barcelona helped establish social and public health services, specifically the institutions aimed at child and adolescent care, see McGann 2008, p. 36. This may have been Montserrat Ripoll Noble, who after directing the Catalan Government's School of Nursing, received a Rockefeller Foundation grant to train in the USA and went on to have an interesting, albeit truncated career in management and teaching in Spain and Venezuela.

¹⁵ The training programmes were inspired by the North American vision of public health, influenced by the principles promulgated by the Rockefeller Foundation, see McGann 2008, p. 41.

¹⁶ Barona/Bernabeu-Mestre 2008, pp. 149-50.

¹⁷ Commission Consultative des Questions Sociales 1939.

¹⁸ Barona 2015.

¹⁹ Goff 1933-34a.

²⁰ Goff 1933-34b.

²¹ Goff 1933-34c.

²² Goff 1933-34d.

²³ Goff 1933-34e.

²⁴ Goff 1933-34f.

²⁵ Goff 1933-34g.

²⁶ Goff 1933-34h.

²⁷ Goff 1933-34i.

²⁸ Goff 1933-34j.

These countries were selected and the reports written in line with the recommendations of the 1931 European Conference on Rural Hygiene.²⁹ The fact that the Conference's recommendations included establishing the present situation of public health nursing in the above-mentioned countries indicates the importance attributed in the field of hygiene and social medicine to the work of nurses in the community. Spain was not included in these reports, probably because it was already undergoing a major transformation in health promoted by the Rockefeller Foundation, as we shall see in subsequent sections.³⁰

The work carried out by the League of Nations through its Hygiene Committee, together with Goff's contribution as expert adviser in the field of public health nursing, formed the basis of systematic efforts to establish suitable training in public health nursing and organised, effective nursing services in Europe.³¹

After the disruptions of World War II, the World Health Organisation (WHO), funded in 1948, formed Nursing Expert Committees composed of leading international figures of the time.³² These committees formulated new ideas and strategies for improving hygiene and nursing, which were published in several reports from 1950 onwards.³³

To alleviate the continuing shortage of nurses in the 1940s, the WHO promoted the formation of a group of "nursing experts" and established a strategy of international alliances with the International Nursing Council (INC), the International Catholic Committee of Nurses and Medical-Social Assistants, the Nursing Office of the League of Red Cross Societies and the International Confederation of Midwives.³⁴ It also launched international nursing teams and proposed nursing school programme reforms, promoting basic training in public health that incorporated maternal and child care and nurse training for teaching and administration.³⁵

²⁹ Commission Consultative des Questions Sociales 1939.

³⁰ It would be of great interest to conduct a comparative study of the situation of nursing in these countries with respect to the situation in Spain. This would shed light on the transnational situation in Europe. However, this is beyond the scope of the present article, although we do not rule out the possibility of addressing it in future research.

³¹ Galiana-Sánchez 2017.

³² Members of this first committee included Olive Baggallay, head of the WHO Nursing Section and one of the first tutors on the course organised in the 1920s by the International Red Cross, which gave rise to the "Old International" association. Daisy Bridges was also a founding member of the committee, and like Baggallay, she was a member of the "Old International" and had replaced Anna Schwarzenberg as Executive Secretary of the International Nursing Council. The committee also included nurses who had been appointed to positions of responsibility in countries such as France, India, New Zealand, Chile, the USA, Finland, the United Kingdom and Switzerland, and who represented institutions and organisations such as the Red Cross, the Rockefeller Foundation, departments of health under national ministries and schools of nursing, see McGann 2008, p. 57.

³³ WHO 1950, 1959, 1962, 1966, 1974.

³⁴ WHO 1958, p. 401.

³⁵ WHO 1958, p. 392.

The WHO's novel approach not only paved the way for demands to improve general training and professional conditions, but above all highlighted the contribution of nursing to achievements in public health and social medicine, although it also revealed inconsistencies in some countries. Such was the case of Spain, as will be analysed below. In the following sections, I will first describe the social, political and health profile of Spain, and subsequently explore the influence of the international context on the development of public health nursing in Spain.

3 Spain's Social and Health Profile

As indicated in the introduction, turn of the century Spain lagged far behind other Western Europe countries. The main differences stemmed from the predominantly rural nature of the economy and society. Land distribution, lease conditions and widespread technological backwardness meant that in Spain, the yield per hectare was five or six times lower than it was in countries such as Germany or Britain. Consequently, poor harvests led to repeated food shortages. Another significant difference was the illiteracy rate. In 1900, 63% of the Spanish population could not read or write, whereas in France, only 24% of the population was illiterate. Furthermore, the illiteracy rate was even higher among women, standing at 71%.³⁶

Health in Spain was typical of a predominantly rural society. The average birth rate was around 35 per 1,000 inhabitants, and the mortality rate was around 25 per 1,000 inhabitants. In contrast, countries such as France or Britain presented birth rates of around 26 per 1,000 population and mortality rates of 19 and 17 per 1,000 population, respectively. The mortality rate for the under-fives was very high, standing at 420.31 per 1,000 live births, whereas the same figure for France was around 194 per 1,000. While Europe generally had witnessed a 50% population increase over the 19th century, in Spain the population had only increased by 20%.³⁷

Nonetheless, as mentioned earlier, the turn of the century witnessed the beginning of a slow but steady change in demography and health, in line with the criteria and structures of other Western European countries. In response to demands from the labour movement and the general population alike, as well as the public debate promoted by the hygiene movement in line with international movements and the need for regeneration and progress, a general health act was passed in 1904 (the *Instrucción General de Sanidad*), ushering in a redesigned health service.³⁸ Social medicine, bacteriology and demographics formed the basis of two major initiatives in healthcare: health campaigns that intensified efforts to combat social diseases, and an outward-looking attitude embodied in an agreement with the Rockefeller Foundation's International Health Board that proved decisive for expanding public healthcare to rural areas and providing grants to train health professionals.³⁹ Combined with the creation

³⁶ Tusell 2001.

³⁷ De Membrillera 1921; Barona/Bernabeu-Mestre/Perdiguerro 2005.

³⁸ Barona 2002.

³⁹ Rodríguez-Ocaña/Martínez-Navarro 2008; Barona/Bernabeu-Mestre 2008.

of the National School of Health as a specialist teaching institution, these initiatives contributed to the development of hygiene and public health and the beginning of the professionalisation of public health nursing in Spain.⁴⁰

4 Early Accomplishments: Public Health Nursing in Spain in the First Third of the 20th Century

The first public health nurses (health visitors) appeared in Spain in the 1920s, again lagging behind other European countries but with strong support from international institutions such as the Rockefeller Foundation.⁴¹ There are various reasons for this delay, the main ones being Spain's very different socioeconomic situation, largely due to the lack of strong industrial development and associated consequences and the absence of a public health movement such as the one in England. With specific reference to the development of nursing as a profession, unlike England and other non-Catholic countries, Spain had a long and rich tradition of professional nursing in a hospital setting. However, this was partially responsible for the idea that care outside the hospital was not a nursing function.⁴² Furthermore, although traditional forms of care delivered in family settings by nuns and mothers helped improve the health and well-being of the population, they also posed an obstacle to the process of nursing professionalisation.⁴³ Previously, in line with the new health act of 1904, Provincial Health Boards had been created and a ladies' committee established to oversee home care and maternal and child health education. The tasks of this committee can be seen as a precedent for the work of the health visitor.⁴⁴

Training for health visitors in the 1920s commenced with the programmes organised by the Red Cross and courses delivered at the National School of Health and the Child Care Schools. Professional health visitors were an innovation in Spain, and they were trained to play a key role in implementing the reformist health policy that had been gradually taking shape over the first thirty years of the 20th century. This process reached its culmination with the scientific and public health collaboration agreements signed with the Rockefeller Foundation in 1922, in which the Foundation undertook to cover the costs of a future school for health visitors and to fund suitable public health training for those who would teach there.⁴⁵ In 1931, prior to organising these training programmes, the Rockefeller Foundation engaged Elisabeth F. Crowell to conduct an analysis of the situation of nursing in Spain.⁴⁶

Her report analysed the nursing education provided by schools located in Spanish hospitals in Madrid, Santander and Barcelona, and concluded that the requirements for

⁴⁰ Bernabeu-Mestre/Gascón 1999.

⁴¹ Bernabeu-Mestre/Gascón 1999.

⁴² Gascón-Pérez/Galiana-Sánchez/Bernabeu-Mestre 2003, pp. 100-101.

⁴³ Gallego-Caminero 2009.

⁴⁴ Domínguez-Alcón 1986, p. 99.

⁴⁵ Bernabeu-Mestre/Gascón-Pérez 1999.

⁴⁶ Crowell 1931.

admission to nursing schools were inadequate, that the courses were characterised by disorganised theoretical teaching delivered by doctors and that practical experience was unsupervised. She also highlighted the absence of professionals with an accurate conception of what a nursing school should be, indicating that this severely hindered the professionalisation of nurses.⁴⁷

Besides these aspects, Crowell also examined the project for a National Public Health Nursing School, identifying the need for places to carry out effective practical experience and the desirability of raising the future school's admission requirements. She also indicated the need to provide suitable training for management and teaching staff by providing grants to study abroad. This latter question was resolved through a training programme in which fourteen nurses participated between 1931 and 1934, studying in the United States for an average of two years to prepare them to teach at the school, which was scheduled to open in Madrid in late 1935.⁴⁸

Experienced nurses predominated among those awarded such grants, although there were also four newly graduated nurses. Their mean age was 29 years old, the mean duration of their overseas study was two years, and they all studied a relatively similar curriculum. First, they participated as special students in the activities of the Western University of Cleveland nursing school, where they studied subjects such as the fundamentals of nursing, advances in nursing, principles and methods of nursing education, social aspects of nursing and, of course, public health nursing. In addition to these theoretical and practical subjects, they spent several months in the East Harlem Nursing and Health Service in the city of New York. Of particular note, six of them also attended an advanced course for nursing teachers and supervisors at the Columbia University Teachers' College in New York. However, none of this helped achieve the main objective: the incorporation of these professionals as teaching staff at the National Public Health Nursing School in Madrid was ultimately prevented by continuing delays in the launch of the school and the outbreak of the Spanish Civil War in 1936.⁴⁹

Despite these ambitious plans for a postgraduate teacher training programme with a view to launching the Public Health Nursing School, the pressing need for professionals meant that public health nurse training could be delayed no longer. Thus, in 1933, a National School for Health Visitors was created, attached to the National School of Health, which was intended to provisionally fulfil the functions of the future institution. Three three-month courses were delivered between February 1933 and July 1935, training a total of 76 nurses.⁵⁰

⁴⁷ Crowell 1931, p. 2-3.

⁴⁸ Crowell 1931, p. 5-6.

⁴⁹ Bernabeu-Mestre/Gascón-Pérez 1999, p. 60; Gascón-Pérez/Galiana-Sánchez/Bernabeu-Mestre 2003, pp. 103-104.

⁵⁰ Some of these courses were reported as "Inauguration of the courses at the National School for Health Visitors" in the "News" section of the *Revista de Sanidad e Higiene Pública* [Journal of Public Health and Hygiene] in 1933 and in the journal *La Visitadora Sanitaria* [The Health Visitor] in 1935.

In the end, none of these initiatives became permanent. Despite demands from health visitors themselves for the construction of a building to house the future school or for the latter's launch in January 1936, the tragic events of July 1936, heralding the outbreak of civil war, brought a halt to the development of this important programme to which so much effort and time had been devoted.

Nevertheless, the new health service designed by the health authorities slowly began to include health visitors.⁵¹ Health policies during the Second Republic incorporated intense State involvement in health campaigns against tuberculosis⁵², trachoma⁵³ and infant mortality.⁵⁴ In order to carry out a health programme such as the one launched by the Republic, health visitors were essential. It was at this point that the first Health Visitor's Association was founded and the first scientific publications were made. Public health nurses became actively involved in health campaigns through targeted and coordinated actions against infectious diseases, and entered the fields of childcare and maternal and child

For example, they played a major role in the tuberculosis⁵⁵ and trachoma campaigns; in the latter case, by carrying out interventions in schools which targeted children with the disease.⁵⁶ Besides conducting school medical inspections, supporting the work of local physicians and ophthalmologists and delivering health and hygiene education, they began to work with families and the community. For each schoolchild with trachoma, nurses opened a family file and carried out home visits to assess risk factors and detect any other members of the household affected by the disease. These were then treated and monitored by the hygiene clinic, and educated about healthy habits and hygiene. As with most of what were known as social diseases, a strictly medical approach was insufficient: it was also necessary for health professionals to carry out social work. In this respect, health visitors played a crucial role, acting as intermediaries between the three groups involved: schoolchildren and teachers; other health institutions and medical and specialist services; and other families and the general population.⁵⁷ They also played a central role in what was known as the "child care movement" and in mother

⁵¹ On changes in the Spanish health system during the 1920s and 1930s and the impact of these on the agreement for scientific and medical collaboration with the Rockefeller Foundation, see: Huertas 1995; Perdiguero/Castejón 2002; Rodríguez/Martínez 2008; Bernabeu-Mestre 2007; Barona/Bernabeu-Mestre 2008.

⁵² Molero-Mesa 2001.

⁵³ Bernabeu-Mestre/Galiana-Sánchez/Cremades Monerri 2013; Bernabeu-Mestre/Galiana-Sánchez 2011a.

⁵⁴ Rodríguez-Ocaña 1999; Perdiguero 2004.

⁵⁵ Verdes Montenegro 1934, pp. 11-12.

⁵⁶ In the campaign against trachoma in contemporary Spain, the disease was viewed as one of poverty, and therefore a having multiple causes and approaches. See: Bernabeu-Mestre/Galiana-Sánchez/Cremades Monerri 2013 and Pozzi/Bernabeu-Mestre/Galiana-Sánchez 2017. Specifically, nursing interventions were implemented in the context of actions targeting schools and the workplace, see Bernabeu-Mestre/Galiana-Sánchez 2011a, 2012a.

⁵⁷ Bernabeu-Mestre/Galiana-Sánchez 2011a.

and child hygiene campaigns.⁵⁸ The work carried out with mothers through home visits is a prime example of the outreach and health education activities performed by health visitors.

As has been shown, nurses played a prominent role in the fields of care and public health, consistent with the guidelines issued by international health organisations and institutions.

5 A Curb on Professionalisation: Exile and Francoism

Besides preventing the launch of the public nursing school, the outbreak of civil war in July 1936 brought a halt to the professional and personal development of many of the nurses who had benefitted from the advanced study programme, with serious consequences for the progress of nursing. As a result of Spain's political and social situation and international isolation, many of these nurses experienced great difficulty in continuing their professional activity. Others adapted to political change and even occupied important posts in the health system under the Franco regime.⁵⁹ Some went into exile abroad, as did many other professionals and researchers, forming a large group of people now obliged to lead their lives elsewhere.⁶⁰ For example, four of the nurses who had received grants from the Rockefeller Foundation went into exile in Venezuela, where they integrated into Venezuelan society and actively participated in the development of nursing there, directing the first school of nursing and creating a professional nursing journal.⁶¹ Thus, although the exile of the health and scientific community as a result of the civil war and the Franco dictatorship represented a damaging loss of human resources in Spain, and in the case of nursing, halted the project to create a public health nursing school, it benefitted Venezuela since the exiled Spanish nurses actively participated in the development of professional nursing there.

Meanwhile, in Spain, the political, social and cultural constraints imposed by the newly established Franco dictatorship represented a major setback in the process of nursing professionalisation. Many of the political actions implemented under Franco's totalitarian system were based on opposition to the former regime, entailing an abrupt change of direction in many of the earlier Republican initiatives. New health policies and guidelines had a severe impact on the emerging discipline and the first professional achievements it had attained during the Republican period. One of the initiatives carried

⁵⁸On the contribution of nurses to maternal and child hygiene campaigns, see: Galiana-Sánchez/Bernabeu-Mestre 2012b.

⁵⁹Such was the case of Mercedes Milá, who was president of the Health Visitors' Association, founded the journal *La Visitadora Sanitaria* [The Health Visitor], and was Inspector-Secretary of the future school during the Republican period. Subsequently, during the Franco regime, she was appointed Inspector General of Women's Hospital Services in 1937. In 1941, she created the Ladies' Auxiliary Corps within the Military Health Service. She was in command of the Association of Military Nurses deployed to Russia alongside the Spanish Volunteer Division, known as the Blue Division, see Becerra 2016.

⁶⁰Barona 2003, 2010; Bernabeu-Mestre 2005.

⁶¹Gascón-Pérez/Galiana-Sánchez/Bernabeu-Mestre 2003.

out by the new regime's health authorities was to restructure the proposed Public Health Nursing School project. Alterations were made to the building constructed to house the school to accommodate a National School for Health Instructors. In the words of its first director, Dr. José Fernández Turegano, the school had a dual practical and moral mission: an educational function aimed at training, but also a spiritual one, aimed at creating the necessary vocation.⁶² Students boarded at the school, and religion and political education were included among the subjects they studied. Religious education was considered essential, since those responsible for the school thought that daily religious practice would elevate student morality. Meanwhile, political education was delivered by instructors from the Women's Section of the Spanish Falange and the JONS,⁶³ the only official political party in Spain, which adhered to a fascist ideology.⁶⁴ The aim of this training was to foment a sense of vocation and patriotism, linking the nursing function to the role once again assigned to women in Spanish society under the Franco regime, that of a wife and mother relegated to the domestic sphere.⁶⁵ At the same time but independently of the school, the role of Social Health Visitor was created in January 1942, together with a body of Rural Health Advisors, under the sole control of the Spanish Falange and the JONS.⁶⁶ The professional activity of these nurses incorporated social, religious and political propaganda, always under the supervision of the religious authorities and provincial party officials. Their work went beyond healthcare and was used as a vehicle for social, political and religious intervention.⁶⁷

In 1953, a further change in nursing education, introduced a new qualification, Technical Healthcare Assistant (Spanish initials: ATS).⁶⁸ This occurred at a time of intensifying ideological and educational regression in Spanish society, and was based on a model of gender discrimination. Its creation signified a major check on the process of nursing professionalisation in Spain, distancing the discipline still further from international trends. With this new modification, the name "nurse" was lost and nurses were obliged to adopt the new title, ATS, reflecting neither their history nor their healthcare functions.⁶⁹ The new qualification underlined the auxiliary, technical nature of nursing

⁶² Escuela Instructoras 1943.

⁶³ The Juntas de Ofensiva Nacional Sindicalista [Unions of the National-Syndicalist Offensive].

⁶⁴ The very presence of the Women's Section in managerial posts at the school reinforced these objectives, see Bernabeu-Mestre/ Gascón-Pérez 1999.

⁶⁵ On the impact of the Franco regime on women's lives, see Richmond 2004 and Sarasua/Moliner 2009.

⁶⁶ Galiana-Sánchez/Bernabeu-Mestre/García-Paramio 2012; Maceiras-Chans/Galiana-Sánchez/Bernabeu-Mestre 2017.

⁶⁷ On the impact of dictatorial regimes on the nursing profession, see Bartoloni 2006, pp.149-174; Steppe 2004. See also Franco et al. 2008.

⁶⁸ The new qualification brought together those of nurse, midwife and practitioner under one umbrella. In Spain, the term "practitioner" referred to an auxiliary medical profession, considered the male branch of nursing, with responsibilities for minor surgery and rural healthcare since its creation in 1888.

⁶⁹ At the first Assembly of Nurses held in 1959 following the creation of the new qualification, nurses penned the following: "We ask the Ministry of National Education to continue to use the classic and

and differentiated teaching content and organisation by gender. This was evident in the curriculum, which now contained different subjects according to gender (e.g. “Domestic Studies” for women and “Forensic Autopsy” for men). Similarly, boarding was compulsory for female students, but not for male students.⁷⁰

Throughout the 1950s, 1960s and 1970s, the situation deteriorated for nurses, as the gender gap widened and the subordinate nature of the profession was accentuated.⁷¹ Nurses’ labour rights, in particular those of public health nurses and educators, were also eroded and there were major deficiencies in continuing education. After completing their studies, nurses lost all supervisory contact or training from the Directorate-General for Health, their relationship with this institution being reduced to bureaucratic aspects. From the 1940s onwards, no advanced training courses were offered, which not only diminished nurses’ level of professional competence but also undermined their incentive and motivation.⁷² In 1977, after the restoration of democracy and much lobbying, nurses gained access to a university education through the university nursing diploma. Recently, with the latest university reform, the diploma has been transformed into a degree in nursing and nurses have also gained access to master’s degrees and doctorate programmes.⁷³

6 Conclusions

As has been shown, the development of public health nursing in Spain in the first decades of the 20th century was influenced by factors in the international arena that had a considerable impact on the discipline’s process of professionalisation. Changes in demography and health in Spain, echoes of the international health movement that emerged in Europe in the inter-war period and the Rockefeller Foundation’s promotion of healthcare models based on improving public health, all helped advance the process of nursing professionalisation in Spain and develop the healthcare specialism of public health nursing. The training of these nurses, delivered in Spain and the United States, facilitated the first professional achievements. Nurses served as counsellors and mentors in families’ everyday lives through home visits and health education, and as mediators between popular and scientific culture. They played a direct role in the study of the causes of infant mortality, analysing families’ living conditions and financial situation, and the domestic and social environment. As has been traditional in nursing activity in Spain and abroad, nurses worked closely with the general population, forging strong links with people in the community, and as a professional group, they constituted the front-line troops in the battle for regeneration.

universally understood name of nurse, instead of the newly created name of Technical Healthcare Assistant, the meaning of which is unintelligible both in Spain and abroad”, Lovingos 1959.

⁷⁰ Boletín Oficial del Estado (BOE) 1955.

⁷¹ Some of the factors that contributed to this process are described in Galiana-Sánchez/García-Paramio Bernabeu-Mestre 2009.

⁷² V Reunión Nacional de Sanitarios 1959.

⁷³ Zabalegui/Maciá 2011.

However, the grave consequences of the military coup, the ensuing Spanish Civil War and the subsequent dictatorship truncated the incipient process of development ushered in during the Second Spanish Republic and rendered it impossible to consolidate or build on earlier advances in the fields of healthcare and public health nursing. The process of modernising healthcare was halted, as was that of the professionalisation of public health nursing in Spain achieved in the first third of the 20th century. This process was delayed for more than forty years, a loss that merits consideration in the historical and ethical debate on the extent to which the Franco dictatorship observed the principles that should govern the actions of politicians in their capacity as stewards of the population's well-being. National and international institutional initiatives and political, social and personal efforts alike were all thwarted in the early stages of the Franco dictatorship, bringing a halt to social progress and improvements in public health and highlighting the ethical implications of the regime's policies.

The new regime's health authorities redirected health policies. Through home interventions, health visitors were expected to restore families' morale, establish surveillance mechanisms and supply information to the authorities. Health goals were discarded, to be replaced by other issues related to political and social control. The work of nurses lost its legitimacy once it became clear that their activities served an ideological purpose.

Furthermore, the Franco regime widened the gender gap in Spanish society, leading to situations of discrimination and inequality for women. This retrograde step for professional nursing cannot be separated from the emphasis placed on the traditional role assigned to women in Spanish society, who were relegated to the role of wives and mothers and excluded from decision-making. As women, nurses were expected to help foment patriotism, but only in the manner decreed by the political regime that the Franco dictatorship embodied.

In contrast to the momentum and consolidation of public health nursing in the international arena over the course of the 20th century, the reverse occurred in Spain, where the emphasis placed on an auxiliary and subordinate role carried out almost exclusively in hospitals led to a severe deterioration in the discipline, heightening its isolation and hindering its process of professionalisation.

María Eugenia Galiana-Sánchez (Dr), Department of Community Nursing, Preventive Medicine and Public Health, and History of Science, Spain

7 Bibliography

Andresen, Astri/Groenlie, Tore (eds.): Transferring Public Health, Medical Knowledge and Science in the 19th and 20th Century. Bergen 2007.

- Baly, Monica E.: Nursing and Social Change. London 1995.
- Barona, Josep L.: Salud, enfermedad y muerte. La sociedad valenciana. Valencia 2002.
- Barona, Josep L (ed.): Ciencia, salud pública y exilio (1875-1939). Valencia 2003.
- Barona, Josep L. (ed.): El exilio científico republicano. Valencia 2010.
- Barona, Josep L.: From Hunger to Malnutrition. The Political Economy of Scientific Knowledge in Europe 1918-1960. Brussels 2012.
- Barona, Josep L.: The Rockefeller Foundation, Public Health and International Diplomacy, 1920-1945. London 2015.
- Barona, Josep L./Bernabeu-Mestre, Josep: La Salud y el Estado. El movimiento sanitario internacional y la administración Española. Valencia 2008.
- Barona Josep L./Bernabeu-Mestre, Josep/Perdiguer, Enrique: Health Problems and Public Policies in Rural Spain (1854-1936). In: Barona, Josep L./Cherry, Steven (eds.): Health and Medicine in Rural Europe (1850-1945). Valencia 2005, pp. 63-82.
- Bartoloni, Stefania: Da una guerra all'altra: le infermiere della croce rossa fra il 1911 e il 1945. In: Goglia, Luigi/Moro, Renato/Nuti, Leopoldo: Guerra e pace nell'Italia del novecento. Bologna 2006, pp.149-74.
- Becerra, Cristina: Mercedes Milá Nolla, líder de las Enfermeras Visitadoras. In: Gomeres: Salud, Historia, cultura y pensamiento, <http://index-f.com/gomeres/?p=1346>, accessed August 30, 2017.
- Bernabeu-Mestre: La contribución del exilio republicano al desarrollo de la salud internacional: Julián de Zulueta Cebrián. In: Laberintos: revista de estudios sobre los exilios culturales españoles 5 (2005), pp. 5-21.
- Bernabeu-Mestre, Josep: La salut pública que no va poder ser. José Estellés Salarich (1896-1990): una aportació valenciana a la sanitat espanyola contemporània. València 2007.
- Bernabeu-Mestre Josep/Carrillo-García, Concepción/Galiana-Sánchez, María Eugenia/García-Paramio, María Pilar/Trescastro-López, Eva María: Género y profesión en la evolución histórica de la Enfermería Comunitaria en España. In: Enfermería Clínica 23 (2013), 6, pp. 284-89.
- Bernabeu-Mestre, Josep/Galiana-Sánchez, María Eugenia: Salud comunitaria y acción social en el control epidemiológico del tracoma infantil, España (1932-1939). Asclepio (2011a), pp. 507-20.
- Bernabeu-Mestre, Josep/Galiana-Sánchez, María Eugenia: La colaboración interdisciplinar en la transmisión del conocimiento de las ciencias de la salud y la internacionalización de las prácticas sanitarias. In: Porras, María Isabel/Gutiérrez, Bertha/Ayarzagüena Sanz, Mariano/De las Heras, Jaime (eds.): Transmisión del

conocimiento médico e internacionalización de las prácticas sanitarias: una reflexión histórica. Ciudad Real 2011b, pp. 363-366.

Bernabeu-Mestre, Josep/Galiana-Sánchez, M^a Eugenia: Determinantes laborales y de género en la epidemiología del tracoma en la España contemporánea. In: Cohen, Arón: El trabajo y sus riesgos en la época contemporánea. Conocimiento, codificación, intervención y gestión. Barcelona 2012a, pp. 91-122.

Bernabeu-Mestre, Josep/Galiana-Sánchez, María Eugenia: Alimentación, enfermería y cultura. El antecedente histórico de las visitadoras puericultoras. In: Gracia, Mabel (ed): Alimentación, salud y cultura: encuentros interdisciplinarios. Tarragona 2012b, pp. 459-478.

Bernabeu-Mestre, Josep/Galiana-Sánchez, María Eugenia/Cremades-Monerris, Angela: Environment and health with respect to a poverty-related disease. The epidemiology of trachoma in Spain, 1925-1941. In: Revista História, Ciências, Saúde-Manguinhos 20 (2013), pp. 1605-1619.

Bernabeu-Mestre, Josep/Gascón-Pérez, Encarnación: Historia de la enfermería de Salud Pública en España (1860-1977). Alicante 1999.

Boletín Oficial del Estado de 2 de Agosto de 1955. Orden de 4 de Julio de 1955. Ayudantes Técnicos Sanitarios. Normas para nueva organización de sus estudios. Ministerio de Educación Nacional 1955.

Borowy, Iris: Coming to Terms with World Health. The League of Nations Health Organisation, 1921-1946. Berlin 2009.

Boschma, Geertje: Writing International Nursing History. What Does It Mean? In: Nursing History Review 16 (2008), pp. 9-12.

Boschma, Geertje: International Nursing History. The International Council of Nurses History Collective and Beyond. In: Nursing History Review 22 (2014), pp. 114-118.

Commission Consultative des Questions Sociales, Sous-Comité pour l'étude de la formation des personnes employées dans la Service Social, 15 February 1939, Ligue of Nations Archive, Health Section. 8A dossier 7283.

Crowell F. Elizabeth: Memorandum re (sic). Nursing in Spain. 1931. Memo, 7 pp. Rockefeller Archive Center. Collection Rockefeller Foundation. Record group, 1.1 projects. Series 795c Box 1. Folder 3.

Davies, Celia: Rewriting Nursing History Again? In: Nursing History Review 15 (2007), pp. 11-28.

De Membrillera, Francisco: El problema sanitario de España. Exceso de mortalidad. Causas que la producen. Influencia de la Higiene en la economía nacional. Medidas de gobierno y acción de los ciudadanos para higienizar España y arrebatarse a la muerte más de 100.000 vidas por año. Madrid 1921.

- Dingwall, Robert/Rafferty, Anne M./Webster, Charles: An Introduction to the Social History of Nursing. London 1993.
- Dominguez-Alcón, Carmen: Los cuidados y la profesión enfermera en España. Madrid 1986.
- Dubin, Martin D.: The League of Nations Health Organization. In: Weindling, Paul (ed.): International Health Organisations and Movements, 1918-1939. Cambridge 1995, pp. 56-62.
- Escuela Nacional de Instructoras Sanitarias. In: Revista de Sanidad e Higiene Pública. Madrid 1943.
- Farley, John: The Cast out Disease. A History of the International Health Division of the Rockefeller Foundation (1913-1951). Oxford 2004.
- Franco, Tania C/Santo Tomás, Magdalena/Dueñas, María J./De Alencar, Ileda/García, María R.: La mujer y la enfermera en el nuevo orden social de los regímenes dictatoriales de Brasil y España. In: Temperamentvm 8 (2008). <http://www.index-f.com/temperamentum/tn8/t2008.php>. Accessed 30 August 2017.
- Galiana-Sánchez, M^a Eugenia: El papel de los organismos internacionales en el desarrollo de la enfermería de salud pública, 1933-1966. In: Guillem-Llobat, Ximo/Barona, Josep L. (ed.): Sanidad internacional y transferencia de conocimiento científico. Europa, 1900-1975. Valencia 2015, pp. 67- 83.
- Galiana-Sánchez, María Eugenia: The Role of International Organisations in the Development of Public Health Nursing, 1933-1974. In: Gesnerus 74 (2017), 2, pp. 188-204.
- Galiana-Sánchez, María Eugenia/Bernabeu-Mestre, Josep: Género y desarrollo profesional. Las enfermeras de salud pública en la España del período de entreguerras, 1925-1939. In: Feminismos 18 (2011), pp. 225-248.
- Galiana-Sánchez, María Eugenia/Bernabeu-Mestre, Josep/García-Paramio, Pilar: Nurses for a New Fatherland in Spain (1938-1942). In: Women's History Magazine (2012), pp. 33-41.
- Galiana-Sánchez, María Eugenia/Bernabeu-Mestre, Josep/Carrillo García, Concepción/García Paramio, Pilar/Mariño Gutiérrez, Lourdes/Trescastro López, Eva: El asociacionismo de las enfermeras de salud pública a través de la revista La Visitadora Sanitaria (1934-1935). In: Álvarez, Carlos/Hernández, Francisca/Fernández, M^a Luz (ed): El asociacionismo en enfermería y su influencia en el desarrollo de la profesión. 150 años de historia del Colegio de Enfermeras de Madrid. Madrid 2013, pp. 475-482.
- Galiana-Sánchez, María Eugenia/García-Paramio, María Pilar/Bernabeu-Mestre, Josep: La frustración de una profesión. La enfermería de salud pública en la V Reunión de Sanitarios, 1959. In: Temperamentvm, 9 (2009). <http://www.index-f.com/temperamentum/tn9/t2408.php>. Accessed 30 August 2017.

- Gallego-Caminero, Gloria: El proceso de profesionalización sanitaria y la transición demográfica en Mallorca (1848-1932). Doctoral Thesis. Mallorca 2009.
- Gascón-Pérez, Encarnación/Galiana-Sánchez, M^a Eugenia/Bernabeu-Mestre, Josep: La aportación de las enfermeras visitadoras sanitarias al desarrollo de la enfermería venezolana. In: Barona, Josep L.: Ciencia, salud pública y exilio (1875-1939). Valencia 2003, pp. 99-129.
- Gascón-Pérez, Encarnación/Galiana-Sánchez, M^a Eugenia/Bernabeu-Mestre, Josep: La acción social de las visitadoras sanitarias. In: Revista de Trabajo Social y Salud 43 (2002), pp. 149-174.
- Goff, Hazel Avis: Nursing in Austria, 1933-34a, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Bulgaria, 1933-34b, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Greece, 1933-34c, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Finland, 1933-34d, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Hungary, 1933-34e, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Yugoslavia, 1933-34f, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Norway, 1933-34g, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Poland, 1933-34h, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Czechoslovakia, 1933-34i, League of Nations Archive, Health Section. 8A dossier 7283.
- Goff, Hazel Avis: Nursing in Romania, 1933-34j, League of Nations Archive, Health Section. 8A dossier 7283.
- Huertas, Rafael: Organización sanitaria y crisis social en España. La discusión sobre el modelo de servicios sanitarios públicos en el primer tercio del siglo XX. Madrid 1995.
- Lovingos, María Luisa: Actas de la Primera Asamblea de Enfermeras. Madrid 1959.
- Maceiras-Chans José Manuel/Galiana-Sánchez, María Eugenia/Bernabéu-Mestre, Josep: Las actividades socio-sanitarias de las divulgadoras rurales de la Sección Femenina de Falange en la comarca de la Ribera, 1940-1958. In: Ferragud, C (ed), Biografies mèdiques, sanitat municipi`pal, educació sanitària i epidèmies. PUV, València 2017, pp. 149-160.

- McGann, Susan: Collaboration and Conflict in International Nursing, 1920-1939, In: Nursing History Review 16 (2008), 1, pp. 29-57.
- Molero Mesa, Jorge: La lucha antituberculosa en España en el primer tercio del siglo XX. In: Atenza, Juan y Martínez, José (eds.), Toledo 2001, pp. 131-147.
- Mortimer, Barbara/McGann, Susan (eds.): New Directions in the History of Nursing. International Perspectives. Abingdon 2005.
- Perdiguero, Enrique (ed.): Salvad al niño. Estudios sobre la protección a la infancia en la Europa mediterránea a comienzos del siglo XX. Valencia 2004.
- Perdiguero, Enrique/Castejón, Ramón (eds): La acción social de la medicina y la construcción del sistema sanitario en la España contemporánea. Trabajo Social y Salud (Monográfico) 43 (2002).
- Pérez-Moreda, Vicente/Reher, David S./Sanz-Gimeno, Alberto: La conquista de la salud. Mortalidad y modernización en la España contemporánea. Madrid 2015.
- Pozzi, Lucia/Bernabeu-Mestre, Josep/Galiana-Sanchez, María Eugenia. Le modèle explicatif des maladies infectieuses associées à la misère et à la pauvreté. L`expérience espagnole et italienne dans la première moitié du XXème siècle. Histoire, Economie et Société (2017), pp. 39-56.
- Rafferty, Anne Marie: Tiptoeing Towards a History of Nursing in Europe. In: Nursing History Review 22 (2014), pp. 107-113.
- Richmond, Kathleen: Las mujeres en el fascismo español. La sección femenina de la falange, 1935-1959. Madrid 2004.
- Rodríguez-Ocaña, Esteban: La construcción de la salud infantil. Ciencia, medicina y educación en la transición sanitaria en España. In: Historia Contemporanea 18 (1999), pp. 19-52.
- Rodríguez-Ocaña, Esteban/Martínez-Navarro, Ferran: Salud Pública en España. De la Edad Media al siglo XXI. Granada 2008.
- Sarasua, Carmen/Molinero, Carmen: Trabajo y niveles de vida en el franquismo. In: Borderias, Cristina. (ed.): La Historia de las Mujeres. Perspectivas actuales. Barcelona 2009.
- Sección de Noticias. In: Revista Sanidad e Higiene Pública 8 (1933), p. 430.
- Sección de Noticias. In: La Visitadora Sanitaria 4 (1935), pp. 17-18.
- Steppe, Hilde: Nursing under Totalitarian Regimes. The case of National Socialism. In: Rafferty, Anne Marie/Robinson, Jane/Elkan, Ruth (ed.): Nursing History and the Politics of Welfare. London 2004.
- Tusell, Javier: Historia de España. Barcelona 2001.
- Verdes Montenegro, José: Las instructoras sanitarias. In: La Visitadora Sanitaria 1 (1934), pp. 11-12.

V Reunión Nacional de Sanitarios. Libro de Actas. Madrid 1959.

Weindling, Paul: Social Medicine at the League of Nations Health Organization and the International Labour Office Compared. In: Weindling, Paul (ed.): International Health Organisations and Movements, 1918-1939. Cambridge 1995, pp. 134-53.

Weindling, Paul: Philanthropy and World Health. The Rockefeller Foundation and the League of Nations Health Organisation. In: Minerva 35 (1997), 3, pp. 269-281.

WHO, Expert Committee on Nursing: Report of the First Session. Technical Report Series 24. Geneva 1950.

WHO: Nursing. In: The First Ten Years of the World Health Organization. Geneva, 1958, 391-402.

WHO, Expert Committee on Nursing: Public Health Nursing, Fourth Report. Technical Report Series 167. Geneva 1959.

WHO: Aspects of Public Health Nursing. Geneva 1962.

WHO, Expert Committee on Nursing: Fifth Report. Technical Report 347. Geneva 1966.

WHO, Expert Committee on Nursing: Nursing and Community Health. Technical Report Series 558. Geneva 1974.

Zabalegui, Adela/Maciá, Loreto: Desarrollo del máster y doctorado oficial de enfermería en España. Castellón 2011.