European Journal for Nursing History and Ethics

Second Issue: Bads in Nursing Ethics, History and Historiography

Content

Editorial

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1 Bads in Nursing Ethics, History and Historiography

The question of what constitutes good care and how the understanding of this varies historically and culturally is the subject of intensive reflections on the history and ethics of care. Less attention, however, is paid to negative experiences in nursing care. According to the Dutch philosopher Annemarie Mol such experiences are termed ambiguously as "bads" in care: "There is something else that bothers me. It is that somehow writing about the goods of care is just too nice. Too cosy. There are also bads to address, but how to do so?"[1]

The second issue of the European Journal for Nursing History and Ethics is related to the International Conference "'Bads' in healthcare: Negative experience as an impetus to reform in nineteenth and twentieth centuries" organised by the Swiss Society of the History of Health and Nursing, 21/22 June 2018 in Winterthur, Switzerland. The aim of the conference was to enlarge our understanding of how nurses were interlinked with "bads" in healthcare, of how they addressed and responded to negative experiences and how they contributed to the reform of healthcare in the 19th and 20th centuries.

The conference showed that historically oriented research is faced with the particular challenge that what we might consider 'bad' today as a matter of course may have been classified by the historical actors as modern, progressive and 'good' care. This is true, for example, of the commitment of nurses to the implementation of eugenic concepts that Mary D. Lagerwey is investigating in the United States. In her contribution, she examines the discourses in the field of nursing that have contributed significantly to establishing eugenics as a modern science for dealing with social problems. With reference to the USSR, Kristina Popova also examines the significance of nurses in the implementation of a new Soviet medical system in the 1950s which could be described as the "utopia of silence". This utopia is symbolic of the Stalinistic project of a well-ordered society where people follow scientifically determined rules which require them to maintain silence and, as a result, their bodies and psyches are brought into a state of health.

Johanna Annola discusses how the understanding of 'good' and 'bad' nursing changed in the process of medicalisation and professionalisation of care, using the example of workhouse nursing. She analyses the multifaced experience of 'badness' in light of English and Finnish poor law records, 1855-1914 and shows that the local-level poor relief agents were often slow to adopt the new ideals and practices associated with nursing. Anna Urbach deals with negative experiences in healthcare from the perspective of nursing staff. Using the example of a Prussian State Asylum, she analyses the beginnings of trade union organisation and highlights the strategies used by nurses to improve working conditions.

In the open section Nadia Primc discusses from an ethical perspective the phenomenon of "care left undone" – the fact that nurses can only perform certain care activities incompletely

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[1] Mol, Annemarie: Care and its values. Good food in the nursing home. In: Mol, Annemarie, et al. (eds.): Care in Practice. On Tinkering in Clinics, Homes and Farms. Bielefeld 2010, pp. 215-234, here p. 229.

due to a lack of resources. Primc discusses on the one hand the scope and limits of individual responsibility of nurses and on the other hand the challenges of an ethically reflected handling of rationing and priority-based decisions. Monika Ankele examines the history of the permanent bath in psychiatry and shows that the nursing practice and the relationship between nurses and patients were significantly influenced by the spatial and material arrangements of the treatment. She pleads for the development of a much greater sensitivity for the effectiveness of material settings in ethical questions.

We would like to thank Sabina Roth and the Swiss Society of the History of Health and Nursing for organising the conference that resulted in the contributions in this issue and for the good cooperation.

Bad Nursing? Workhouse Nurses in England and Finland, 1855–1914

Johanna Annola

Abstract

This article discusses workhouse nursing in England and Finland by analysing the ways in which local-level poor law records reflect the contemporary understandings of bad nursing. The article shows that in England, the workhouse system was established long before the emergence of the principles of medical nursing in the 1850s, which is why the evolution of workhouse nursing is long and versatile. In Finland, by contrast, these two developed simultaneously at the turn of the nineteenth and twentieth centuries, which explains the attempts to combine professional nursing with workhouse management from the beginning. Local-level records show that in both countries the definition of 'good nursing' and 'bad nursing' – in other words the expectations associated with a nurse's duties and her ethical principles – changed over time as nursing became more medicalised and professionalised. However, the local poor relief agents were often slow to adopt new ideals and practices, and instead tended to stick to their own understandings of nursing. Both in England and Finland pauper nurses remained a common phenomenon well into the twentieth century.

1 Introduction

Workhouses were first established in England and Wales after the passing of the Workhouse Act of 1722/1723. These institutions were gradually replaced by new workhouses, which were established by Poor Law Unions after the passing of the Poor Law Amendment Act of 1834. The main purpose of a nineteenth-century workhouse was to exclude the able-bodied poor from receipt of poor relief: paupers were no longer to be granted relief while out in the community but were placed in the workhouse, where they were required to earn their keep.[1] The overall conditions in a workhouse were to be harsh enough so that the paupers would prefer to earn their living instead of resorting to poor relief. Thus the workhouse system would reduce the costs of poor relief to the ratepayers.[2] In practice, the transition from the old workhouses to the new ones was slow, because the Poor Law Unions were often reluctant to abandon their old poor relief practices and the state poor relief authorities – the Poor Law Commission and its successors, the Poor Law Board and the Local Government Board[3] – lacked both workforce and means of hastening the local-level actors.[4]

The English Poor Law Amendment Act of 1834 inspired a wave of poor relief reforms, which reached the Nordic Countries in the 1860–70s. In Finland, a new Poor Relief Act was passed in 1879 and a

[1] Broad 2000, p. 167; King 2000, p. 24.
[2] Fraser 2009, pp. 52–55.
[3] Bellamy 1988; Wood 1991, p. 83; Fraser 2009, pp. 60–65; Fowler 2014, pp. 11–15.
[4] King 2000, pp. 66–67; Levine-Clark 2000, p. 109; Hooker 2013, pp. 3–6, 290–291, 298; Reinarz/Schwarz 2013, p. 3.

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network of workhouses[5] was established from the 1880s onwards.[6] Compared to the English Union workhouses, those in Finland were not only newer but also decidedly smaller. While the former were intended to serve a catchment area of 10,000 people, the latter were established by individual municipalities and were planned to serve an average population of a couple of thousand people. Consequently, while the English workhouses could in most cases accommodate several hundred paupers, the largest urban institutions in Finland were usually designed for 100–200 paupers and rural institutions might have capacity for as few as fifteen to forty paupers.[7] Practical arrangements in the institutions were nevertheless similar in both countries.

A nineteenth-century workhouse served as a deterrent for the able-bodied poor, but it also provided shelter and medical care for infirm paupers. In fact, the aged and the sick comprised a large proportion of workhouse inmates in both England and Finland throughout the period studied.[8] Lynn McDonald has described the English (British) workhouse infirmaries as 'the real hospitals of the sick poor' – especially the chronically ill.[9] However, according to Steven King, the exact place of workhouses in the 'mixed economy of medical care' for the nineteenth-century English poor remains unclear, because these institutions coexisted in the medical market with friendly societies, medical charities, worker subscription charities, quack doctors and medical self-help.[10] Conversely, in Finland Minna Harjula has suggested that for most poor people municipal poor relief was indeed the only route to medical care well into the twentieth century, because the number of other providers of medical care was extremely low, especially in rural areas.[11] At the same time, the role of the workhouse itself in grassroots medical care has not been a subject of scholarly interest in Finland.[12]

While there exists an overwhelmingly large body of research on the English workhouses, only a small part of it specifically analyses medical care in these institutions. Workhouse nursing, in particular, has not attracted much scholarly attention since Rosemary White's pioneering work, which was published in 1978. Perhaps the most detailed recent works are Kim Price's study of medical negligence in Victorian Britain as well as Angela Negrine's doctoral thesis on poor law medical services in Leicester Poor Law Union, 1867–1914, and Alistair Ritch's doctoral thesis on the same subject in Birmingham and Wolverhampton Poor Law Unions, 1834–1914.[13] Nursing in workhouse infirmaries is also discussed in studies that deal with the nursing pioneer Florence Nightingale, such as those authored by Monica Baly, Anne Summers and Lynn McDonald. The scarcity of research is even more pronounced in Finland: nursing is usually not even mentioned in the context of

[5] In the interests of clarity, the term 'workhouse' is used in this article for both English and Finnish poor law institutions established after the poor relief reforms in 1834 (England) and 1879 (Finland). This is a conscious departure from the scholarly convention of referring the Finnish municipal poor law institutions as 'poorhouses' (*köyhäintalo*) and the specific penal institutions for hardened vagrants and other criminals as 'workhouses' (*työlaitos*). For similarities between English and Finnish poor law institutions, see Annola 2019 a; for British discussion on terminology, see Reinarz/Schwarz 2013, p. 2; King 2013, pp. 230–232.

[6] Between 1809 and 1917, Finland was a part of the Russian Empire having the status of an autonomous Grand Duchy with a central administration and legislative bodies of its own.

[7] Longmate 2003, p. 64, 88; Annola 2011, pp. 62–63.

[8] Fraser 2009, pp. 67–68, Annola 2011, pp. 49–53.

[9] McDonald 2004, p. 485; McDonald 2009, p. 578.

[10] King 2013, p. 230, 239–240.

[11] Harjula 2015; Harjula 2016.

[12] There are, however, sporadic accounts of non-resident people seeking the nurse's attention in the local workhouse, see Annola 2011, p. 217.

[13] For a more detailed overview on previous research on workhouse nursing, see Negrine 2008; Ritch 2014.

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workhouses despite the fact that the Finnish state poor relief authorities stipulated nursing skills among the qualifications for workhouse matrons from the very beginning of the 'workhouse boom'.[14]

This article contributes to the discussion by focusing on workhouse nurses and the ideals associated with nursing in England and Finland, 1855–1914, that is until the Poor Law Institutions (Nursing) Order of 1913 came into force in England and Wales. The article analyses workhouse nursing and the multifaceted experience of 'badness' in light of English and Finnish poor law records, which contain information on the appointments and dismissals of workhouse officers, intra-staff relations, treatment of paupers and communication with the state poor relief authorities. The article does not seek to provide a comprehensive picture of the quality of nursing in poor relief as a whole. Rather, it discusses the ways in which local-level documents reflect the contemporary understandings of 'bad nursing'.

The concept of 'badness' provides an interesting framework for a study of workhouse nursing for two reasons. First, in nineteenth-century England there existed a correlation between 'badness' and inferior professional skills with a career in a workhouse. Previous research has shown that workhouse positions in general were regarded as 'second-class service' because of the monotonous and unpleasant working environment and low salaries. As it was believed that that no one would willingly take up such a position, those who nevertheless did so were easily labelled by their professional community as professionally inferior. Workhouse medical officers, for example, were often depicted as 'third-rate' doctors.[15] Similarly, Finnish research has shown that women of the upper social strata shunned the occupation of a workhouse matron because of the hard work, the low salary and the ambivalent social status associated with such a position.[16]

Secondly, the research so far seems to be unanimous in suggesting that with a few exceptions, workhouse nursing in England exemplified 'bad nursing' for most of the nineteenth century. Prior to the 1870s, and in many places beyond that date, a trained nurse in a workhouse was rare indeed. In most institutions, nursing was in the unskilled hands of able-bodied paupers or female workhouse officers, such as the matron or the schoolmistress.[17] Workhouse histories of late have departed from the earlier dark view of the workhouse and instead concentrated more on interactions between the inmates and the staff, and on the more positive experiences of inmates.[18] But the history of workhouse nursing remains dark, concentrating on scandals and cases of maltreatment of paupers.

The English source material comprises the minute books of the Board of Guardians (1855–1914) and the House Committee (1904–1914) of Banbury Poor Law Union.[19] The Union included 51 parishes surrounding the market town of Banbury in Oxfordshire, south-eastern England. A

[14] The connection between nursing, healthcare and workhouses has been discussed by the present author (2011, 2020) and Minna Harjula (2015).

[15] Crowther 1981, p. 141; Wood 1991, p. 91; Crompton 1997, p. 233; Negrine 2013, pp. 192–193; Reinarz/Ritch 2013, p. 141; Ritch 2014, p. 257; Price 2015, p. 31, 85, 134.

[16] Annola 2018, pp. 48–49.

[17] Crowther 1981, p. 131, Wood 1991, p. 91, 111; Longmate 2003, p. 203.

[18] See for instance, Green 2006, 2010; Humphries 2010, 2013; Tomkins 2013, Carter/James/King 2019.

[19] The material was collected during the present author's visit to the University of Oxford in 2016 in order to get an overview of the material available and find out how (if at all) female staff members are presented in different kinds of poor law records.

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workhouse was established in the 1830s for 300 paupers, and a separate workhouse infirmary was built in the 1870s.[20] The Finnish accounts of workhouse nurses, by contrast, are too sporadic for a case study on a single workhouse. Therefore, workhouse nursing in Finland is discussed in light of documents held in the archives of the state poor relief authorities, which included an Inspector and three Instructors of Poor Relief.[21] These documents cover all workhouses in Finland. They include correspondence between the state authorities and local-level actors, as well as workhouse inspection records (1880–1914).

Local-level records are explored in relation to the broader contemporary discussion on the quality of workhouse nursing. The source material includes the reports compiled by the British Departmental Committee on Workhouse Nursing (1902)[22] and Royal Commission on the Poor Laws and Relief of Distress (1909)[23], general guidelines for nurses such as those specified by Florence Nightingale, and the more specific guidelines for workhouse officers in both England and Finland. The time gap of almost fifty years between the passing of the Poor Law Amendment Act of 1834 in England and the Poor Relief Act of 1879 in Finland allows for an analysis of the similarities and differences between the two countries.

2 The Reform of Workhouse Medical Care in Mid-Nineteenth-Century England

As established earlier, nursing in mid-nineteenth-century English workhouses left a lot to be desired. The shortcomings were due equally to lack of demand and of supply. On the one hand, there was no adequate reserve of trained sick-nurses,[24] that is, nurses who – according to Florence Nightingale – would help the patient suffering from a disease to live.[25] On the other hand, the central poor relief authorities showed little interest in workhouse nursing. The Consolidated General Order for Poor Law Unions issued in 1847 remaining largely unchanged until the end of the period studied, provided no specific instructions concerning the qualifications, working hours or accommodation of workhouse nurses.[26] It was simply stated in the Order that a workhouse nurse's duties included attending upon the sick according to the directions of the medical officer and informing the medical officer of any defects in the arrangements of the sick. In addition, a nurse was to take care that a

[20] Banbury Union workhouse staff included a master and a matron, a medical officer, a chaplain, a porter and a cook throughout the period of interest. The number of other employees – such as schoolmaster, schoolmistress and nurses – varied over the course of time.

[21] Pulma 1995; Annola 2016, pp. 207–209.

[22] Report of the Departmental Committee appointed by the President of Local Government Board to enquire into nursing of the sick poor in workhouses. Part I: Report and Summary of Recommendations, London 1902 (1902 Report).

[23] Report of the Royal Commission on the Poor Laws and Relief of Distress. London 1909, pp. 1–645 (1909 Majority Report); Report of the Royal Commission on the Poor Laws and Relief of Distress. London 1909, pp. 719–1238 (1909 Minority Report).

[24] For a discussion on the number of professional nurses in pre-WW1 Britain, see Price 2015, pp. 128–129.

[25] In her article on sick-nursing and health-nursing, published in 1893, Florence Nightingale explained that 'nursing the sick is an art [--] requiring an organised, practical and scientific training, for nursing is the skilled servant of medicine, surgery and hygiene'. Health-nursing, in turn, was 'to keep or put the constitution of the healthy child or human being in such state as to have no disease'. McDonald/Nightingale 2004, pp. 205–208.

[26] Wood 1991, p. 111.

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light was kept at night on the sick-ward. In order to perform her duties, she had to be able to read the written instructions upon medicines.[27]

The process of appointing a workhouse nurse generally involved no medical expertise, because the appointment was made by the local Board of Guardians, not by the medical officer. Previous research has suggested that the Guardians were primarily interested in saving the ratepayers' money by using able-bodied paupers as free labour in workhouse infirmaries.[28] Pauper nurses, who were often regarded as women of questionable reputation, became the embodiment of bad nursing. According to the contemporaries' accounts, these women 'could neither read nor write' and their 'love for drink often drove them to rob the sick of the stimulants which they should have given to them'. Pauper nurses' 'treatment of the poor was, generally speaking, characterised neither by judgment or by gentleness'.[29] As observed by one of the reformers of workhouse medical care, Louisa Twining, the patients were helplessly at the mercy of these violent women, 'of whom they dare not complain, knowing what treatment would be visited upon them in revenge if they did'.[30] Nurse Matilda Beeton, who had worked at two London workhouses, stated in her testimony that there were patients dying on the floor of the sick ward, and Florence Nightingale suggested that workhouse patients could, in fact, be murdered at will.[31]

The campaign for the reform of workhouse medical care began after the discovery of horrific shortcomings in medical care in two London workhouses in 1864–65.[32] In addition to Florence Nightingale, the principal campaigners included the Workhouse Visiting Society under the leadership of Louisa Twining, the author Charles Dickens, a London-based workhouse medical officer Joseph Rogers as well as the leading medical journal the *Lancet*.[33] The campaign resulted in the passing of the Metropolitan Poor Act in 1867, which separated the administration of London poor law hospitals from that of workhouses.[34] The new law set the tone for future development by emphasising the role of professionalism in workhouse medical care.

Florence Nightingale especially stressed that nursing in workhouse infirmaries was to be organised according to the modern principles of sick-nursing, which she had introduced after the Crimean War and were already being followed, to varying degrees, in voluntary hospitals.[35] The Nightingale Home and Training School for Nurses had been opened in 1860 as a part of St Thomas's Hospital in London. The school heralded the emergence of institutions which trained women to be professional nurses by offering them an education in anatomy and physiology, as well as practical training on

[27] Consolidated General Order (1847), Art 165, Art. 213.
[28] Longmate 2003, p. 199, 203; McDonald/Nightingale, p. 578.
[29] The 1866 Report on Metropolitan Workhouses quoted in 1909 Majority Report, p. 239. See also Twining 1858, pp. 13–15; Rogers 1889, pp. 12–13, 113–114.
[30] Twining 1858, p. 14.
[31] McDonald/Nightingale 2004, p. 224. Price 2015, p. 65. Florence Nightingale became involved in workhouse nursing as early as in the 1840s, as she attempted (unsuccessfully) to acquire nursing experience in the Salisbury Workhouse Infirmary. However, it was only after Crimean War that she would start working on trained workhouse nursing, first in Liverpool Workhouse Infirmary. McDonald/Nightingale 2009, pp. 12–13.
[32] Baly 1988, pp. 85–86; Price 2015, pp. 58–60.
[33] Richardson/Hurwitz 1989, pp. 1507–1510; Wood 1991, pp. 112, 131–132; Longmate 2003, pp.142–143, 204–205; Price 2015, pp. 61–67.
[34] Baly 1988, pp. 87–89; Green 2010, pp. 245–246; Price 2015.
[35] McDonald/Nightingale 2004, 2009; see also Summers 2002, p. 144.

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the wards and in the operating theatres.[36] At the same time, Nightingale formulated the practicalities for the proper care for the sick – such as the importance of cleanliness and a holistic approach to patients' well-being – in her epoch-making guidebook *Notes on Nursing: What It Is and What It Is Not*, first published in 1860.[37] These developments increased the supply of trained nurses especially in the capital and other large cities and changed the public understanding of what was to be required of a nurse.

According to Nightingale, a trained sick-nurse did not 'physick' her patients with calomel and aperients as 'amateur females' often did. Instead, she observed the patient in order to distinguish between real and fancied imagined disease, and to discover which symptoms indicated improvement and which the opposite; which were of importance and which were not; which were evidence of neglect – and what kind of neglect. In other words, it was a nurse's ethical duty to put the patients 'in the best condition for nature to act upon' them. When in charge, a good nurse did not only carry out the proper measures herself but saw that everyone else did so as well. She knew how to ensure that nursing duties were performed when she was not in charge: her stores, closets, books and accounts were kept in such a manner that anybody could understand and carry on. A good nurse had a firm, light, quick step and a steady, quick hand. She was punctual, calm and persevering. She did not burden the patients with her own uncertainties – or as Nightingale put it: 'Let your doubt be to yourself, your decision to them'.[38]

In addition to her professional skills, a good nurse had a good moral character: she was sober and chaste, strictly honest and truthful. These qualities were important, first, because they were regarded as an essential part of 'true womanhood',[39] or as Nightingale put it: '[…] anyone would see how, of all women, a nurse […] must never allow a free word or look.' Second, the motivation was professional: by deviating from sobriety, chastity and honesty, a nurse would jeopardise her ability to take care of her patients. 'For how can a drinking woman attend properly to her patients?' Nightingale asked in a letter written in 1879, 'And how can a dishonest woman attend to her patients? […] she will – the cardinal sin in all unreformed nursing – exact petty bribes of all sorts from the patients. And those patients, who do not and cannot give it will be cruelly, sometimes fatally, neglected.' In addition, as crucial as professional skills were, a nurse devoid of kindness, devotion and patience was not a good nurse. Nightingale described 'the merely clever nurse', who might 'be wanting in all these things' and remarked that in the worst cases 'the bad woman, the clever nurse, must be an idiot if she cannot hoodwink a doctor'. By this, Nightingale was referring to the bad nurses' tendency to keep their maltreatment of patients secret from their superiors.[40]

Florence Nightingale believed that in order to improve the quality of care in workhouse infirmaries, they should be totally removed from the workhouse system.[41] As Lynn McDonald points out, Nightingale's vision was radical in her own time. Louisa Twining and the Workhouse Visiting Society,

[36] O'Brien King/Gates 2007, pp. 309–333.
[37] O'Brien King/Gates 2007, pp. 309–333. According to Ruth Davies, there were three different versions of Florence Nightingale's book: the first one (published in 1860) was intended for the general reader, the second (1860) for professional nurses and the third (1861) for the working classes. Davies 2012, pp. 624.
[38] Nightingale 1860. See also McDonald 2010, pp. 100–105.
[39] On the ideal of womanhood, see for example Welter 1966; Smith-Rosenberg 1985; Davidoff/Hall 1987; Häggman 1994; Tosh 1999.
[40] Florence Nightingale to Marie von Miller, March 17, 1879, quoted in McDonald/Nightingale 2009, pp. 475–476.
[41] McDonald/Nightingale 2009, p. 581.

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for example, only sought to eliminate the most obvious abuses in workhouse infirmaries, not to radically transform the system. According to McDonald, Nightingale's revolutionary view resulted from her understanding of the sick poor: for her, they were no longer paupers to be subjected to harsh workhouse life and punitive measures. Instead, they were 'fellow creatures in suffering', who deserved the best care, provided by trained nurses.[42]

The question of good workhouse nursing was also bound to the question of social class. It was emphasised by Florence Nightingale that, while pauper nurses would only gain authority over pauper patients by resorting to violence, a trained nurse would encourage a major improvement in the patients' behaviour without any forcible measures.[43] This view of a trained workhouse nurse as someone who could cultivate the masses was bound in to a wider contemporary pattern of thought, in which a middle-class woman (a 'lady') had an obligation to 'mould the conduct of her social inferiors' through her maternal influence in their lives.[44] It was in this very spirit that Nightingale published in 1871 an article entitled *Una and the Lion* with the purpose of urging women to be self-sacrificing, to embark on a career in professional nursing – and even to nurse in workhouse infirmaries.[45]

3 Nursing in a Nineteenth-Century Rural Workhouse in England

For someone looking for vivid local-level accounts of bad nursing or tracing the experience of workhouse nursing reform, the nineteenth-century Banbury poor law records are disappointing: remarks on nurses' qualifications, their everyday duties in the infirmary or complaints about the way in which the nurses performed their duties are extremely rare. The scarcity has also been noted by Angela Negrine and Alistair Ritch in their works on Leicester, Birmingham and Wolverhampton Poor Law Unions.[46] It appears that the quality of nursing simply did not normally merit the nineteenth-century Guardians' attention – or that if there were discussions on nursing, they did not end up in the records, which tend to be very concise.

In 1855, nursing in Banbury Union workhouse was the responsibility of a man named William Freeman. He was helped by an assistant nurse Ellen Veary, who was the daughter of the master and the matron.[47] After nurse Freeman's resignation the same year, the matron turned to the Board of Guardians signifying 'her desire to dispense with the services of such an Officer provided that her daughter Ellen Veary were allowed to assist her.' The Board granted the matron's request and

[42] McDonald/Nightingale 2009, pp. 577–582.
[43] Nightingale 1867, p. 31; see also McDonald/Nightingale 2004, p. 481.
[44] Summers 2002, p. 142, 149. Margaret Crowther has suggested that the early nurses were not recruited from among the upper social strata. In fact, those nurses who ended up practising their profession in a workhouse infirmary were often working-class women, who in some cases had failed in the voluntary hospitals. Crowther 1981, pp. 176–177; see also Negrine 2008, p. 102, 111.
[45] Nightingale 1871; McDonald/Nightingale 2009, p. 420. Nightingale's article was a tribute to her friend, nurse Agnes Jones, who worked at Liverpool Workhouse infirmary prior to her untimely death at the age of 35. For more on Jones and her role in workhouse infirmary reform, see Baly 1988; Summers 2002; McDonald/Nightingale 2004.
[46] Ritch 2014, p. 262; Negrine 2008, p. 107.
[47] Banbury Poor Law Union Board of Guardians (Board of Guardians): Minute Book, January 11, 1855, Oxfordshire History Centre (OHC), PLU1/G/1A1/10.

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appointed Ellen Veary under the title of assistant matron.[48] Nursing duties were shared among the women of the Veary family for a decade, and it was not until after the resignation of the matron in 1866 that the Board decided to dismiss Ellen Veary, too, and appoint a nurse from outside the workhouse.[49] Relying on family bonds was typical of the English workhouses at the time: for example, married couples were preferred to unmarried workhouse masters and matrons throughout the period studied, due to considerations of propriety, family economy and efficiency.[50]

Banbury poor law records indicate that the nurse was paid from early on.[51] Given that there was no specific order making it obligatory for the Boards of Guardians to employ salaried nurses,[52] the Banbury Guardians can be regarded as progressive. However, no specific training was required of the nurse. For example, it was stated in an advertisement published in the *Oxford Times* in 1867 that the Guardians intended to appoint a 'Nurse for the Union Workhouse' and that 'persons seeking the situation must be able to read and write'.[53] The situation remained similar for decades: In 1888, the Guardians received a letter from the Local Government Board enquiring as to whether nurse Mary Elizabeth Roberts had acquired 'any experience in Nursing and if so where'. The Guardians replied that while Roberts had *not* practised nursing before commencing her duties in Banbury Union workhouse, she was nevertheless performing satisfactorily.[54] Judging by the fact that Roberts was still at her post in 1890,[55] her lack of training bothered neither the Guardians nor the central poor relief authorities. In their eyes, Mary Roberts was a good nurse.

In order to understand the Guardians' silent content, one has to know what was required of a nurse in an average rural workhouse. It is not without reason that historian Kim Price has characterised the 1860s as the 'false dawn' of professional workhouse nursing as opposed to the 'true dawn' at the end of the century:[56] while the overall conditions and the quality of nursing improved in workhouse hospitals in London and some large urban unions elsewhere after the passing of the

[48] Board of Guardians: Minute Book, April 26, 1855, OHC, PLU1/G/1A1/10.
[49] Board of Guardians: Minute Book, November 29, 1866, OHC, PLU1/G/1A1/14 and October 3, 1867, OHC, PLU1/G/1A1/15.
[50] Crowther 1981, p. 116, 143. The Guardians' habit of appointing married couples as Master and Matron of a workhouse was increasingly criticised by contemporaries. For example, according to the 1909 Minority Report, it would be surprising if both husband and wife would be competent at their specific tasks, see 1909 Minority Report, pp. 730–731. In Banbury Union workhouse the master and the matron were not necessarily a married couple – rather, it seems that in the latter part of the century the role of matron was taken by the mothers or daughters of just two families. In the 1850s the institution was managed by Thomas and Mary Ann Veary, who were succeeded in the 1860s by George and Jane Hedges. After the death of Mrs. Hedges in 1871, her two daughters were appointed consecutively as matrons. These, in turn, were succeeded in 1875 by Amelia Ann Veary, the daughter of the previous master and matron. She held the post until 1901. During the latter part of the period studied Banbury Union workhouse was once again run by a married couple, the Carringtons. Board of Guardians: Minute Book, 1855–1914, OHC, PLU1/G/1A1/10–44.
[51] Pauper nurses are not mentioned explicitly in Banbury poor law records. However, as Angela Negrine points out in her work on Leicester Union workhouse infirmary, the limited mention of pauper nurses in the source material does not mean that they were not used as additional workforce. Negrine 2008, p. 100; see also Price 2015, p. 138.
[52] Minority Report, p. 861.
[53] The *Oxford Journal,* April 20, 1867.
[54] Board of Guardians: Minute Book, April 12, 1888, OHC, PLU1/G/1A1/25.
[55] Board of Guardians: Minute Book, September 25, 1890, OHC, PLU1/G/1A1/27.
[56] Price 2015, p. 181.

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Metropolitan Poor Act, most provincial workhouse infirmaries remained backward.[57] It appears that neither the changing ideals associated with nursing nor the increasing number of trained nurses available had an impact on everyday life in these institutions.

For the local Guardians, a salaried nurse was not a sick-nurse in the true sense of the word but someone who took care of duties that had much in common with ordinary women's chores in a large household.[58] After all, neither the Consolidated General Order nor the early guidebooks on workhouse management pointed in any other direction. For example, according to a manual authored by one of the assistant secretaries of the Poor Law Board and first published in 1848, a nurse's everyday tasks included taking proper care of the sick, providing them with the proper diet according to the orders of the medical officer, as well as furnishing the patients with 'such changes of clothes and linen as may be necessary'. These instructions were repeated in the second edition of the book, which was published twenty years later.[59] In another workhouse manual, written by the medical officer of the Poor Law Board and published in 1870, it was stated that a nurse was to make the patients comfortable by keeping an eye on hygiene, ventilation and the order of the sick beds.[60] Thus no specific medical expertise let alone difficult ethical choices were required of the nurses, as all major decisions were taken by the Guardians, the master or the medical officer.

Correspondingly, the Banbury Board of Guardians' evaluation of the early nurses were not based on their skills in sick-nursing but on their literacy[61] and general conduct, such as sobriety, honesty and sense of duty. It is likely that, for the Guardians, proper conduct marked the distinction between a good and a bad woman, and hence also the distinction between a good and a bad nurse – not to mention a pauper nurse. For example, according to a statement given in 1873 by the Guardians, 'during the time Ellen Veary occupied the position of Assistant Matron at the Union Workhouse' she had 'discharged her duties satisfactorily' and the Board were 'quite satisfied with her general character and conduct'.[62] Similarly, the Board stated the following year that nurse Sophia Brown 'had conducted herself with propriety during the time she held the Office of Nurse' and that she was 'strictly sober and honest'.[63] Judging by the Guardians' standards, the only example of 'bad nursing' was Mary Cleaton. The master had discovered that nurse Cleaton 'after leaving the Workhouse had returned thereto in state of Drunkenness and totally unfit for her duties and that she had since absconded'. The Board resolved unanimously to dismiss her.[64] The mentions of intoxicated nurses are thus extremely rare in Banbury poor law records. The paucity of accusations of drunkenness suggests, in line with Alistair Ritch, that the tales of drunken and disorderly workhouse nurses were probably exaggerated.[65]

[57] 1909 Minority Report, p. 728.
[58] See also Negrine 2008, p. 99; Hawkins 2010, p. 76.
[59] Lumley 1848, p. 31; Lumley 1869, pp. 25–26.
[60] Smith 1870, pp. 230–234.
[61] For example, in 1870, the Poor Law Board wished to know if nurse Mary Rogers could read and properly understand the medical officer's 'written directions upon the Medicines prescribed for the sick'. In their reply, the Guardians gave their assurance that the medical officer was satisfied with Rogers' ability to read. Board of Guardians: Minute Book, February 3 and February 10, 1870, OHC, PLU1/G/1A1/16.
[62] Board of Guardians: Minute Book, December 24, 1873, OHC, PLU1/G/1A1/18.
[63] Board of Guardians: Minute Book, January 8, 1874, OHC, PLU1/G/1A1/18.
[64] Board of Guardians: Minute Book, October 10, 1869, OHC, PLU1/G/1A1/16.
[65] Ritch 2014, p. 296.

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In the 1890s, at the 'true dawn' of professional workhouse nursing, the appointment of pauper nurses was officially banned by the passing of the Nursing in Workhouses Order of 1897. It was also stipulated in the Order that where Guardians appointed three salaried workhouse nurses, one of them must be a trained nurse and hold the position of a superintendent nurse. Furthermore, as Kim Price so aptly puts it, the Local Government Board 'opened the floodgates to probationer nurses', that is, nurses who were trained in workhouse infirmaries for a career in the same.[66] However, the speed of development should not be exaggerated in the case of the 'true dawn', either: as pointed out in the 1909 Minority Report, Guardians in some unions chose to evade the Nursing in Workhouses Order altogether by appointing what were called 'ward maids' to do the work of nurses.[67] In addition, pauper nurses were still employed under the title of 'helpers' or even 'probationers' in the less developed workhouses well into the twentieth century.[68]

Banbury poor law records give the impression that towards the end of the nineteenth century the Guardians were to a certain extent interested in modernising medical care and nursing in the workhouse. In the early 1890s, the Board decided to erect a separate building for sick children 'at the North end of the present Infirmary for the purpose of isolating the sick children from the aged and infirm Inmates'.[69] It was planned that 'the Nurse or Nurses would attend to the Children in the new building in the same manner they had hitherto done in the Infirmary'.[70] Given that the 1909 Minority Report mentioned the lack of separate wards or buildings for sick children as one of the common shortcomings of workhouse medical care,[71] the Banbury Board of Guardians' resolution seems fairly progressive; neither did the Guardians attempt to circumvent the Nursing in Workhouses Order but appointed a superintendent nurse at the turn of the century. She was responsible for overseeing the work of charge nurse(s) and assistant nurse(s).[72]

4 Workhouse Nursing in Late Nineteenth-Century Finland

By the late nineteenth century, the Finnish workhouse system was taking shape. The Finnish state poor relief authorities, the Inspectorate of Poor Relief, sought among other things to monitor the qualifications for workhouse staff. In the early 1890s the state authorities recommended that small rural workhouses – which, in fact, comprised the majority of Finnish workhouses – should be managed by a female governor, a matron. In the eyes of the authorities workhouses represented an extension of the private home, thus, rendering them amenable to female leadership. The Inspectorate's notion was in line with the contemporary pattern of thought typical of Florence Nightingale among others: as women had an inborn aptitude for nurture and education, they were more than capable of both taking care of the infirm paupers and converting the able-bodied ones into respectable citizens. In supervising activities that were considered more masculine – such as male paupers' work in agriculture and forestry – the matron was assisted by a male steward. The

[66] Price 2015, p. 181; see also Hawkins 2010, p. 90. For scandals and debates which led to the passing of the Order, see Price 2015, pp. 135–137.
[67] 1909 Minority Report, p. 861.
[68] Twining 1893, p. 122; Wood 1991, p. 91, 136; Longmate 2003, pp. 206–207; Price 2015, pp. 124–125; 135–136.
[69] Board of Guardians: Minute Book, July 28, 1892, OHC, PLU1/G/1A1/28.
[70] Board of Guardians: Minute Book, September 8, 1892, OHC, PLU1/G/1A1/28.
[71] 1909 Minority Report.
[72] See for example Board of Guardians: Minute Book, August 29, 1901, OHC, PLU1/G/1A1/34.

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supreme power within the institution nevertheless rested with the matron, because the results of a workhouse mainly depended on the internal order in the institution and not on its agricultural productivity.[73]

Not all women were regarded as fit for the position of a matron. In order to clarify this, the Inspectorate introduced qualifications for workhouse matrons in 1892. These included literacy as well as skills in housekeeping, nursing, mental health nursing, childcare and bookkeeping.[74] This meant that in small workhouses the duties of matron and nurse were combined – and where both a matron and a nurse were appointed, it was nevertheless regarded as useful for the matron to have a good knowledge of nursing.[75] In fact, similar preferences emerged in England, where the improvements in the standards of workhouse infirmaries affected a matron's qualifications as well: matrons with nursing qualifications were much in demand.[76]

As there was no bespoke education available for workhouse matrons in Finland until the 1920s, prospective applicants had to decide unaided where to practise in order to meet the qualifications. The state poor relief authorities pointed out that a training period in a hospital was especially useful, because it both provided the applicant with practical skills in nursing and helped her find out whether or not she was fit to be a nurse (or a matron). After all, most people were 'likely to find the patients miserable, their wounds and bodily injuries repulsive and the lunatics frightening'.[77] The state authorities' records, however, contain information on nurse training for less than one fifth of those women who were appointed as workhouse matrons between 1880 and 1918. In addition, this information is often sporadic regarding the place and duration of nurse training. 'Nursing experience' could mean anything: a certificate from a private physician stating that the applicant had 'practised nursing' for a couple of days, a six-weeks' training course organised by the Finnish Red Cross, a six months' training course in a provincial hospital or several years' experience as a professional nurse or a deaconess.[78]

The wide variety covered by the term 'nursing' was linked to the fact that a systematic training scheme for nurses was not established by the government until 1892, when the Finnish Senate began to organise nurse training courses in all six provincial hospitals.[79] At the same time, an

[73] For more on the ideal of female leadership in workhouses, see Satka 1994, pp. 261–263; Pulma 1995, p. 117; Annola 2011, pp. 66–82, 200–201; Annola 2019 a. For more on how taking up the role of a matron affected individual women's lives, see Annola 2017, pp. 145–155; Annola 2018; Annola 2019 b, pp. 190–195.

[74] Helsingius 1892, pp. 2–4.

[75] Annola 2011, p. 105.

[76] 1902 Report, p. 18, 40; see also Crowther 1981, pp. 117, 124–125, 149.

[77] Helsingius 1892, pp. 2–4.

[78] The database, which contains 483 workhouse matrons, was compiled by the present author for her doctoral thesis.

[79] Florence Nightingale's *Notes on Nursing* was translated into Swedish in the early 1860s, Swedish being the official language of Finland until 1863. The first steps towards Nightingale nursing were taken in the late 1880s by nurse Anna Broms, who was appointed superintendent nurse of the newly-opened Helsinki Surgical Hospital in 1888. She organised the first training course for Finnish nurses there in 1889. Broms had studied nursing in Stockholm and at the Edinburgh Royal Infirmary under Angelique Lucille Pringle, who was one of Florence Nightingale's pupils. Broms also visited St Thomas's hospital in London. Nurse Ellen Ekblom, however, was the only Finnish nurse ever to meet Florence Nightingale in person. Ekblom visited St Thomas's hospital in 1896, and Nightingale was eager to learn more about the aseptic methods then in use in Finland. According to Nightingale, Ekblom could teach her and the nurses at St Thomas's 'a great deal more than we could teach her'. Nurse Sophie Mannerheim, in turn, studied at St Thomas's in the years 1899 to 1902. She was appointed the superintendent

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alternate route to nurse training existed in the form of four Deaconess Institutions. Two of these were established in the 1860s in Helsinki and Vyborg. The model for these was taken from similar institutions in Kaiserswerth (where Florence Nightingale had studied nursing in the 1850s), Dresden and St. Petersburg. The two other Finnish deaconess institutions were established after a Norwegian model in the 1890s.[80] Both provincial hospitals and deaconess institutions provided training in theoretical and practical aspects of sick-nursing.

Variation in Finnish nurse training was reflected in the quality of workhouse nursing. On the one hand, a record of Johannes workhouse in eastern Finland, dated 1914, reveals that the state poor relief authorities were of the opinion that a matron who was a trained nurse could to a certain extent substitute for a doctor. The authorities gave the following statement on the local Poor Relief Board's choice of matron: 'Deaconess Anna Serenius has, without any doubt, sufficient nursing skills and experience. This is especially important in municipalities such as Johannes, where there is no municipal medical officer.'[81] Given that there were over 500 municipalities but only 144 municipal medical officers in Finland in 1910,[82] the state authorities' statement was certainly topical.

On the other hand, the records reveal that in some workhouses practical nursing duties were entrusted to pauper women – and that the local Poor Relief Boards were happy with their performance. For example, it was reported from Hausjärvi workhouse, southern Finland, in 1910 that nursing was satisfactorily performed by a female inmate who preferred men's clothes and went by a man's name.[83] In Kirkkonummi workhouse, southern Finland, a female inmate named Karolina Pettersson was used as a nurse in between her illegitimate pregnancies in the early 1900s. Surprisingly enough, it appears that she was still in her post in 1913, taking care of the mentally ill. According to the inspection report, both the Poor Relief Board and the medical officer considered her skilled and trustworthy despite her background and the fact that her vocal cords were damaged as a result of a venereal infection which she had contracted earlier in her life. One of the state authorities described her appearance as 'forbidding', while even more amazingly, another state official appears to have later added, rather dryly, in the margin of the report: 'I suppose we cannot demand beauties?'[84]

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nurse of Helsinki Surgical Hospital in 1904. Sorvettula 1998, pp. 41–42, 67, 429, 432, 447; Tallberg 2003, pp. 816–817; McDonald/Nightingale 2009, pp. 12, 491–495. For a detailed account of the development of the nursing profession in Finland, see Tallberg 1989; Tallberg 1991; Sorvettula 1998.

[80] Markkola 2016, pp. 139–144; Paaskoski 2017, pp. 35–39, 97. Louisa Twining, one of the prime movers behind the English workhouse infirmary movement of the 1860s, was also profoundly impressed by the deaconess institution in Kaiserswerth. In a pamphlet published in 1858, Twining suggested that a similar institution – albeit remodelled to suit 'the English tastes' – could benefit those women in her home country who wished to work in poor relief. However, according to Carmen M. Mangion, the deaconess movement gained only marginal significance in Britain, as the development of nursing profession was bound to the emergence of the secular model of voluntary hospitals. Twining 1858, p. 25; Mangion 2016, p. 181.

[81] Instructor Bruno Sarlin to Inspector Gustaf Adolf Helsingius, April 3, 1914, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Johannes municipality, Fb:13.

[82] Hakosalo 2010, p. 1548.

[83] Inspection record, September 19, 1910, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Hausjärvi municipality, Fb:19.

[84] Inspection record, September 5–6, 1902; Instructor Axel Nilsson to Inspector Gustaf Adolf Helsingius, November 29, 1913, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Kirkkonummi municipality, Fb:3. Judging by handwriting, the dry remark was added by Inspector Helsingius.

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Furthermore, it appears that the line between a pauper and a nurse was a fine one: a pauper could become a nurse, but at the same time, a nurse could become a pauper. In an inspection held in Kuopio workhouse, eastern Finland, in 1900, a former nurse was found among the unmarried mothers residing in the institution. According to the inspection protocol, her downfall was the consequence of an affair with the workhouse steward.[85] While it is not known whether she was a trained nurse or not, her fate nevertheless highlights a characteristic of early twentieth-century Finland: individual misfortunes could not be relieved by the primitive social security system of the time.[86]

The ambivalence considering the practical nursing arrangements in workhouses indicates that, similar to England, the Finnish Poor Relief Boards were often slow or reluctant to follow the instructions given by the state poor relief authorities. In principle, the Finnish state authorities had the right to intervene in Poor Relief Boards' choices of workhouse officers by virtue of their legal obligation to ensure that the existing poor relief and health legislations were obeyed in the municipalities. At the same time, however, the qualifications for workhouse matrons, for example, did not bind the local boards in the same sense, as for example, the English Consolidated General Order did. Thus the qualifications represented a grey area in the legislation. Given that the Inspectorate consisted of one Inspector and three Instructors, there was only so much the state authorities could personally do in a relatively large country with inadequate means of communication.

5 Workhouse Nursing in the Early Twentieth Century

The number of nursing staff in Banbury Union workhouse increased steadily over the years. While in 1855 nursing had been the responsibility of a male nurse and his female assistant, in 1911 the nursing staff consisted of a superintendent nurse, a senior charge nurse, a junior charge nurse, two senior nurses, and two junior nurses.[87] The following year the Local Government Board gave their blessing to the introduction of a probationer nurse scheme at Banbury Workhouse infirmary.[88] With the opening of an infirmary in the 1870s and a separate building for sick children in the 1890s, the number of beds for sick inmates had also increased. In 1914 it was reported by the medical officer that there were over a hundred beds for the sick in the institution.[89] It seems therefore that medical functions gained more floorspace in Banbury Union workhouse during the period studied – a development that culminated after the Second World War with the transformation of the workhouse into a National Health Service hospital. These changes reflect the fact that the

[85] Inspection record, June 11–12, 1900, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Kuopio city, Fb:32.

[86] For more on encountering impoverishment in nineteenth- and early twentieth-century Finland, see Frigren/Hemminki 2017.

[87] Board of Guardians: Minute Book, March 23, 1854, OHC, PLU1/G/1A1/9; January 4, 1855, OHC, PLU1/G/1A1/10; November 9, 1911, OHC, PLU1/G/1A1/42. The Banbury Board of Guardians formulated qualifications for nurses in 1911. Both superintendent nurse and senior charge nurse were to have undergone at least three years' training in nursing as well as to hold a recognised qualification in midwifery. A junior charge nurse, too, was to be a trained nurse. The two senior nurses, by contrast, were only expected to have practical experience in nursing.

[88] House Committee: Minute Book, December 31, 1912, OHC, PLU1/G/2A1/4.

[89] Banbury Poor Law Union House Committee (House Committee): Minute Book, May 19, 1914, OHC, PLU1/G/2A1/4.

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workhouse formed an 'organic' unit, which evolved to meet the changing ideologies and needs associated with poor relief and healthcare.[90]

The development was not without problems: the emergence of a superintendent nurse at the turn of the nineteenth and twentieth centuries complicated power relations in English workhouse infirmaries and caused friction among staff members.[91] The main cause of these problems was the ambivalent status of superintendent nurses, as provided for by the Nursing in Workhouses Order (1897). Although the superintendent nurse supervised the work of other nurses and pauper helpers in the infirmary, these were all nevertheless under the master's and the matron's command.[92] These conflicts are represented also in Banbury poor law records. In the summer of 1901, the Board of Guardians were contacted by the superintendent nurse stating that she was dissatisfied because 'she had not the power to give Assistant Nurses leave of absence'. The Board, who were aware that 'certain difficulties' had indeed 'arisen between the Master and Matron and the Nurses at the Workhouse',[93] tried to ameliorate the situation later the same year by authorising the superintendent nurse to give leave of absence to assistant nurses.[94]

It appears, however, that the friction persisted and that the tense atmosphere in the workhouse infirmary provided a fertile soil for accusations of bad nursing. For example, in early 1902 the master reported to the Banbury Board of Guardians that 'the Superintendent Nurse had been rude and insulting to the Matron' and that an inmate had complained about the way in which the superintendent nurse had treated her.[95] The superintendent nurse, in turn, presented the Board with two letters stating that the inmate in question, 'a woman named Emily Edwards', had withdrawn her accusations. As a consequence, the Board decided to free the superintendent nurse of any blame, and instead dismiss the master and the matron.[96] It seems that the Banbury Board of Guardians believed in fresh starts: as the superintendent nurse and the assistant nurse handed in their resignations the following year, the Board resolved to give notice to the second assistant nurse as well. Although no fault was found with the manner in which the said nurse had performed her duties, it was 'desirable for the good administration of the Workhouse Infirmary that a complete change of the nursing staff be made'.[97]

It is likely that the power struggles contributed to the difficulties the Banbury Board of Guardians experienced in retaining the nurses they appointed between 1903 and 1906. There was nothing

[90] See also Crowther 1981, pp. 136–137; Crompton 1997, p. 235; Reinarz/Schwarz 2013, pp. 3–5. Correspondingly, a schoolmaster and mistress were an essential part of the staff until the late 1870s, when Banbury Board of Guardians decided to send workhouse children to the local schools and schoolteachers' services were thus no longer needed. Board of Guardians: Minute Book, November 28, 1878, OHC, PLU1/G/1A1/20; September 27, 1881, OHC, PLU1/G/1A1/22.

[91] 1902 Report, pp. 29–30; 1909 Minority Report, p. 862; see also McDonald/Nightingale 2009, p. 587. See also Board of Guardians: Minute Book, August 29, 1901, January 16, 1902, February 24, 1902, March 13, 1902, OHC, PLU1/G/1A1/34.

[92] 1902 Report, p. 33, 35.

[93] Board of Guardians: Minute Book, August 29, 1901, OHC, PLU1/G/1A1/34.

[94] Board of Guardians: Minute Book, December 19, 1901, OHC, PLU1/G/1A1/34.

[95] Board of Guardians: Minute Book, January 16, 1902 and March 13, 1902, OHC, PLU1/G/1A1/34.

[96] Board of Guardians: Minute Book, March 24, 1902, OHC, PLU1/G/1A1/34.

[97] Board of Guardians: Minute Book, January 29, 1903, OHC, PLU1/G/1A1/35. The local newspapers such as the *Banbury Guardian* and the *Banbury Advertiser* followed the disagreements keenly – an interesting topic for a study of its own.

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unusual *per se* in the rapid turnover of nurses: it was stated in the 1909 Majority Report that rural Guardians 'frequently experience a difficulty in obtaining nurses for their workhouses'[98] It appears that nurses' lack of commitment was not necessarily regarded as a sign of their bad nursing ethics but rather as an indicator of an intolerable working environment. It was suggested in the Majority Report that trained nurses were not interested in positions in rural workhouses because of the 'inadequacy of the nurses' salaries, the unsatisfactory accommodation provided, the long hours and monotony of the occupation, the absence of companions of equal social status, and the general dislike of young people for quiet country districts'.[99] The turnover of nurses in Banbury Union workhouse, however, was exceptionally rapid: between 1903 and 1906, no less than fifteen nurses resigned from service in the workhouse.[100] For example in Wolverhampton Union workhouse a total of eighteen nurses were employed over a period of *fifty* years.[101]

In 1906, the Banbury Board of Guardians appointed a special committee to consider the situation, because the rapid turnover of nurses was regarded as detrimental to the quality of nursing as a whole. Bad nursing ethics was not brought into discussion in this case, either. In pondering the nurses' lack of commitment, the special committee pointed out that although the relations among nurses were now good, continuous friction persisted between the nursing staff and the workhouse staff. However, it appears that as the committee were unable to prove that the friction was the direct cause of the difficulties in retaining nurses, and because there was, in fact, little they could do to reorganise the power relations in the workhouse as a whole, they chose to lay the blame elsewhere. The committee decided to concentrate on improving the nurses' harsh working conditions and ended up suggesting that their lives and surroundings should be made 'as bright as possible'.[102] As an immediate response, the House Committee decided to improve the nurses' diet with cake and jam.[103] In 1908 further plans were made to refurbish the nurses' common room in order to make it more comfortable.[104] These proceedings, too, indicate that the local Guardians were interested in maintaining the quality of nursing in the workhouse.

Accounts of friction among workhouse staff become more numerous again around 1910. This time the majority of the Guardians laid the blame on superintendent nurse H. A. Hart, who had held her office for several years and whose 'relations with certain other officials of the Workhouse' had not proved 'altogether happy'.[105] It appears, firstly, that there was indeed a series of minor conflicts between nurse Hart and other staff members. She had, for example, trodden on the master's toes by granting one of the assistant nurses a permission to accommodate a guest for a couple of

[98] 1909 Majority Report, p. 273.

[99] 1909 Majority Report, p. 273. Similar thoughts had been expressed in the 1880s by Louisa Twining, who encouraged female Guardians in particular to relieve the monotony of the nurses' lives. Moreover, as pointed out by the matron of Marylebone Workhouse Infirmary in 1894, a trained nurse would not stay where pauper help was allowed, because in such places a nurse 'who is not conscious deteriorates at once and is no longer a nurse but labour mistress'. Twining 1858, p. 16; Twining 1887, pp. 9–11; Twining 1893, p. 261; Elizabeth Vincent to Florence Nightingale, December 23, 1894, quoted in McDonald/Nightingale 2004, p. 487.

[100] Board of Guardians: Minute Book, November 1, 1906, OHC, PLU1/G/1A1/38.

[101] Ritch 2014, p. 256.

[102] Board of Guardians: Minute Book, November 1, 1906, OHC, PLU1/G/1A1/38.

[103] House Committee: Minute Book, November 13, 1906, OHC, PLU1/G/2A1/1.

[104] House Committee: Minute Book, February 2, 1908 and February 18, 1908, OHC, PLU1/G/2A1/2.

[105] Board of Guardians: Minute Book, November 9, 1911, OHC, PLU1/G/1A1/42.

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nights,[106] insulted the matron,[107] and failed to cooperate with the laundry staff.[108] Second, the number of accusations of bad nursing increased in 1911–1912, which either indicates that nurse Hart was unable to properly supervise her juniors, or implies that the friction resulted into more or less fabricated accusations. Superintendent nurse Hart resigned in January 1912.[109] It seems, however, that the situation calmed down completely only after 1912, when the Guardians finally received new orders from the Local Government Board, stating that master and matron were to be 'relieved of the duty of visiting the sick and lying-in wards' and that some of their responsibilities were to be delegated to the superintendent nurse.[110]

The complaints recorded in Banbury Union 1911–1912 show that the line between good and bad nursing manifested in a variety of ways. In one case a patient received a burn from a too-hot water bottle;[111] in another, a patient was allegedly gripped too tightly;[112] while in a third example, an infant patient was left unfed for ten and a half hours (instead of four).[113] In other examples: the nurses failed to report to the medical officer that one of the patients had fallen over;[114] and one of the nurses neglected her patients and apparently failed to 'use both fact and kindness in dealing with patients under her charge.'[115] These complaints reveal that a nurse's obligation to promote the well-being of her patients was considered so important that failures – whether real or fabricated – were likely to receive public attention. In addition, the resignation of superintendent nurse Hart indicates that – as Florence Nightingale had stated – nursing skills alone did not make a good nurse. While the Board of Guardians desired to acknowledge Hart's qualities as a nurse, they were nevertheless of the opinion that her resignation was likely to be in the best interests of the institution.[116]

As in England, accounts of bad nursing become more numerous in the Finnish material during periods of power struggles in or around the workhouse. The poor law records show that friction among workhouse staff was not unknown in Finland, either. Conflicts between the matron and the nurse were inevitable given their overlapping expertise and the practical work in the institution. It seems that such disagreements became more common towards the end of the period studied, heralding the major change which was to take place after the passing of the Finnish Poor Law of 1922, when the workhouses ceased to exist as multipurpose institutions and the focus shifted towards professional care for the elderly. As in the English case, this implies that as nursing in general became more professionalised, it was natural for the nurses to aim at organising their wards in the way that *they* regarded to be most practical. In other words, the move away from bad nursing could result in conflict in the institution.

Accusations of bad nursing could also reflect the prevailing – or changing – power relations in society at large. In 1912, Matilda Bergström, the matron of Siuntio workhouse in southern Finland, was accused of neglecting the care of Elin Lindgren, a seventeen-year-old girl, who was 'in the last stage

[106] House Committee: Minute Book, October 13, 1908, OHC, PLU1/G/2A1/2.
[107] House Committee: Minute Book, May 23, 1911, OHC, PLU1/G/2A1/3.
[108] House Committee: Minute Book, March 2, 1909, OHC, PLU1/G/2A1/2; September 27, 1910, OHC, PLU1/G/2A1/3.
[109] Board of Guardians: Minute Book, January 18, 1912, OHC, PLU1/G/1A1/42.
[110] Board of Guardians: Minute Book, March 28, 1912, OHC, PLU1/G/1A1/42.
[111] House Committee: Minute Book, March 28, 1911, OHC, PLU1/G/2A1/3
[112] House Committee: Minute Book, March 28, 1911, OHC, PLU1/G/2A1/3.
[113] House Committee: Minute Book, August 29, 1911, OHC, PLU1/G/2A1/3.
[114] House Committee: Minute Book, December 19, 1911 and January 2, 1912, OHC, PLU1/G/2A1/3.
[115] House Committee: Minute Book, October 22, 1912, OHC, PLU1/G/2A1/4.
[116] Board of Guardians: Minute Book, November 9, 1911, OHC, PLU1/G/1A1/42.

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of tuberculosis'. According to Elin's mother, the matron had left the seriously ill girl all alone in the workhouse infirmary for two nights, which is why the mother had decided to bring her daughter home. Elin died soon after. In the police investigation that followed, the matron stated that she had tried to take care of Elin 'to the best of her ability' and that the girl herself had not complained about anything at all. Matilda Bergström further explained that she had not left the patient alone for the first night but 'checked on her'. As for the second night, the matron had 'asked one of the inmates to stay' with Elin, but the patient had preferred to sleep alone. In the end, no further measures were taken against the matron, because the local Poor Relief Board was in general satisfied with her. It was also pointed out that the complaints of Elin Lindgren's mother were not to be taken seriously because she was known to be 'a woman with a reputation', who was not married to the man she was living with.[117] The case of Elin Lindgren shows that the plaintiff's social status may have had an impact on the way in which his or her complaint about bad nursing was dealt with. A mother with a questionable reputation could not convince the state poor relief authorities or the police that the matron had been wrong in leaving the terminally ill patient alone.

In the early 1900s and the 1910s the shortcomings of Finnish workhouse nursing as well as the perceived inconsistencies in dealing with the complaints were to a growing extent brought up by socialists, who collected paupers' complaints and published them in the newspapers.[118] The socialists regarded the workhouse system as a prime example of inequality in municipal decision-making and the oppression of the poor and were thus eager to provide the paupers with an opportunity to appeal to public opinion.[119] In the tense political atmosphere of the time, this led into a plethora of complaints about bad nursing, such as maltreatment of patients, filthiness in infirmaries and carelessness in dealing with patients with infectious diseases. According to one of the most blatant complaints, the matron of Pietarsaari workhouse in western Finland had allowed a consumptive patient to gnaw at bones, after which the bones were dried in the oven and served to the rest of the inmates in a soup.[120] The authorities dismissed most complaints as groundless.

6 Conclusion

This article has explored 'bad nursing' in local-level poor law records in England and Finland and discussed the findings against the contemporary reports and guidebooks on nursing and workhouse maintenance. As Banbury Union workhouse in England was both fifty years older and ten times larger than most workhouses in Finland, the evolution of workhouse nursing is much longer and more versatile in the former. In England the workhouse system was established long before the emergence of the principles of medical nursing. In Finland, by contrast, these two developed simultaneously at the turn of the nineteenth and twentieth centuries, which explains the

[117] August Wrede to Inspector Gustaf Adolf Helsingius, June 15, 1912; A record of a police investigation, July 30, 1912; District Police Superintendent Carl W. Troberg to Inspector Gustaf Adolf Helsingius, August 15, 1912, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Siuntio municipality, Fb:2.

[118] For paupers' agency, see Green 2006, 2010; Annola 2019 a.

[119] Annola 2011, pp. 234–239. Finland introduced universal suffrage in national elections in 1906, but universal suffrage in local government elections had to wait until 1917. Prior to that, the right to vote was based on property qualifications.

[120] A newspaper clipping from *Vapaa Sana*, September 10, 1909, The National Archives of Finland, The Archives of the Inspector of Poor Relief, Pietarsaari municipality, Fb:23.

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attempts to combine professional nursing with workhouse management from the beginning. Models were taken from abroad. In addition to realigning themselves with the nursing principles introduced by Florence Nightingale in Great Britain, the Finnish intelligentsia also acquired knowledge from Germany and Norway.

In both countries 'bad nursing' manifested in nurses' failure to perform their duties, in their maltreatment of paupers, their tendency to end up in power struggles with other workhouse staff members, and, to some extent, in their disorderly conduct such as drinking or promiscuity. It also appears that the expectations associated with a nurse's duties and her performance changed over time as nursing became more medicalised and professionalised. However, this article's findings concur with previous studies in suggesting that the speed of change in local-level poor relief should not be exaggerated. In fact, one of the things the English and Finnish workhouses have in common is the local Boards' tendency to stick to their own understandings of nursing and resort to pauper nurses as 'helpers' well into the twentieth century. As such, a local-level study may yield valuable knowledge by showing that the definitions of 'bad nursing' and 'good nursing' were, indeed, relative.

The article raises the question whether or not local-level poor law records provide enough information for a study of bad nursing in the workhouse. The English source material used in this article is ample, but as the documents were created for administrative purposes only, they have their limitations. While the minutes of Banbury Poor Law Union do indeed deal with the everyday life in a workhouse, they fail to reflect certain subtle undercurrents such as practical working arrangements or minor crises in the institution. Similarly, the Finnish documents provide information on workhouse officers and the overall conditions in the workhouses, but as the Finnish documents arose from situations in which the normal routine of the institution was interrupted by an intervention by the state authorities, it is likely that problems and discontinuities are overrepresented in the material.

Moreover, as both English and Finnish poor law records tend to be fairly concise, detailed quotations from individual nurses or other officers are extremely rare. Consequently, it has not been possible to track individual nurses' experiences in the scope of this study. This calls for a broader analysis of workhouse nurses utilising a more extensive set of material. In the English case, this would mean using poor law records from different unions and from the central files held at The National Archives. In the Finnish case, a more detailed study on workhouse nursing would mean digging deeper into local-level material and finding new kinds of sources, sporadic as they may be. It is likely that a closer analysis of disagreements between local workhouse officers would provide more information on individual nurses' experiences and agency vis-à-vis bad (or good) nursing.

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How Much Politics is Permissible in the Nursing of the "Insane"? The History of the Unionisation of Psychiatric Nurses in the German Reich through the Lens of the Uchtspringe Prussian State Asylum 1900–1933

Anna Urbach

Abstract

This article sheds light on nurses' early ventures into union work, it analyses the conditions, circumstances and boundaries the unionisation of psychiatric nurses entailed during the German Reich in the early 20th century. I use the staff files of selected nurses and orderlies from the former Uchtspringe Prussian State Asylum to reconstruct case histories of unionised nursing staff. We can say that until the ban on organising was lifted in 1918, the nurses of the "insane" were strictly forbidden to act independently of the institution's management within a trade union. Nonetheless, there is evidence that a number of nurses and orderlies of Uchtspringe were members of the German Association of Nurses and Orderlies (Deutscher Verband der Krankenpfleger und Krankenpflegerinnen) even before the beginning of the First World War. In 1919, a branch of the Association of Municipal and State Workers (Verband der Gemeinde- und Staatsarbeiter, VGS), which had close ties to the Social Democratic Party of Germany (SPD), was founded at Uchtspringe, and during the Weimar period it became the main union representative of Uchtspringe's committed staff. When the National Socialists seized power, they abruptly ended the activity of the Uchtspringe branch board members, which were branded as "politically unreliable". Through the investigation of diverse historical sources including ego documents this article focuses on the self-perception and perception others had of the unionised nurses, in the context of changing management and political systems and the impact of gender issues. Beyond that I investigate the input the VGS headquarters had to a new concept of nursing ethics which provided an alternative to the ethical basis of denominational and secularised sisterhoods.

1 Introduction

Spring 1933: after the National Socialists had gained power at the beginning of the year, they immediately began to restructure Germany. Leading Communists and Social Democrats were deposed from their political offices, and Jews and politically unpopular civil servants were removed from their positions. The new leaders occupied the offices (and editorial offices) of the "free" unions[1], took leading functionaries into "protective custody" and confiscated the union assets. In the weeks following the remaining unions were likewise forced to join and submit to the newly founded Deutsche Arbeitsfront (German Labour Front).[2] The rapid removal of the democratic political order and the destruction of the German labour movement could be felt in the cities as well as the countryside. Similarly, in healthcare institutions changes of staff took place on the management level. In the Landes-Heil- und Pflegeanstalt Uchtspringe (Uchtspringe State Asylum) in the Prussian Province of Saxony the National Socialists abruptly ended the appointment of the leading consultant for psychiatry Heinrich Bernhard (1893–

[1] "Free" unions was the term for unions of the 19th and 20th century that promoted a socialist agenda. The term evolved during the 1890s to delineate these unions both from older liberal and also from younger Christian unions. Umbreit 1931.

[2] Lorenz 2013, pp. 49–50.

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1945). The parliament of the province decided to dismiss the practising Jew and Social Democrat based on the recently enacted Gesetz zur Wiederherstellung des Berufsbeamtentums (a law for the restoration of the professional civil service).[3] Bernhard was murdered in 1945 in a concentration camp. His fate is representative of many other Jewish doctors during the time of National Socialism.

In 2017 the medical historian Annette Hinz-Wessels published an article on Bernhard[4] in which she also describes the circumstances of his deposition in 1933. Bernhard who had been the head of the asylum in Uchtspringe since 1929, was accused of having preferentially hired staff with Marxist convictions. Furthermore he was supposed to have misused his professional role to invite both personnel and patients to become members of the Sozialdemokratische Partei Deutschlands (SPD) (Social Democratic Party of Germany) and the union Verband der Gemeinde- und Staatsarbeiter (VGS) (Association of Municipal and State Workers). His behaviour was one of the reasons, according to his accusers, that the asylum was also nicknamed "Red Uchtspringe".[5]

Hinz-Wessels does not mention in her article that while the proceedings to dismiss Bernhard were under way, three orderlies and four nurses were also let go from the asylum due to engaging in union activities.[6] The report states that the nursing staff had largely been Marxist in attitude and organisation in the past. It attributes the responsibility for this to a few agitators and continues that these had to be removed today in order to rule out further Marxist influence on nursing staff in the future if possible.[7]

The accusations against Bernhard and the nursing staff were based on interviews that the National Socialists conducted among the doctors, administrative staff and nurses at Uchtspringe. At the time of the interviews both the respondents and the accused had already experienced the violent events of the National Socialists' assumption of power. Yet while the interview transcripts as a historical source must be regarded with due caution, they depict an unusual image of psychiatric care.

At the beginning of the 20th century when the system of psychiatric institutions in the German Reich underwent a founding boom and was largely put under the control of the authorities, the nurses of the "insane" were regarded as uneducated, crude and hardly organised in terms of unionisation. We can deduce this much from the debates between psychiatrists and politicians about the issue of nursing assistants around 1900.[8] Other sources – mainly written by both orderlies and nurses themselves – are rare for the time period in question. Yet, this is only one possible explanation for the blind spot that existed for a long time in the historiography. Rather, the prejudices – prevalent to this day – about nursing in general and psychiatric

[3] Reichsgesetzblatt 1933.
[4] Hinz-Wessels 2017.
[5] Commissarial Governor of the Province of Saxony [Comm. Governor] to the Prussian Minister of the Interior [Pruss. Minister]: Bericht über die Kündigung des Direktors Heinrich Bernhard (Report on the dismissal of director Heinrich Bernhard), 01/07/1933. LASA, C 92, no. 5312, fol. 2–3, here fol. 2.
[6] LASA, C 92, no. 6649.
[7] Comm. Governor to Pruss. Minister: Bericht über die Kündigung des Pflegers August Barth (Report on the Dismissal of Orderly August Barth), 13/05/1933. LASA, C 92, no. 6653, fol. 8.
[8] For more details see: Höll/Schmidt-Michel 1989.

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care in particular[9] are the reason for the limited research that has been conducted on the engagement of mental health care workers in vocational policy matters. Even though newer studies in the history of nursing contradict the prejudices, in the public eye in the German speaking countries in Europe, members of the nursing professions are still considered as uncritical and apolitical. In contrast to doctors they supposedly would not fight for their own professional interests on a larger scale. "To let nursing speak and decide for itself is still unusual and the nurses themselves hardly demand to have their say."[10]

2 Objective and Sources

The history of nursing focussed for a long time on those women who worked in general nursing care, in particular on sisters of religious orders and communities and on those nurses who worked on battlefields. In addition, so-called "elite nurses" who pushed within nursing associations for a more academic approach to nursing care, were early subjects of historical studies. This angle manifested the image of female nursing even further.[11] Psychiatric care tended to be overlooked in the histories of nursing and psychiatry which only changed a few decades ago. The reason was that the staff consisted to a large part of attendants and carers who had not been formally trained. In addition, psychiatric institutions have provided a substantial area of work for men in nursing.

Only in the last three decades have nurses who did not serve in denominational sisterhoods but worked as professional nurses become increasingly noticed for their contribution to shaping a heterogeneous landscape of psychiatric nursing in Europe.[12] In addition, various unions have been analysed more closely either as traditional representatives of the "nursing proletariat" or because of their contribution to the professionalisation of psychiatric care in Europe.[13] The researchers focussed here mainly on full-time trade union officials that included some former psychiatric nurses. However, nursing historians are also increasingly focusing on the involvement of psychiatric nurses at the grassroots level in professional associations and trade unions. Such work specifically focuses on the self-perception and perception others had of the nurses involved. One example is Barbara Douglas' publication from 2015 on the impact of the National Asylum Workers' Union (NAWU) in the United Kingdom. Drawing on narratives by nurses and attendants Douglas recreates the reform processes of psychiatric care that culminated in the implementation of the Mental Treatment Act in 1930.[14]

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[9] Psychiatric care within nursing is a specific and marginalised area that had been linked to an idea of a preventive detention until a few decades ago and it has been fighting for being respected as an independent discipline. See here for more details: Meyer 2006.

[10] Instead different agents of healthcare policy discuss the issues on behalf of the nurses. Kuhn 2016, p. 54.

[11] For more details see: Hähner-Rombach 2015.

[12] As examples see: Gijswijt-Hofstra 2005; Hähner-Rombach/Nolte 2017; for Germany: Faber 2015; Urbach 2017; for Austria: Ledebur 2007; Watzka 2009; for Switzerland: Braunschweig 2013 and 2018; for the United Kingdom and Ireland: Borsay 2015; for the Netherlands: Boschma 2003.

[13] For Germany: Helmerichs 1992; Wolff/Wolff 2002; Kreutzer 2003; Ley 2006; Ankele 2015 b; for Switzerland: Braunschweig 2004 and 2018.

[14] Douglas 2015.

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This present work sheds light on psychiatric nurses' early ventures into union work in the German Reich and the Weimar Republic. My subjects are selected nurses from the former Uchtspringe state asylum during the period from the opening of the institution in 1894 and the seizure of power by the National Socialists in 1933. Which issues did these nurses put on the agenda for union activities? What shape did their commitment take within the highly hierarchically organised psychiatric institution? How did colleagues and superiors react to their endeavours? How did the collaboration with officers at the trade union headquarters and the administration at the provincial level evolve? How important was the gender of the specific participants? Using the example of Uchtspringe in the context of changing management and political systems I will reconstruct the conditions, circumstances and boundaries a union involvement of "nurses of the insane" entailed during the aforementioned time period.

I expanded the corpus of my sources (the interrogation of transcripts from 1933) with further files from the Provincial Administration, including staff and complaint files, reports from the inspection commission that had been established by the province, and annual reports of the asylum. Another, very special, source is Die Irrenpflege[15], the first monthly journal for mental and nursing care for the instruction and further training of nursing staff to be published in the German speaking countries. It was first published by Konrad Alt (1861–1922) in 1897.[16] Alt was the first and long-time director of the Uchtspringe asylum.[17] In the articles of Irrenpflege not only doctors, economists and educators from many different institutions but for the first time also nurses themselves got a chance to have their say. For the time period of the Weimar Republic I further cite articles from the trade union journal Die Sanitätswarte (Paramedic Guardian), published from 1901 to 1932 as the trade union organ of the Reichssektion Gesundheitswesen (RG) (Empire Health Services Branch) in the VGS. In particular the reports of the local meetings of the RG that were published in Sanitätswarte attracted my attention.

3 The Vocational Policy Landscape of Nursing at the Beginning of the 20th Century

For some time psychiatric care remained untouched by the developments that occurred in general nursing care. "For long periods of time the conditions in psychiatric institutions were different for the staff which consisted in the German speaking countries – and for longer periods than in general hospitals – often of untrained or semi-trained attendants."[18] Furthermore the proportion of men working as nurses in psychiatry had always been quite high. The general assumption that the attendants belonged to the working class and were thus not very politically involved proves problematic.[19] Indeed, Anja Faber was able to contradict the common prejudice on the social origins of "nurses of the insane" as being lower class in her

[15] The full title of this journal is Die Irrenpflege: Monatsschrift für Irren- und Krankenpflege zur Belehrung und Fortbildung des Pflegepersonals.
[16] In 1904, the Austrian psychiatrist Heinrich Schlöss (1860–1930) became the editor. The journal Irrenpflege was published until 1930.
[17] For more details see: Nyhoegen 2012.
[18] Hähner-Rombach 2009, p. 10.
[19] Schweikardt gives this attribution without reference to the applicable source material. Blessing 2009.

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analysis of the carers of the Illenau asylum in Baden.[20] In 1906 the State of Prussia had issued Regulations on the State Examination of Nursing Personnel for general nurses, while nurses of the "insane" were completely excluded from them for a long time. There is evidence that the Kingdom of Saxony[21] was an exception. Here a systematic, binding training of psychiatric nursing staff was already centralised and organised by the state in 1888.[22] In the remaining areas of the Empire, the following rule continued to apply for nurses of the "insane": "Since this was not a recognised profession, the staff was subject to the (Prussian) Servants' Law that included compulsory board and lodging at the institutions."[23] This Servants' Law, in place in the German Empire longer than in other Western countries, regulated the legal situation of servants, among others. It was characterised by the disparity between the rights of the employees and those of the employers. For instance, the servants could be let go without adhering to a notice period, servants were forced to live in celibacy and banned from organising. Thus the servants were denied the opportunity to found and join trade unions and employee organisations.[24] However, the reach of the Servants' Law cannot be clearly established for nursing staff because there are no reliable figures as to how many nurses were indeed subject to it.[25] Nursing staff who were civil servants, such as the senior nurses and nurses in wards of public institutions, had limited freedom to organise because they were stripped of the right to go on strike.[26]

At least for the orderlies, professional celibacy required in the state institutions was slowly abolished. The low wages, however, made it impossible for married nurses to raise a family. There was a lot of turnover among the staff. The situation became even more precarious when around 1900 the institutions were increasingly over-crowded, new labour and nursing-intensive therapies such as the bed and bath treatments were introduced[27] and nurses drifted increasingly towards more attractive occupations. The issue of nursing assistants was discussed in the German Reichstag as part of the "social issue".[28]

At the same time numerous professional associations and trade unions were founded in the German Empire that claimed to represent the nurses. The two largest nursing organisations around 1900 were the nurses of the denominational motherhouse organisations.[29] Here the

[20] Accordingly, the staff during the period from 1900 to 1930 came from the lower middle class, i.e., mainly from families with farming and craftsmen backgrounds. The lower class represented less than one tenth of the carers. There were no significant differences between orderlies and nurses. Faber 2015, pp. 86–89.

[21] The Kingdom of Saxony was located to the south of the Prussian Province of Saxony.

[22] In connection with other improvements of the professional and personal circumstances, including the promise to be taken on into the Saxon civil service and to work in one of the state institutions, the fluctuation of male staff in particular could be eliminated. Böhm 2014.

[23] Kuhn 2016, p. 43.

[24] Vormbaum 1980, p. 15.

[25] Ley 2006, p. 19.

[26] Köhler 1907.

[27] Schott/Tölle 2006, p. 440.

[28] Höll/Schmidt-Michel 1989, p. 58.

[29] In the US denominational care faced a recruitment problem at a much earlier time, since it was easier for women, due to the excess of men, to get married there. To remain attractive to women from the upper middle classes, the denominational nursing institutions supported the academic professionalisation of the profession, including the setting up of nursing schools. Hähner-Rombach 2012, p. 148.

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nurses did not represent themselves but "clergymen negotiated on behalf of nurses".[30] Before World War I no fewer than three competing organisations were founded to represent nurses from middle-class backgrounds: the Evangelischer Diakonieverein (Protestant Diaconia), the Rot-Kreuz-Schwestern (Nurses of the Red Cross) and the association Agnes Karll (1868-1927) founded in 1903 titled Berufsorganisation der Krankenpflegerinnen Deutschlands (BOKD) (Professional Organisation of Female Nurses in Germany).[31] The BOKD was supported by the middle-class women's movement and it was the only association of nurses that demanded a thorough programme for professionalisation following the Anglo-American model.[32] They did not want to leave the regulation and development of nursing to strangers of the profession.[33] Furthermore access to the nursing profession was supposed to be strictly regimented and nursing was supposed to become an academic profession by introducing university courses.[34] Orderlies were prohibited from joining the BOKD. Overall the political influence of this professional association was weak as the BOKD was not represented in any political decision-making body.[35]

Just as the bourgeois female nurses failed in establishing a unified representation of interests, so too did the male and female asylum attendants. In 1900 two unionised organisations were established that targeted this group. In 1903 the Christian-oriented Deutscher Verband der Krankenpfleger und Krankenpflegerinnen (German Association of Orderlies and Nurses) was founded, later to be called the Streiter-Verband (Streiter Association) after one of its chairmen. This association strove for a relative autonomy of political parties and churches. Georg Streiter (1884–1945) urged the development of the profession of nurse from a "transient job to a profession for life".[36] To achieve this goal he demanded improvements to the economic and social situation of professional nursing, ensure a regulated training of nurses and the expansion of the involvement of women in Christian unions. The Streiter-Verband was outspoken against socialism and communism and declared that a strike was a justified means only during the initial years of the unions' fights.[37] By 1909 the organisation had reached a size of 1,400 members. Nonetheless it could only indirectly, i.e. through lobbying, influence the legislation –

[30] Schweikardt 2008, p. 171.
[31] Schweikardt 2008, p. 171.
[32] Kuhn sees a reason for the difficult and long path towards professionalisation of nursing in Germany in its close connection to the professionalisation efforts the physicians pursued at the same time. Kuhn 2016, p. 35. In the United Kingdom, Florence Nightingale (1820–1910) established a nursing training school in the 1860s which was independent of both doctors and denominational sisterhoods.
[33] Karll had already proposed, in 1906, the foundation of a board of nursing to get nurses directly involved in the legislation. Kuhn 2016, p. 46. In the UK, The College of Nursing was founded in 1916, which led in 1919 to the foundation of the General Nursing Council and the introduction of registration for all trained nurses. In the US the first boards of nursing were established in 1903 in the states of North Carolina and New York.
[34] Schweikardt 2008, p. 171.
[35] Schweikardt 2008, p. 165. Cf. here the situation of "trained nurses" in the USA around 1900: "Nursing care in the US included a powerful and financially strong bourgeois women's movement that could achieve much more in a shorter period of time than was the case in the German Empire. The reason for this was the vast number of their members, their scope of influence and their relative unity." Hähner-Rombach 2012, p. 153.
[36] For more details see: Wolff/Wolff 2002.
[37] Schweikardt 2008, p. 168.

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comparable to other trade unions in the German Empire. The political activities of the organisation focused mainly on discrediting the competing VGS.[38]

In the VGS which was close to the Social Democratic Party, the nurses also represented themselves. Founded in 1895 by Berlin gas workers of the local plants, the organisation initially developed into an organ of the male nursing attendants.[39] The Reichssektion Gesundheitswesen (RG) (Empire Health Services Branch) was founded as a subgroup of the VGS. It represented all healthcare workers.[40] Like the Streiter-Verband the VGS made the case for recognising nursing of the "insane" as an integral part of nursing care.[41] To counter a further fragmentation of nursing, the VGS suggested that all future nurses should complete a common basic training for one year and specialise afterwards.[42] However, the VGS also favoured opinions that were clearly opposed to a professionalisation of nursing. For instance, nursing was supposed to remain an auxiliary medical profession (hierarchically below the doctors), and doctors were supposed to maintain their responsibility for the examination and hiring of nurses.[43] Contentious ideas concerning more academic approaches to, and for the self-administration of, nursing were vehemently combated. "It would have contradicted the idea of a unified working class and hence it went against the socialist attitude of the unions."[44] Until the beginning of World War I the Prussian Government successfully fended off the social-political demands of the VGS. One contributing factor here was also a lack of sympathy between the "proletarian" VGS and the "bourgeois" doctors which was absent in the Streiter-Verband.[45]

With the beginning of World War I the work of the numerous unions that nurses organised stopped because many members were drafted into military service. Only the abolition of the monarchy and the major radical social changes that accompanied it facilitated the strengthening of the trade unions in Germany. As a result of the November Revolution from 1918, unions were recognised as representatives of employees both by law and through contracts with employers. The Servants' Law was abolished and the complete right to organise and assemble was announced. From 1918 the Reichssektion Gesundheitswesen (RG) became the largest subgroup of the VGS. It quickly evolved into the healthcare organisation with the most members in the Weimar Republic.[46]

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[38] Wolff/Wolff 2002, pp. 30, 33.
[39] Schweikardt 2008, p. 172.
[40] Until 1919 the branch was referred to as Sektion des Krankenpflege-, Massage- und Badepersonals Deutschlands (Branch of Nursing, Massage and Bathing Personnel in Germany) in the VGS.
[41] Ley 2006, p. 41.
[42] Kuhn 2016, p. 44.
[43] Kuhn 2016, p. 44.
[44] Kuhn 2016, p. 44.
[45] See here the conditions in Switzerland: After 1900, the Verband des Personals öffentlicher Dienste (VPOD) (Organisation of Personnel in Public Service) gained a lot of influence in the large state-asylums. The active members of the VPOD united in 1920 and founded an asylum cartel. To increase the union's chances for success it sought to collaborate with doctors. Due to the commitment of the psychiatrist Walter Morgenthaler (1882–1965) they were able to close ranks with the professional association of Swiss psychiatrists. Subsequently, in 1922 they began to jointly publish the journal Kranken- und Irrenpflege (General and Mental Nursing). Braunschweig 2004, p. 117–118.
[46] It remains unclear, however, to what degree the healthcare workers were indeed organised. In particular, the proportion of unskilled attendants cannot be reconstructed. Ley 2006, pp. 30–31.

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In 1918 civil servants were given for the first time the unrestricted right to organise including the right to strike. Immediately the Deutscher Beamtenbund (DBB) (German Association of Civil Servants) was founded as an umbrella organisation of unions for civil servants and teachers. At the beginning of the Weimar Republic, the DBB managed to enshrine the interests of its members in the new constitution mainly because of the integration of its leaders in political parties. As a result of the subsequent restorative tendencies, the right to strike was withdrawn from civil servants again in 1922.[47] Both the Bund der höheren Beamten (Association of Higher Officials) and those civil servants who were more oriented towards "free" unions left the DBB at the beginning of the 1920s and formed their own umbrella organisations. After the fusion with the branches for civil servants of the Christian unions (1926) and the liberal trade unions (1928) the DBB comprised two thirds of all people organised in unions for civil servants.[48]

Before discussing how the nurses at Uchtspringe were organised in unions, I begin with a description of the state asylum.

4 "Pioneers for the Less Restrained Treatment of the Insane" – Nursing staff at the Uchtspringe Asylum

The institutional landscape of psychiatric care at the beginning of the 20th century in Prussia was decisively shaped by the Law on Extended Care of the Poor (Gesetz über die erweiterte Armenpflege) of 11 July 1891. This law made the "preservation, cure and care of the mentally ill people who required help, idiots and epileptics, the deaf and blind" obligatory. Before then this care had been optional. The public duty of care was explicitly defined as care in an asylum.[49] Because of that a large proportion of this group of patients was hospitalised and put under state supervision.[50] In 1894, Landes-Heil- und Pflegeanstalt Uchtspringe opened as the "first link in the chain of large newly founded institutions" of Prussia.[51] It was answerable to the Provincial self-administration of the Provincial Association whose executing bodies were the Provincial Governor and the Provincial Committee.[52] Uchtspringe was set up in the rural area of the Altmark to provide treatment, schooling and occupational therapy for approximately 500, later 1000 "epileptics", "epileptic lunatics", "idiots" and "mentally deranged people". About one-forth of the patients were children and adolescents.[53] Uchtspringe gained model status for the whole of Europe by successfully implementing both the concept of the "agricultural colony" to grow its own supplies and the "doctor-supervised foster family care", an approach that had already been demanded in 1867 by the German reform psychiatrist

[47] Hoffmann 1964, p. 612.
[48] For more details see: Fisch 2018.
[49] Laehr 1892.
[50] Randzio 2006, p. 197.
[51] Weber 1914, p. 805.
[52] Tullner 1996, p. 110. From 1877 to 1900 Wilko Levin Graf von Winzingerode (1833–1907), a Protestant theologian and conservative politician, who was the Provincial Governor of the Province of Saxony. Hainbuch/Tennstedt 2010, p. 175.
[53] Nyhoegen 2012, p. 42.

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Wilhelm Griesinger (1817–1868).[54] Furthermore, the first head of the institution, the psychiatrist Professor Dr Konrad Alt, was highly committed to experimental and clinical research and pathological anatomy.[55]

To master the numerous tasks at the institutions, it became necessary to train dedicated permanent staff and provide them with special skills. The institution's compound with its buildings in pavilion style was divided by gender into two areas. Orderlies cared for the male patients while the nurses were entrusted with the care of female patients and children. The role of head nurse was open to both orderlies and female nurses.[56] The nursing staff at Uchtspringe consisted almost completely of "free" orderlies and nurses.[57] Preferred employees were former servicemen and craftsmen. The nurses served as foremen in the numerous workshops at the institution and at the agricultural farm that belonged to it. They were also "pioneers of foster family care" using so-called "attendant villages"[58] in direct proximity to the asylum. Furthermore, the nursing staff at Uchtspringe was decidedly involved in the documentation and implementation of interventions during events that were interpreted as epileptic seizures, and into the implementation of new somatic therapies and clinical trials. The staff received specific training to that purpose within the institution.[59] Konrad Alt also introduced financial incentives and improvements in nurses' work and life conditions, including an increase of nursing staff to such an extent that one nurse looked after only seven patients. This also paved the way for the introduction of night shifts and paid holidays.[60] In addition, beneficial for the development of staff were the provisions for the state asylums of the Province of Saxony which came into effect in 1908 and provided significantly higher salary rates and entitlement to earlier retirement for the entire nursing personnel. Nurses were granted the status of civil servant after only ten years of service.[61]

[54] On the historical origins and the various types of "foster family care" in Europe see for more details: Beddies/Schmiedebach 2001. Specifically on Uchtspringe see: Müller 2004.

[55] Kolling 2004 a, p. 7.

[56] In contrast in the Netherlands around 1900 the only leading role that orderlies were offered in the institutions was that of foreman at the workshops. This resulted in the formation of the Nederlandse Verplegers Vakvereniging, the first association of orderlies in 1906. Boschma 2003, pp. 187–188. See also: Svedberg 2005, pp. 364–365.

[57] So-called "free" nurses emerged at the beginning of the 20th century as an alternative to the motherhouse system. The members of this very heterogeneous group shared a lack of lifelong commitment to a motherhouse or a sisterhood and received a salary for their work. Therefore they were also called "professional" nurses or, more derogatorily, "wild" nurses. For more details see: Rübenstahl 2011.

[58] With the construction of apartment buildings for married male caregivers, up to three fosterlings per apartment were able to live and work in the caregiver families over a longer period of time. This enabled Alt to provide more cost-effective care for patients capable of working than in an institution, to retain suitable nursing staff in the long term and to reduce prejudices in the population against mentally ill persons, so that additional families could be won over to take in fosterlings. Nyhoegen 2012, pp. 108–111.

[59] For more details see: Urbach 2017.

[60] Nyhoegen 2012, p. 110.

[61] Governor of the Province of Saxony to all directors of state asylums, 15/04/1908. LASA, C 92, no. 1262, fol. 111–113).

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5 Only with the Aid of the Medical Gentlemen – Uchtspringe's Call to Found an Association

By 1899 the asylum already consisted of 15 buildings with 870 beds, and the staff consisted of "among others nine junior doctors, 73 (trained) orderlies and 53 nurses and 16 (non-trained) male attendants and 15 female attendants".[62] Alt worked his entire life to "elevate" the position of the nursing attendants. Accordingly, he started the aforementioned journal Die Irrenpflege (Nursing of the Insane) that he edited until 1902 and for which he wrote numerous articles himself. Yet, as much as Alt gave impulses for a professionalisation of psychiatric care through qualifications linked to the institution, he was just as much interested in preserving the hierarchy within the asylum. The director was very keen to keep the power of control over the nursing staff entirely to himself. This patron-like relationship to nursing is also reflected in the early editions of the journal Irrenpflege.[63] In this publication in 1901 an orderly wrote: "We do have a journal that represents our interests, we are allowed, thanks to the honourable editor, to share our opinion in it […]." In line with Alt the author declared with respect to the foundation of a professional organisation: "I want to issue a warning against illusions: only an association with a director of an asylum as its head can help us [,] today's nursing staff can never by itself think of acting independently."[64]

Two years later, in 1903, the Uchtspringe nurse Hans Gattringer called for the foundation of an association for psychiatric nurses. According to Gattringer the new organisation was supposed to promote "specialist training", "socialising" and networking as well as the fight for a base salary and the creation of retirement and benefit funds. He also favoured an arbitration court consisting of experienced directors, a lawyer and an electable committee consisting of orderlies and nurses with an impeccable record of at least ten years of service that was to act impartially in difficult situations – similar to trade courts.[65] Gattringer's call for the foundation of an association was only successful in Silesia. Between 1903 and 1908 Irrenpflege also served as the mouthpiece of the Verein schlesischer Irrenpfleger (Association of Silesian Nurses of the Insane).[66]

6 Acting in Secrecy – Uchtspringe Nurses in the Streiter-Verband

Not all nurses in Uchtspringe followed the well-meaning advice with respect to the relationship of nurses of the "insane" and trade unions. Thus, in 1905 it emerged for the first time that some of them were members of the Christian Deutscher Verband der Krankenpfleger und Krankenpflegerinnen (German Association of Orderlies and Nurses) that had been founded two years earlier. Georg Streiter asked the staff at Uchtspringe in a letter to keep their

[62] Kolling 2004 a, p. 6.
[63] "After 1902, i.e. when Schlöss, Thoma and Schott were the editors, the nurses' articles became braver and were increasingly political." Höll/Schmidt-Michel 1989, p. 11.
[64] Werner 1901/02, pp. 46–47. Werner worked at the Charité in Berlin.
[65] Gattringer 1903/04.
[66] Höll/Schmidt-Michel 1989, p. 11.

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membership in the Christian union a secret and to report complaints about superiors directly to him:

> Everyone should act as if they do not belong to the association. We will achieve much more than, as happened in some instances, when some would go wild and damage our reputation. That said I do not want to imply that everyone should act as if they were asleep. All supposed injustices can still be reported to me; but be calm towards your superiors. Rather swallow it and write it down for me instead of kicking up a row [...].[67]

What was the possible strategy behind this request? At this point in time Streiter was probably still working as an orderly himself, yet he was also acting as honorary manager of the association and editor of its newsletter.[68] The letter certainly served to avoid tainting the reputation of the young association by imprudent actions of individual members. Simultaneously, by asking the nurses and orderlies to bypass the official complaint channels, i.e. writing to the Provincial Administration, Streiter offered himself as a new confidante to the members with whom they should share their issues. This helped him to collect valuable, "unfiltered" information about the working and living conditions of nurses in the institutions and to use it later in the interests of the association.

However, Streiter's letter to the members in Uchtspringe fell into the hands of the asylum's directors. The director of Uchtspringe and the governor of the Province could not tolerate meddling with the internal matters of the institution.[69] Those nurses who were exposed as members of the association were dismissed. The staff rules at Uchtspringe were supplemented with the phrase "that membership of associations that interfere with the interior matters of the institution's administration is not compatible with discipline at the institution".[70] Yet, only two years later, in 1907, a large number of nurses was dismissed again "merely because of their membership of association".[71] Streiter who in the same year became the full-time chairman, manager and editor in the central office of the association in Berlin, complained to the governor. After the governor swiftly dismissed his complaint, Streiter turned to the local press and denounced in his article how the personal freedom of the personnel in Uchtspringe was curtailed by measures such as the censorship of letters addressed to the nursing staff.[72]

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[67] Georg Streiter to nurses and orderlies at Uchtspringe (certified copy of excerpts), 23/03/1905, contained in: Alt to Governor, 22/06/1907. LASA, C 92, no. 2715, fol. 195.

[68] Serving for the Inner Mission, he had also gained experience in caring for mental patients. In 1901/02 Streiter worked at the Johannesstift für Alte und Sieche (St John's Home for the Old and Sick) in Cracau/Magdeburg. He later wrote that "because of the lack of an adequate apartment [he] had to 'live' in an attic chamber in which [he] could barely 'walk' upright. The staff slept behind a curtain on the ward with 20 psychotic patients." Cited in Wolff/Wolff 2002, pp. 6, 16. It is possible that Streiter was already in contact with the staff at the nearby asylum in Uchtspringe.

[69] From 1908 to 1921 the nationalist-conservative politician Kurt Freiherr von Wilmowsky (1850–1941) served as the Governor of the Province of Saxony. Lilla 2005.

[70] Alt to Governor, 22/06/1907. LASA, C 92, no. 2715, fol. 195.

[71] Georg Streiter to Governor, 04/06/1907. LASA, C 92, no. 2715, fol. 193.

[72] Alt to Governor, 16/07/1907. LASA, C 92, no. 2715, fol. 197. Unfortunately, the original source is no longer available so that potential reactions to Streiter's article cannot be verified.

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In 1910 Streiter published his book "Die wirtschaftliche und soziale Lage des Krankenpflegepersonals in Deutschland" ("The Economic and Social Situation of Nursing Staff in Germany") that was later revised and repeatedly reprinted and is regarded as the first academic book on German nursing care. Among Social Democrats there was approval of the study since it was at this time an unparalleled collection of data for the German speaking countries.[73] It was based on publicly accessible sources but also on Streiter's interviews with nurses and orderlies that had partially been conducted in secrecy as the example in Uchtspringe illustrates. One year after the publication Streiter travelled to various asylums, and as an official of the association, negotiated the working conditions of the nursing staff with the administrations.[74] No evidence of such a visit can be found for Uchtspringe which is not surprising given the previous history. Instead another agent became significant for the trade union representation of Uchtspringe's nursing staff. From 1919 the VGS decisively shaped the vocational commitment of nurses and orderlies in all state asylums of the Prussian Province of Saxony. This is the topic of the next section.

7 The Foundation of the Uchtspringe Chapter of the Empire Health Services Branch in the Association of Municipal and State Workers

During the time from 1918 to 1933 the RG contributed to essential improvements of the working and living conditions, in particular for psychiatric nurses. Even though their demand for a one-year common training in nursing with a subsequent specialisation was not implemented and nursing became even more divided, the nursing attendants now had the opportunity to sit a state exam. The RG succeeded in obtaining social benefits for their members.[75] Even though compulsory board and lodging was abolished, in most cases unmarried nurses and orderlies continued to live in the institutions. Here, collective bargaining agreements could certainly accomplish improvements, even if they did not reach all – and in nearly all cases only the public – institutions. The same applied to regulations on working hours, payment of overtime and sick-pay.[76]

When during the 1920s occupational therapy was increasingly used in the treatment of mental patients, this also changed the everyday working routine of the nursing staff. Both the VGS and the Streiter-Verband took this as an occasion "to bring about a social and economic betterment for themselves and – pointing to the argument of an increased risk of accidents [...] – admittance to the accident insurance of the Empire from which [nurses and orderlies] had so far been excluded."[77] Many positive reforms for the nursing staff had their origin during the

[73] Wolff/Wolff 2002, p. 28.
[74] Wolff/Wolff 2002, p. 33.
[75] Kuhn 2016, pp. 41–43.
[76] Ley 2006, p. 45.
[77] Ankele 2015 a, p. 15.

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Weimar Republic in Prussia. For the RG it was beneficial that, until 1932, the Social Democrats had continuously led the Prussian state government.[78]

I will now take a closer look at the trade union commitment to the RG by the nurses and orderlies at Uchtspringe. Central to my analysis is the ward orderly August Karl Barth (1879–?) who was found guilty in 1933 by the National Socialists of having been the "soul of the social-democratically-minded nursing staff in Uchtspringe".[79] His commitment to the trade union and politics can be traced in the sources from 1919. Throughout the entire period of the Weimar Republic, and against the background of changing management of the staff and the political and economic turmoil throughout Germany, he succeeded in making a name for himself as an important representative of the Uchtspringe staff. But when the National Socialists seized power, he was branded as a "politically unreliable orderly" and was removed from his job.

Barth was by far not the only orderly at Uchtspringe who took a stand for his own profession. However, because of his superior role and his work within and outside the asylum, the source material on him is extensive and multi-faceted. The multiple sources such as Barth's correspondence with the management of the institution and the Provincial Administration, reports of meetings of the Uchtspringe branch of the RG, newspaper articles and interrogation transcripts allow us to approach this person from different perspectives.

In 1901, as a 22 year-old, he began to work as an orderly at Uchtspringe. During the following three decades he developed into a person who sought to gradually expand his sphere of influence within the institution and who decisively helped to shape the future of the institution. From his personal file we learn that Barth, after ten years of service, was entitled to a retirement pension and a notice period of three months. Only one year later he was hired for life. He married and had four children with his wife. The file notes further that he worked as a ward orderly in a villa with forty male patients.[80] In his apartment in the nearby "attendant village" he and his wife housed three additional wards which the family looked after. During this time Barth repeatedly had arguments with the management of the institution, the Provincial Administration and both his female and male colleagues. At times, he openly opposed the instructions of the management. He was repeatedly accused by Alt and other doctors of being a "neurasthenic", a "troublemaker" and an "informer".[81] Nonetheless Barth managed to hold important positions within the nursing hierarchy of the institution.

We cannot determine whether Barth was already involved in (vocational) political activities before WWI began. It became only possible for the staff of public asylums to openly show their commitment after the November Revolution. When in December 1918 the government of the Empire made workers' committees obligatory, including in general and mental hospitals, and considerably increased the scope of the tasks of the committees, Barth put himself forward as the representative of the Uchtspringe personnel, consisting of more than 150 civil servants

[78] Ley 2006, p. 26.
[79] Comm. Governor to Pruss. Minister: Bericht über die Kündigung des Pflegers August Barth (Report on the Dismissal of Orderly August Barth), 13/05/1933. LASA, C 92, no. 6653, fol. 8.
[80] Table with an overview of service ranks. LASA, C 92, no. 5278, n. p.
[81] Senior physician Dr Bufe to Governor, 22/03/1916. LASA, C 92, no. 5278, fol. 3–4.

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and employees.[82] Around the same time, Barth became a member of the SPD. On 18 February 1919 he founded the local chapter of the RG in the VGS at Uchtspringe, whose chairman he was since that time. Uchtspringe was thus the third state "insane" asylum of the Prussian Province of Saxony that dared to become affiliated to the VGS.[83]

Initially many nurses and orderlies euphorically welcomed this step. They cherished a hope that, with the help of union officials, they would be able to force through their demands to the Provincial Administration for higher pay, training and better working and living conditions. The first Uchtspringe meetings were always well attended and took place at the Society House of the institution. Often the union officials of the RG took part. They had an open ear for complaints from the staff, informed members of their rights and called for a unified course of action by all employees in the interests of the labour movement. In particular, the most important concern of the local chapter in Uchtspringe was set as the implementation of a legally-required eight-hour workday, as this had not yet happened at the institution: "The organisation has to take vigorous action here. The same applies to the complaints about the living, wage, and holiday conditions."[84] As a solution to these problems they looked to a collective wage contract for all state institutions in the Province of Saxony.[85]

Yet not all members of staff at Uchtspringe liked the affiliation with the RG and opposition grew, especially among those employees who had civil servant status. As an immediate consequence the Gauleitung (regional leadership) of the RG was asked to take action. The RG addressed the management and initially it seemed that they were successful. In his response to the board of the union Alt expressly acknowledged the staff members' right to organise and disapproved of "senior nurses etc. who put pressure on their subordinates because they belonged to the association."[86] In return, together with the secretary of RG in Berlin and editor of the Sanitätswarte, Georg Renner (1881–1962)[87], Barth asked the union members to "engage in a friendly manner with the non-organised colleagues because only through congenial behaviour we can win over those who are distant to the association."[88]

In July 1919 in the neighbouring asylum, Nietleben, the long awaited collective bargaining finally took place. Representatives of the staff from all state institutions of the Prussian Province of Saxony took part in the negotiations. Directors, consultants, the senior nursing staff at Nietleben, and the representatives of the respective workers' committees were present, "but also the newly established association of civil servants had sent a 'silent' participant."[89] Initially, the Provincial Administration denied entry to the two RG Gauleiter (regional leaders) who had

[82] In this first workers' committee at Uchtspringe members were appointed during a staff meeting. In March 1919 regular elections were held. Renner 1919.
[83] Sanitätswarte 1919 a.
[84] Sanitätswarte 1919 b.
[85] Sanitätswarte 1919 b.
[86] Sanitätswarte 1919 b.
[87] Renner was a former orderly i. a. at the Bunzlau Provincial Insane Asylum and the Dresden City Insane Asylum and Infirmary. Since 1905 he had been a VGS member, and from 1907 the association had appointed him as secretary to the board of the RG and from 1918 to 1933 he was the editor of the Sanitätswarte. Kolling 2004 b.
[88] Sanitätswarte 1919 b.
[89] B.[?] 1919.

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travelled from Magdeburg and Leipzig. Only hours later, after the entire staff of Nietleben had walked out in protest, the two leaders were admitted to participate in the negotiations. The results of the talks were sobering: instead of the eight-hour day and 48 hour working week, only a 56 hour working week was agreed and a single cost of living bonus proposed for the entire staff.[90]

The expectations of Barth in his double function as head of the RG branch and simultaneous representative of the entire Uchtspringe staff had been high. He was well aware of his negotiating role between Provincial Administration, management and staff. In a letter to the governor he wrote: "With the best intentions I have tried to present the [...] contract that had been agreed with the local staff in a way to avoid any bad feeling and friction." It is surprising that Barth wrote: "In general contentment prevailed."[91] Surely, this was more wishful thinking than a reflection of the reality.[92] In his dealings with the Provincial Administration it was important, however, that he presented himself as a staff representative capable of negotiating but loyal to the authorities. Barth stated "that in a hospital, more than in any other organisation, order and discipline are essential."[93] At the same time Barth tried to remove staff members from Uchtspringe who held different political views. While the director of the institution was on a three-month holiday, Barth tried to get rid of a disagreeable colleague, the ward orderly Theuerkauf, by accusing him of abusing a patient.[94]

Yet, Alt was not idle during his absence from Uchtspringe. In September 1919 he attended a conference of the Empire's Ministry for Work during which the introduction of an eight-hour workday was discussed. Various representatives of the employees and employers and the Prussian Department of Medicine had been invited to the talks. Furthermore, representatives of the newly founded Bund der Oberpflegerschaft Preußens (Association of Senior Nurses and Orderlies in Prussia) were also present. This association acted ambivalently towards the VGS and sought to join the DBB.[95] The Sanitätswarte commented that the director at Uchtspringe declared "with all the pathos at his disposal [...] 'The day when the eight-hour workday is introduced in medical institutions is the day when orderly, humane nursing care dies.'"[96]

The opposition of the doctors, administration and competing nursing associations towards the efforts of the RG could be felt in the entire country.[97] The RG lamented that the provincial administrations especially in rural areas had shown little understanding for the implementation of the new legal regulations: "Out in the countryside where the asylums are mostly

[90] B.[?] 1919.
[91] Barth to Governor, 14/08/1919. LASA, C 92, no. 2715, fol. 222–225, here fol. 225.
[92] After the bargaining negotiations the staff at Nietleben expressed "bitter disappointment" in a resolution it published. B.[?] 1919.
[93] Barth to Governor, 14/08/1919. LASA, C 92, no. 2715, fol. 222–225, here fol. 225.
[94] The deputy director, senior physician Josef Hoppe to Governor, 06/09/1919. LASA, C 92, no. 2715, fol. 228–229, here fol. 228.
[95] Sanitätswarte 1919 c.
[96] Alt cited in: Sanitätswarte 1919 d, p. 266.
[97] Already in February 1919 – "in view of the vigorous efforts of the workers and 'lower' civil servants and employees" – an association of civil servant psychiatrists was founded at the state institutions in the Province of Brandenburg. Sanitätswarte 1920 a, p. 25.

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located, one is desperately trying to uphold the old order. […] Where they cannot achieve their goals with force, they try to breed discord among the staff."[98]

At the end of 1919 the Uchtspringe branch sent Barth to the third conference of the RG in Jena. This meeting included more than one hundred attendees including the authorities such as the Empire's Ministry of Work. Under the newly elected head of the RG central office, Paul Schulz (1873–1953), the programmatic groundwork, in particular in the areas of training and examinations, was outlined and a resolution was passed against the preliminary version of a law on the working hours of nurses and orderlies, which had been drafted by the Empire's Ministry of Work. Barth was one of very few delegates, who were mentioned by name in the minutes of the meeting. This suggests that even at major events like this one he was not afraid to draw attention to himself.[99]

At the first anniversary of the Uchtspringe branch of the RG, Barth tried to interpret the few concessions the administration made during the bargaining sessions as important steps on the way to a better professional life. He said to the members of the association: "We remember the amazing progress in bringing relief to the work in general. Sleeping among the patients has been abolished and, compared to before, the freedom of the individual is like day against night."[100] However, not everyone was convinced by his words. One colleague who had quit the union questioned Barth's leadership position. He wrote: "As a member of an association I demand that the job is done well – or not at all […]."[101] The local chapter in Uchtspringe attempted to find additional members predominantly among the female nursing staff. For that reason, in the spring of 1920 Marie Friedrich-Schulz (1878–1967) was invited as a speaker.[102] The new secretary of the Berlin headquarters was known for her "sharp tongue".[103] The Uchtspringe board of the RG adopted an increasingly harsh tone against competing associations: "It is time to draw a clear line between us and our opponents."[104]

In 1920 a new body entered the structure of the advocacy across the German Reich: the Work Council. In contrast to previous regulations the say of the employees during hiring and dismissal procedures was significantly increased, but while the Work Council also had the right to look at the books and accounts, interfering with management was not allowed. The law also made it possible to merge individual Work Councils from several similar companies into a general Work Council to simplify negotiations. However, the double loyalty required – towards both the employees and the employers – prevented the Work Council from developing into a clear advocacy group for the employees.[105] "This was the beginning of a tension that has been continuing to this day between trade unions which pursued higher interests and Work Councils that pursued mainly the interests of an individual company."[106] During the election of the

[98] Sanitätswarte 1920 a, p. 25.
[99] Sanitätswarte 1919 e.
[100] Sanitätswarte 20 b, p. 53.
[101] Sanitätswarte 1921 a.
[102] Sanitätswarte 20 b, p. 54.
[103] Kolling 2008, p. 96.
[104] Sanitätswarte 1921 b.
[105] Rehling n. d., pp. 3, 12.
[106] Lorenz 2013, pp. 25–26.

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first Work Council in Uchtspringe, the RG was able to gain six out of the available seven seats.[107] Later a central Work Council for all state asylums and homes for the blind in the Province of Saxony was founded. In the spring of 1921 between 80 and 85 percent of the members of staff in all institutions in the Province of Saxony were members of the RG.[108]

At the same time, after nearly three decades, Konrad Alt stepped down from his office as director of the institution due to illness. His successor was the psychiatrist Hermann Bockhorn, who had been a senior physician in the nearby institution at Nietleben until then.[109] In the subsequent period the board of the RG branch wanted to strengthen the union's influence in negotiations with the Provincial Administration. Barth still lamented that representatives of the RG branch had not been invited to the negotiations on the salary scales for the second time since it had come into existence. Now, after the national-conservative Kurt Freiherr von Wilmowsky (1850–1941) stepped down as long-time governor of the Province, the hope was that things would improve.[110] He was succeeded by the left-liberal politician Erhard Hübener (1881–1958).[111]

8 "Red Uchtspringe"

Without doubt the good train connection between the institution at Uchtspringe and both the capital Berlin and capital of the Province Magdeburg aided the pro-union efforts of the nursing staff. During the Weimar Republic the Social Democrats coined the name "Red City in the Red State" for Magdeburg. In 1922, the 9th Conference of the Federation of "Free" Trade Unions was held here.[112] In 1924 the Reichsbanner (Empire's Banner) was founded here – a political military association that was meant to protect the Weimar Republic from its radical enemies.[113] Again, it was in Magdeburg where the SPD celebrated its party convention in 1929. "The healthcare system in Magdeburg that was established during the Weimar Republic had model character, and not only from today's perspective. It was characterised by innovation and was clearly influenced by social-democratic ideas. […] [This was] largely initiated and encouraged by the first Social Democratic mayor of the city, Hermann Beims (1863–1931)."[114]

There are numerous documents that illustrate how the nurses and orderlies at the state institutions and homes for the blind in the Province of Saxony were in contact with union officials

[107] Sanitätswarte 1921 d.
[108] Sanitätswarte 1921 c, p. 127.
[109] Kreuter 1995. On Bockhorn's political views no documents could be found.
[110] Sanitätswarte 1921 e.
[111] Hübener, member of the Deutsche Demokratische Partei (DDP) (German Democratic Party), remained in office until the National Socialists seized power. After the war, in 1945, the Americans appointed him again as Provincial Governor. Hübener became a founding member of the Liberal-Demokratische Partei Deutschlands (LDPD) (Liberal Democratic Party of Germany). For more details see: Tullner/Lübeck 2001.
[112] Sanitätswarte 1922 b.
[113] The Reichsbanner Schwarz-Rot-Gold (Black-Red-Gold Banner of the Realm) was founded in 1924 in Magdeburg by the three parties of the Weimar coalition (SPD, DDP, German Central Party). See here for more detail: Herlemann 1999.
[114] Brinkschulte/Fabian 2017, p. 127.

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in Magdeburg.[115] In addition staff representatives were well connected with each other through the common central Work Council. Because the Uchtspringe orderly Barth enjoyed the trust of his colleagues he was elected in June 1924 as one of three representatives to the central Work Council of the Province of Saxony.[116] During the subsequent years Barth managed to expand his position of union leader even more. Until the end of the Weimar Republic he was re-elected each time as the head of the RG branch at Uchtspringe and as member of the Work Council. In addition, he continued to maintain a lively exchange with the RG headoffice in Berlin and the regional leaders of the cities of Middle Germany. At the nationwide RG conferences he made sure to share his opinions during the discussion sessions.[117] He moved not only in union circles but was also well connected within the SPD, which he had been a member of since 1919 and had served as its local community representative. In 1924 he joined the Reichsbanner.[118]

The Uchtspringe RG branch could celebrate the success of having received state recognition of the nursing staff of the Uchtspringe asylum in 1922.[119] In 1927 the application of the RG branch boards to introduce a standardised uniform and protective gear in all institutions of the Province of Saxony was finally implemented. The Provincial Administration committed itself to reimburse half of the costs incurred.[120] Despite the remarkable impressive network of staff representatives, the RG clearly did not succeed at all times to push through the desires of union members during the tough negotiations with the Provincial Administration. In order to weather certain political hard times, taking recourse to a trade union culture that was already well established was probably helpful. Festivities that were celebrated together, libraries, choirs, sports clubs and music organisations created space for gatherings. The boards of the RG branches supported their members' efforts to create symbols and practices that promoted identification with the association.[121] [Fig. 1: Brooch of the Reichssektion Gesundheitswesen in the Verband der Gemeinde- und Staatsarbeiter before 1933]

The institutions of the Province of Saxony were hit especially hard by the decision of the Provincial Committee in 1924 to dramatically reduce staff. The number of nurses and orderlies was supposed to be reduced by a quarter. In a way this corresponded to the situation before the war. The remaining staff was supposed to make up for the resulting loss of work force.[122] Union officials of the RG tried to oppose this. In May 1925 Barth and the regional leader from Magdeburg had "announced the justification of their demands in the salary committee in a number of meetings of the delegates" at the Saxon Provincial Landtag,[123] initially without success. Yet, subsequently the RG managed to increase its political weight during the negotiations, after an internal reorganisation at the VGS, which established a "department for civil

[115] See for instance: Sanitätswarte 1926 c.
[116] Sanitätswarte 1924 b, p. 179.
[117] Sanitätswarte 1919 e, Sanitätswarte 1926 d, p. 361, Sanitätswarte 1929 d.
[118] Comm. Governor to Pruss. Minister: Bericht über die Kündigung des Pflegers August Barth (Report on the Dismissal of Orderly August Barth), 13/05/1933. LASA, C 92, no. 6653, fol. 8.
[119] Sanitätswarte 1922 c.
[120] F[lücht] 1926 b, p. 189.
[121] Sanitätswarte 1922 a, Sanitätswarte 1929 b, Sanitätswarte 1929 c.
[122] F[lücht] 1926 a, p. 171.
[123] Sanitätswarte 1925.

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servants finally made it attractive for members of staff with civil servant status. Subsequently nearly the entire senior nursing staff at the provincial institutions sided with the VGS in 1926 and also joined the negotiations.[124] As a result of the negotiations, the number of layoffs was reduced from 219 to only 72 nurses and orderlies.[125] About 90 percent of the employees at the provincial institutions were now members of the VGS.[126] The staff representatives at all asylums and homes for the blind were now without exception VGS members.[127] The Sanitätswarte mocked the competing "dwarf organisation" of the DBB.[128]

Despite these successes the efforts of the RG-unionists during the Weimar Republic were often doomed to fail because the respective provincial committees had the final decision and in the whole country their members were largely nationalist-conservatives. For example, they blocked a standardised professional arrangement for the whole nursing staff at the provincial institutions.[129] In addition, the individual institutions differed so vastly in their conditions that "central actions" did not always seem possible.[130] The nurses at the Prussian asylums who were civil servants or about to become civil servants for the most part were particularly disadvantaged. With this status their working hours could be expanded to 60 per week.[131] At the same time because they were nursing staff they were not included in the Empire's salary scale which meant they remained second class civil servants.[132] Not even the Great Depression of 1929 and the resulting mass unemployment moved the Provincial Administration to shorten the working hours in the institutions.[133] Instead, so-called "nurse-free wards" were introduced to save money where a dozen calm patients were looked after by a female or male patient, respectively.[134] Another dream which failed to materialise for the RG local branches was a common nursing school for the trainee staff at the institutions of the Province of Saxony.[135]

9 Silent comrades? – The Female Nurses in the RG Branch at Uchtspringe

In my previous descriptions I have nearly completely excluded the role of the female nursing staff at the state institutions of the Province of Saxony. This is not surprising because the reports by the RG branches that I studied are silent on this subject – or so it seems at a first glance. Yet, if we make the effort to "read between the lines" and find the gaps we discover next to the often quite vociferous orderlies that nurses were also involved in the vocational-

[124] Sanitätswarte 1926 b.
[125] F[lücht] 1926 a, p. 171.
[126] F[lücht] 1926 b, p. 190.
[127] Sanitätswarte 1926 b.
[128] Sanitätswarte 1930 a.
[129] Hartenstein 1931, p. 172.
[130] Lehnert 1926.
[131] As civil servants they were not included in the directive on the working hours at nursing institutions from 13 February 1924. Hartenstein 1931, p. 169.
[132] Sanitätswarte 1926 d, p. 361.
[133] Hartenstein 1931, p. 169.
[134] Sanitätswarte 1929 a.
[135] Sanitätswarte 1927 b.

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political activities of the RG. They cannot have been entirely idle. After all the National Socialists wrote in their report in July 1933 "that due to the activities of some nurses nearly the entire female nursing staff at Uchtspringe had Marxist conviction and were largely also organised accordingly."[136] Accusations that male and female colleagues made during the interrogations by the National Socialists against these female union members sound nearly identical to the accusations against their male comrades. This suggests that the nurses at Uchtspringe were just as active in their efforts at winning new members for the RG as their male counterparts. For instance, the report notes that "The ward nurse [Gertrud Cäcilia] Dassui advertised the state workers' association during her working hours. [...] The evaluation and treatment of the nurses differed depending on their membership in the association."[137] In the same vein, ward nurse Minna Franke was accused that she had "got trainee nurses out of bed to get them to visit social-democratic meetings."[138] The ward nurse Käthe Flier was accused of having prevented patients from singing National Socialist songs and to have ripped off the swastika off the clothing of a female patient in the spring of 1933.[139]

Each of the three accused nurses had to fill in a questionnaire that was supposed to reveal which political party she belonged to and whether she was a member of a republican organisation. They show that Dassui, Franke and Flier had been members of the SPD for a few years until the end of 1932/beginning of 1933. The accused nurses reaffirmed their innocence, Dassui, for instance, stating:

> Even though I have been a continuous member of this association since 1924, I only followed the key objective of the others. The representatives of the aforementioned organisation regularly negotiated with the Provincial Administration so that I could not detect a state or union organisation within this institution representing my economic concerns.[140]

Nurse Flier explained she was incapable of undertaking political work because of her gender: "As a woman I did not concern myself with politics, and hence I have never acted as an agitator."[141] The new rulers were not convinced by this; the evidence seemed overwhelming:

> In particular, I want to mention that during the police search of the house, Nurse Dassui [...] positioned herself next to the local policeman, smoked cigarettes and blew the smoke in his face [...]. During the house search fliers were found [...] that took a stance against the national government.[142]

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[136] [Representative of the Provincial Administration in implementation of the law on the restoration of the professional civil service] Hans Tiessler to Comm. Governor, July 1933. Court files on Dassui, Gertrud Cäcilia. LASA, C 92, no. 6649, fol. 10.

[137] Statement by ward nurse Hedwig Voß, 15/05/1933. LASA, C 92, no. 6649, Court files on Dassui, Gertrud Cäcilia, fol. 11.

[138] Hans Tiessler to Minna Franke, 08/07/1933. LASA, C 92, no. 6649, Court files on Franke, Minna, fol. 7.

[139] Hans Tiessler to Käthe Flier, 08/07/1933. LASA, C 92, no. 6649, Court files on Flier, Käthe, fol. 8.

[140] Statement by Gertrud Cäcilia Dassui, 10/07/1933. LASA, C 92, no. 6649, Court files on Dassui, Gertrud Cäcilia, fol. 8–9, here fol. 9.

[141] Statement by Käthe Flier, 13/07/1933. LASA, C 92, no. 6649, Court files on Flier, Käthe, fol. 9.

[142] Hans Tiessler to Comm. Governor, Juli 1933. LASA, C 92, no. 6649, Court files on Dassui, Gertrud Cäcilia, fol. 10.

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The reports in the Sanitätswarte about the meetings of the RG branch at Uchtspringe at the time of the Weimar Republic mention nurses, if at all, only from the middle of the 1920s, and then only occasionally and only by name when they were elected as representatives of the Work Council.[143] Potential oral contributions that they made during the meetings have not been recorded. Neither could I find complaints to the Management or the Provincial Administration in which nurses complained about the conditions at the institution and that point to union activities.

In the higher levels of staff representation, female nurses are as difficult to find as a needle in a haystack. Instead women are mentioned in the reports of the RG branches mainly when negative issues are being discussed. Barth and other RG boards of the state institutions of the Province of Saxony repeatedly complained that the young trainee nurses were hardly interested in state training in psychiatric nursing.[144] Indeed, they would not understand the meaning of the "free" trade union. "They believed that the social services that they found here had always existed."[145] The boards of the local branches thought that they could counter this by informing and thus warning the young colleagues about the working and living conditions of nurses of the "insane" before the time of unions.[146] Yet, only in 1931 Barth summarised: "Due to the intensive work of the officials it was possible to guide most of the female nurses towards the union."[147]

Nevertheless the gender proportions of the members of the entire RG changed during the time of the Weimar Republic in favour of the women. The number of female comrades jumped up at the beginning of the 1920s before stabilising at a little more than half of all members. "This proportion is, however, rather low, given the proportion of 84% of women in the entire nursing staff," as Ley points out.[148] The union officials were able to greatly increase the attractiveness of the VGS for female nursing staff against other associations and orders by founding

[143] The nurses Käthe Flier and Frieda Klaas were suggested for the Work Council elections in 1924. Sanitätswarte 1924 a, p. 39. Nurse Dassui was mentioned once in 1930 in the report of the Provincial Control Commission as a representative of the Work Council. Inspection of the Uchtspringe state asylum on 28/11/1930, report from 20/03/1931. LASA, C 92, no. 4395, fol. 15–18, here fol. 15. It is telling that Dassui, in her position as the first secretary taking the minutes at the RG branch at Uchtspringe was wrongly titled "[male] colleague". Sanitätswarte 1931 a.

[144] Renner 1926. See also: Sanitätswarte 1926 a.

[145] Sanitätswarte 1927 a, p. 70.

[146] See also the contributions of long-time nurses that increased from the middle of the 1920s in the union journal of the RG, including Neubert 1925.

[147] Sanitätswarte 1931 a.

[148] Ley 2006, p. 33.

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a sisterhood within the RG.[149] This "free" union female nurses' association received state recognition in 1929 including its uniform and badge.[150]

In parallel, the RG headquarters formulated its own "socialist ethics" of nursing. Against accusations by Christian nursing orders and the BOKD that the RG's materialist demands would mean the end of nursing ethics, Georg Renner wrote in an editorial on Mayday of 1931 that a unified regulation of the best-possible training, moderate working hours and the appropriate payment of nurses would provide the necessary requirements for nurses or orderlies to act in accordance with ethical ideals. These ideals were to treat all patients equally, independent of their religious or party affiliations.[151] Furthermore the "free" unionist care regarded itself to be a part of the entire healthcare staff within the framework of a united workers' movement.

So where does this seemingly silent existence at the base level of female nurses organised in unions come from? Is it only a result of the minutes of the meetings that were recorded by the male board members of the RG branches? One of the reasons for the possible rather passive membership of the female nurses within the local chapters of the RG could be the more restricted public mobility that women had in general at that time. Different break-time regulations, which clearly disadvantaged female nurses and prevented them from joining public meetings beyond the compound of the institution, were not uncommon – especially in the rural, isolated institutions of psychiatric care.[152] The working hour regulations pushed nurses to the limits of exhaustion and were even during the Weimar period noticeably tougher for female nurses than for their male colleagues. Hence, an active engagement in politics was made nearly impossible. Similarly, the interest of the young trainee female nurses in the training courses offered by the institution seems to have been small due to their extreme work load.[153] Thus it is even more unfortunate that some of the long-time senior female nurses fought against a shortening of the working hours because they feared their young colleagues would decline morally.[154]

In addition, we need to identify further reasons for the assumed silence of the female comrades, reasons that were inherent to the union itself. At least the RG headquarters were aware of the issue. The desired change from being the "mouthpiece of male orderlies" into a representation of both genders can be vividly reconstructed through the few illustrations that were printed in the Sanitätswarte. [Cf. the illustration for the 25th anniversary of the RG and the

[149] Until the nurses' association was banned in 1933, it organised approximately 10,000 nurses. "Thus the nurses' association of the RG was the largest organisation of its kind in the German Empire." Ley 2006, p. 34. According to Friedrich-Schulz "as support and additional guidance during particularly important professional issues, the leadership of the [RG] should be accompanied by a committee consisting of 6 nurses. [Furthermore] local groups were to be established that were to join the local [RG] branch." 1928, p. 205. I have not been able to discover evidence for a local group of the nurses' association in Uchtspringe.

[150] Ley 2006, p. 33–34. Only trained and state certified nurses were accepted. The foundation of the RG sisterhood was the result of the tireless efforts of comrade Marie Friedrich-Schulz whom I mentioned above. Especially in her role as secretary to the board of the RG between 1920 until 1929 she was made responsible for the "unforeseen uptake" of the RG during the Weimar period. Kolling 2008, p. 99.

[151] Renner 1931.

[152] Faber 2015, p. 131.

[153] Boschma 2003, pp. 230–231.

[154] Sanitätswarte 1927 b.

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one for the 5th Empire conference of the RG, Fig. 2 and 3] The union officials demanded that "the numerically superior strength of the female members" should be considered when nominating candidates for the election of delegates at the Empire Conferences of the RG.[155] The result of the elections, however, painted a different image. In 1924, women gained only nine out of 55 available seats.[156]

Susanne Kreutzer has described similar, if not worse conditions for the proportion of female delegates in the successor organisation of the VGS after the end of World War II. According to Kreutzer, even at the beginning of the 1950s the life and work conditions of the "free" unionist female nurses were still defined by the ideal of a "labour of love". This fundamentally differed from the other professions that the union represented. The leadership of the union declared female nurses to be a special case within the union organisation. As Kreutzer concluded, "The assigned special status resulted from the assumption of a 'natural' professional mentality [in female nurses] that nobody questioned and that demanded the 'protection' from the battling male organisation."[157] The (self)-understanding of female nursing thus included not being able to stand up for one's own interests, e.g. not being allowed to take part in strike actions because of a gender-specific perceived obligation towards the sick.

While female nurses were ethically superior to other female comrades, they were not perceived "as a serious competition for roles and influence within the union."[158] Hence, it is not surprising, as Ley points out, "that the RG, despite its own demands for a gender-independent equal pay, was unable to remove its own gender-specific social injustice. In nearly all agreements, female nurses are more or less clearly disadvantaged."[159]

10 Uchtspringe under the Leadership of a Professed Social Democrat

After the director of Uchtspringe, Hermann Bockhorn, retired in 1928, psychiatrist Dr Heinrich Bernhard was appointed on 1 April 1929 as head of the institution at the age of 35. This decision by the Provincial Parliament caused surprise because in contrast to his fellow applicants, Bernhard had no explicit experience in child and adolescent psychiatry.[160] Yet, Bernhard quickly worked his way into his new task and expanded the concepts of treatment and care that Alt had established.

That a professing Social Democrat took office was certainly a lucky coincidence for the local chapter of the RG at Uchtspringe. The board praised Bernhard's lively interest in the continued training of his nursing staff. Accordingly, Bernhard conducted a four-week seminar with his

[155] Reichssektion Gesundheitswesen 1924, p. 152.
[156] Sanitätswarte 1924 c.
[157] Kreutzer 2003, p. 21.
[158] Kreutzer 2003, p. 21.
[159] Ley 2006, p. 44. Cf. "A particular hardship is the considered salary deduction of ten percent from the unmarried female civil servants, since the unmarried staff is already under extreme pressure from increases in rent and utilities." Sanitätswarte 1931 b, p. 391.
[160] Hinz-Wessels 2017, p. 94.

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nursing staff on "Guidelines of modern mental and medical care".[161] The new director's political disposition was also reflected in some of the reforms in the routines of the institution. Uchtspringe received free copies of the newspaper Volksstimme (The People's Voice) that clearly positioned itself in the social-democratic spectrum.[162] Bernhard even agreed to a visit by a journalist of the Volksstimme.[163] Furthermore the Work group of carers at the care centres for alcoholics and other addicts in Berlin visited Uchtspringe.[164] Further visitors included the Workers' Samaritan Foundation and a social-democratic association of teachers.[165] In addition the Association of Socialist Doctors from Berlin held their 1930 conference in Uchtspringe.[166]

Bernhard's ventures caused resentment among the national-conservative members of staff, who were organised into the Civil Servant Committee at Uchtspringe. In the summer of 1929, the inspecting committee of the Provincial Administration still offered praised during their visit:

> Whereas previously, the final meeting with representatives of the civil servants and the staff would last a long time and reveal the strong tensions and misunderstandings between the Directorate and staff, this time the final meeting was pleasingly harmonious and was evidence of trust and joy of work![167]

But, two years later, the report stated "that the relationship with the Civil Servant Committee was tense"[168], and towards the end of 1932, Bernhard was accused of redirecting state funds for party-political purposes: "The Civil Servant Committee uniformly believes that the director fails to manage his office in a manner as unpolitical and unbiased as is the case in other institutions."[169]

Even though, at the beginning of the 1930s, nearly 90 percent of the staff at Uchtspringe were members of the RG, some departments of the institution remained for the VGS "white spots" on the map of the union. This included the department for curative and general education that had opened in Uchtspringe in 1927, consisted of eight buildings which could take a maximum of 500 "imbecile" children. While this department had modern equipment and stood for progressive medical and educational concepts, the majority of the staff were untrained nursing attendants, as the union paper critically remarked. "The managers of this department are supposedly opponents of the union and they watch like hawks that no union member works among them."[170] The foremen of the workshops at Uchtspringe presumably did not join the

[161] Sanitätswarte 1930 b.
[162] Hinz-Wessels 2017, p. 96.
[163] Bernhard to Governor, 23/01/1930. LASA, C 92, no. 4395, fol. 14.
[164] Governor to Bernhard, 25/01/1930. LASA, C 92, no. 4395, fol. 13.
[165] Inspection of the Uchtspringe State Asylum on 24/09/1932, report from 02/12/1932. LASA, C 92, no. 4395, fol. 41–43, here fol. 43.
[166] Statement by the secretary of the institution Girle, 23/06/1933. LASA, C 92, no. 5312, fol. 12.
[167] Inspection of the Uchtspringe State Asylum on 15/08/1929, report from 11/11/1929. LASA, C 92, no. 4395, fol. 6–9, here fol. 9.
[168] Inspection of the Uchtspringe State Asylum on 28/11/1930, report from 20/03/1931. LASA, C 92, no. 4395, fol. 15–18, here fol. 16.
[169] Inspection of the Uchtspringe State Asylum on 24/09/1932, report from 02/12/1932. LASA, C 92, no. 4395, fol. 41–43, here fol. 43.
[170] Levy 1927, p. 209.

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RG either and found their representative in Herr Rossau, the national-conservative foreman of workshops at Uchtspringe.[171]

Furthermore, in 1932 a "badly concealed marsh plant of National Socialism", as Barth sarcastically remarked, was forming under the guise of an allegedly politically neutral "social club".[172] The anti-democratic military organisation Stahlhelm (Steel Helmet) also found a few supporters among the staff of the institution at Uchtspringe. Hence it is not surprising that representatives of these two groups were those who in 1933 strongly incriminated Bernhard and the former board member of the Uchtspringe RG branch during the National Socialist interrogations. The long-time ward orderly Theuerkauf who was previously mentioned also used the opportunity to express his long-cherished resentment against Barth.[173] Similarly, the orderly Paul Unger who himself was a RG comrade who was accused too, nevertheless incriminated the chairman of the RG branch.[174] Barth's declaration of innocence could not help him at all. The final report said: "According to these statements the orderly Barth was an extremely damaging and particularly eager representative of Marxism."[175] Together with other male and female comrades Barth had to submit to the new rulers and had to say good-bye to the Uchtspringe institution after 32 years of service. In the subsequent period, Uchtspringe became unfortunately famous as one of those state institutions responsible for numerous forced sterilisations and "euthanasia" killings of psychiatric patients and disabled persons in the Third Reich.[176]

11 Conclusion

In summary, we can say that until the ban on organising was lifted in 1918, the nursing staff of the Prussian Uchtspringe asylum were strictly forbidden to act independently of the institution's management within a trade union and were punished for such a membership with immediate dismissal. Nonetheless, there is evidence that a number of nurses and orderlies communicated regularly with Georg Streiter, the chairman of the Christian Deutscher Verband der Krankenpfleger und Krankenpflegerinnen (German Association of Nurses and Orderlies). Only after the end of the First World War and the political and social upheavals that went along with that did an open involvement in trade unions become possible at Uchtspringe. Together with the staff of other state asylums and institutions for the blind in the Province of Saxony, committed nursing staff formed a network of branches of the Reichssektion Gesundheitswesen (Empire Health Services Branch), an organisation within the Verband der Gemeinde- und Staatsarbeiter (Association of Municipal and State Workers) which had close ties to the Social Democratic Party (SPD). They received active support from full-time union officials

[171] Das Handwerk in einer modernen Landesheilanstalt. Denkschrift, bearbeitet im Auftrage der Werkstättenvorsteher-Gruppe der Landesheilanstalt Uchtspringe von Werkstättenvorsteher Rossau, 25/01/1927. LASA, C 92, no. 2710, fol. 167–171.
[172] Sanitätswarte 1932.
[173] Statement by ward orderly Theuerkauf, 18/05/1933. LASA, C 92, no. 6653, fol. 13.
[174] Statement by orderly Paul Unger, 18/05/1933. LASA, C 92, no. 6653, fol. 11.
[175] Bericht über die Kündigung des Pflegers August Barth (Report on the Dismissal of Orderly August Barth), 13/05/1933. LASA, C 92, no. 6653, fol. 8.
[176] For more details see: Synder 2001.

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of the RG. The good travel connections between Uchtspringe and the capital Berlin and the Provincial capital Magdeburg also proved helpful.

During the Weimar period, the RG managed to strengthen the influence of staff representatives vis-à-vis the management of both the institution and the Provincial Administration and to achieve further improvements, such as the state recognition of nursing staff and the introduction of work uniforms and protective clothing. Many additional demands of the RG failed due to the resistance of the largely national-conservative Provincial Administration that had the last word in any matter. In addition some local factors also undermined the RG's achievements. Yet, the lines of conflict also ran amongst the nurses and orderlies themselves, as some of the senior staff that had civil servant status boycotted the progress of the RG for a long time. Neither side of the conflict was particularly squeamish when it came to choosing the means to get rid of a competitor of the other party. The Great Depression at the end of the 1920s aggravated the difficult working and living conditions in psychiatric institutional care even more and sounded the death knell of the Weimar Republic.

We have also seen that the term "Red Uchtspringe" did not only refer to the medical director and professed Social Democrat Heinrich Bernhard who began his work at Uchtspringe in 1929 but that it had its origins also in the fiery commitment of many nurses and orderlies at Uchtspringe to their leader, the ward orderly August Barth. As founder and chairman of the Uchtspringe RG branch, Barth shaped the "face" of the nursing staff's union work in Uchtspringe during the entire Weimar period. However, the involvement of the female nurses in the local chapter in Uchtspringe remains largely unknown. Further research and the investigation of potential further sources are needed

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12.3.2 Images

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Fig. 1: Emig, Klaus-Peter: Brosche der „Reichssektion Gesundheitswesen“ (RG) [Pin of the Empire Health Services Branch] im Verband der Gemeinde- und Staatsarbeiter (VGS) [Association of Municipal and State Workers] before 1933, https://www.kpemig.de/5635b-Verband-der-Gemeinde-und-Staatsarbeiter-Reichssektion-Gesundheitswesen, accessed May 27, 2020.

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Fig. 2: Klimesch, F.: Illustration for the 25th Anniversary of the RG and Illustration of the 5th Empire Conference of the RG. In: Sanitätswarte 26 (1926), 1, n. p.

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Fig. 3: Klimesch, F.: Illustration for the 25th Anniversary of the RG and Illustration of the 5th Empire Conference of the RG. In: Sanitätswarte 26 (1926), 19, n. p.

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Eugenics and Healthy Families. Interdependence and Legitimation

Mary D. Lagerwey

Abstract

There was significant popular support for eugenics in the first part of the twentieth century. Discourses from various organizations promoting the health of children and families interacted with eugenic discourses and provided support for eugenics to health care providers and the general public. Linking eugenics with better health of the population was an essential aspect of legitimizing eugenics among the general population. The American Journal of Nursing (AJN) provided an avenue for informing nurses about eugenics, gaining their support, and encouraging them to gain support for the movement among their patients and the public. This paper provides an overview of organizations in the US focused on or encompassing the eugenics movement and an analysis of eugenic discourses in AJN. All issues of AJN from 1900–1950 were read for eugenic and related language. These texts then were analyzed for authoritative, moral, rational, and story-telling support for eugenics. Nursing leaders worked closely with eugenic societies and organizations that were designed to improve the health of infants, children, and families. Eugenics was seen as a tool to reduce social and health problems, and eugenic leaders looked to these organizations and nursing to gain broad public support. AJN participated in the work of legitimizing eugenics through various means of legitimation, including appeals to authority, nurses' moral values, the rationality of science, and moral tales.

1 Introduction

The term "eugenics" was introduced into public discourse in 1883 when Sir Francis Galton of Great Britain wrote of eugenics as a science of racial improvement through controlled breeding. The term has since taken on broad and at times contradictory meanings, ranging from negative eugenic practices of euthanasia and non-consensual sterilization to limit reproduction among those deemed physically or mentally "unfit" or "socially inadequate" to positive eugenic practices that encouraged the healthy, fit, and native-born to have larger families and protect their children's health. Eugenics included legislation, institutionalization, marriage restrictions, and quotas on immigration.

This paper provides an exemplar of how eugenics interacted with discourses of infant, child, and family health, how it gained popular support, and of one venue by which it was legitimized to and by the nursing profession. The first section of the paper discusses some of the distinctive characteristics and contexts of eugenics in the US[1] and of various associations that were established to prevent illness and improve the health of the population, particularly of children and families. Nursing groups and individual nurses were active members of many of these organizations and helped translate eugenic concepts into everyday life. The next section is an analysis of the *American Journal of Nursing (AJN)* from 1900–1950 to determine how texts in this popular journal reflected and provided legitimation for eugenic discourses and

[1] For more detail and images see the American Eugenics Archive at http://www.eugenicsarchive.org (accessed March 30, 2020) and the American Eugenics Society Records, American Philosophical Society collections and its digital "Genetics and Eugenics" collections at https://www.amphilsoc.org/library/guides (accessed March 30, 2020).

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practices over time. During those years AJN was the official journal of the American Nurses Association (ANA) and the most widely-read nursing journal in the US.

Legitimation refers to justifications and explanations that provide a normative validity to discourses. The concept draws from a rich tradition of critical theory, social, and linguistic scholarship as developed by Theo Van Leeuwen.[2]

2 Background

In 1907, the US state of Indiana passed the world's first law legalizing non-consensual sterilization. Laws in Japan were passed on the heels of US laws; later in 1907, the first of Japan's Leprosy Prevention laws allowed for lepers to be segregated in sanatoria; many were sterilized without their permission.[3] "In 1921, the Canadian National Committee for Mental Hygiene recommended sterilization of those with mental defects or disorders."[4] This law was interpreted broadly in Alberta, in British Columbia, and in "14 different federally operated Indian Hospitals across Canada."[5] Eugenic laws in Switzerland, Denmark, and the state of Veracruz in Mexico[6] preceded eugenic legislation in Germany, which did not pass eugenic laws until 1933 when the Nazi regime came to power.[7] By World War II, non-consensual sterilization was legal in Nordic countries, Switzerland, Austria, Estonia, Mexico, Canada, Japan, and the United States.[8] Throughout these countries, as well as in Scandinavia and much of northern Europe, however, eugenic practices preceded, were broader than, and were not dependent upon, sterilization laws.

As the first country to legalize non-consensual sterilization, and the country whose laws formed a model for Nazi Germany's eugenic laws,[9] the US provides a case study in eugenics as not just political sets of laws, but also as a movement that required, and for many years received, broad public support. Gallup polls from 1938 found that 84 % of the US population supported mandatory sterilization for the "unfit"[10]. The nursing profession's public discourses provide a fitting perspective from which to obtain a glimpse into legitimation not only for negative eugenics such as sterilization of the unfit, but also for positive eugenics. Nurses worked closely with everyday matters of families' health and were gaining recognition as knowledgeable health care providers. As in other western countries, nursing was becoming more professionalized, with individual states requiring licensure for practice, and standardization of curricular content. Public health nurses had significant and often long-term contact

[2] Van Leeuwen 2007, p. 92.
[3] Amy/Rowlands 2018 a.
[4] Amy/Rowlands 2018 a, p. 127.
[5] Amy/Rowlands 2018 a, p. 127.
[6] Amy/Rowlands 2018 a, pp. 126-127.
[7] Amy/Rowlands 2018 b, p. 195.
[8] Broberg/Roll-Hansen 1996, 2005; Amy/Rowlands 2018 a; Amy/Rowlands 2018 b.
[9] Amy/Rowlands 2018 a, pp. 123-126; Amy/Rowlands 2018 b, pp.195-196.
[10] Lombardo 2008, p. 227.

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with families and enjoyed more professional independence than their counterparts in hospitals.[11]

The eugenics movement grew in legitimacy at a time when much of the industrialized world had been transitioning from a rural to a more urban society. Within the US the Great Migration of African Americans from the rural south to northern cities and new immigrants settling in cities, combined with racism and xenophobia, contributed to overcrowding, poverty, and unhygienic living conditions. Microbiology had identified the causes of many diseases, but the poverty and overcrowding in many large cities made it difficult to control the spread of infectious disease.[12]

Eugenic leaders such as Harry Laughlin, the Eugenics Record Office Superintendent, led successful efforts to pass legislation to restrict immigration from countries outside northern Europe.[13] This was coupled with dire warnings of "race suicide," a decrease in the percentage of the population who were white, native-born, and "fit". AJN did not publish overtly anti-immigrant articles, but many articles addressed social problems and conditions of poverty commonly experienced by immigrants and racial and ethnic minorities.

3 Eugenic Organizations in the United States

Much of the eugenics movement in the US was organized around five societies, with overlapping memberships. The American Breeders Association (ABA) was organized in 1903 and grew out of the American Agricultural Colleges and Experimental Stations' focus on livestock and other farm animals. It published the *Journal of Heredity*. Its purpose was to apply Mendel's 1865 research on hereditary patterns of dominant and recessive traits to eugenic research on human inheritance. The association captured some of the nation's optimism for the potential to eliminate inherited disease through controlled breeding. Charles Davenport, a zoologist and the Director of the Station for Experimental Evolution in Cold Spring Harbor, Long Island, New York, worked closely with the ABA. In 1914 the ABA changed its name to the American Genetic Association. It continues today with a focus on genetic research.[14]

The Race Betterment Foundation was founded in 1911, supported by John Kellogg of Kellogg Cereal fame. International Conferences for Race Betterment were held in 1914, 1915, and 1928. It did not survive Kellogg's death in 1943.[15]

The Galton Society, founded in 1918 in New York City, was exclusive, overtly racist, and nativist, yet had close ties with more moderate eugenics organizations, the Eugenics Records Office (ERO), and eugenics leaders in Europe. Harry Laughlin, superintendent of the ERO, drafted

[11] Buhler-Wilkerson 1985, pp. 1155–1161.
[12] See data from the United States Census Bureau from the 19th and 20th centuries for details on changing immigration patterns and growth of urban areas, https://www.census.gov/prod/www/decennial.html, accessed April 1, 2020.
[13] Lombardo 2008.
[14] Engs 2005.
[15] Wilson 2014.

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the US legislation on which Germany's eugenics laws were modeled.[16] The Galton Society supported German Nazi views in its journal, *Eugenical News,* which it published with the Eugenics Record Office (ERO). The Galton Society disbanded in 1939.[17]

The Eugenics Record Office (ERO) was not strictly a society, but its influence was significant, and it worked closely with other eugenic societies. The ERO considered women superior observers of families and employed them as field-workers and researchers who collected multigenerational family data and analyzed the data to identify intergenerational eugenic patterns.[18]

The goals of the fifth organization, the American Eugenics Society (AES), included legitimation of eugenics through education of the public. The AES originated at the 1921 Second International Congress of Eugenics, was officially incorporated in 1926, and was renamed the Society for Social Biology in 1972. Its members lobbied for eugenic legislation such as immigration restrictions and mandatory sterilization of the "unfit." It promoted eugenics through social agencies, professional groups, and public exhibits, linking eugenics with discourses of physical, social, and family health. The AES sponsored several conferences on eugenics for professions with significant contact with the public, including social work, education, and nursing. Its assertion at the March 20, 1937 Conference on Education and Eugenics summarized its approach to popularizing eugenics. "[E]ugenic propaganda will go furthest if it is treated as incidental to all other social advance."[19]

Eugenics education included positive eugenics and called upon the "well-born" to have large families, reinforcing traditional gender roles among the middle and upper classes.[20] Perhaps the best-known example of this was a variation on the baby contests held at cultural events such as rural county and state fairs, which had been popular during the latter part of the 19th century. It was a small step to infuse the contests with agriculturally-based eugenic ideals of breeding. An idealized robust rural identity, health for future generations, and nurses' participation in eugenic discourses came together in the popular Better Baby Contests. The AES relied on professional women such as nurses to educate women in so-called "scientific motherhood" and euthentics, the means of providing the best environments for children to reach their full genetic potential.[21]

The first Better Baby Contest was in 1908 in Louisiana. This and subsequent contests used standardized measurements and criteria to evaluate how children were developing compared to their peers. Physical and intellectual testing were conducted, with the two seen as interdependent domains of health.

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[16] Amy/Rowlands 2018 b, p. 195.
[17] Engs 2005.
[18] Bix 1997; Black 2003.
[19] McCracken, Henry N.: Report on "Conference on Eugenics in Relation to Education" for the 1937 Annual Meeting of the American Eugenics Society, American Eugenics Society Records, American Philosophical Society, Box 1, p. 22.
[20] Kline 2005.
[21] Kline 2005.

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Photographs of the contests show nurses in starched white uniforms and caps judging babies and toddlers in curtained-off sections of large tented pavilions, with proud mothers looking on or holding their children.[22] Conference Proceedings from the first National Conference for Race Betterment contained quotes from mothers who had brought their young children to compete in Better Baby Contests, illustrating scientific motherhood, or dual emphasis of eugenics and euthenics. "I did not bring my baby because I expected him to win a prize, but to learn if there is anything wrong and what I can do to aid his development".[23] Parents were to correct areas in which their children scored low. These contests quickly spread to 40 states before World War I, with over 100,000 babies examined at agricultural fairs in 1914.[24] Photographs of winners were prominently displayed in Eugenic magazines and local newspapers, and at national eugenics conferences.

The American Eugenics Society soon realized that a stronger eugenic message could be communicated by incorporating other family members into the contests, assessing family lineage, and focusing on the health of future generations. The first Fitter Family Contest was held at the 1920 Kansas State Free Fair. Teams of health care providers, including nurses, performed physical and psychological exams on family members. Individual family members were given overall letter grades of eugenic health, and families with the highest grade averages were given silver trophies. All families with an average of B+ or better were given bronze medals, engraved with a quote from Psalm 16:6 that lent religious authority to the competition and the award: "Yea, I have a goodly heritage". Photographs of winning families were prominently displayed in the AES's *Eugenics: A Journal of Race Betterment* and local newspapers, and at national eugenics conferences.[25]

The AES held a conference, The Relation of Eugenics to the Field of Nursing, on February 24, 1937. US nursing leaders, as well as ASE members from public health, education, infant and child health, and visiting nurse services attended.[26] Charles Davenport and nursing leaders such as Naomi Duetsch, Director of Public Health Nursing at the Federal Children's Bureau, and Lillian Hudson, Professor of Nursing Education at Teachers College in New York City spoke of the moral duty of nurses to understand eugenics as a science and guide for practice. Papers were presented on the role of public health nurses in identifying cases for sterilization, the fit between eugenics and good nursing care for infants and children, and application of eugenic principles. Marie Kopp, a German eugenicist, presented a paper that Osborn cited as "The

[22] See examples in Archives of Michigan Box 850 Folder F2 and in the American Eugenics Society Records, American Philosophical Society collections and its digital "Genetics and Eugenics" collections at https://www.amphilsoc.org/library/guides, accessed March 30, 2020.

[23] Proceedings of the First National Conference on Race Betterment 1912, p. 622.

[24] Kline 2005.

[25] These and many other eugenics images can be found in the American Eugenics Society Records, American Philosophical Society collections and its digital collections at https://www.amphilsoc.org/library/guides (Genetics and Eugenics), accessed March 30, 2020.

[26] Summary of Proceedings-Conference on Eugenics in Relation to Nursing 1937, American Eugenics Society Records, American Philosophical Society, Box 17, Folder 8.

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Nature and Operation of the German Eugenical [sic] Program."[27] Kopp contextualized German eugenics laws within severe health and social problems there and provided details on related legislation and practices, such as the Race and Hygiene and Marriage Health Law of November 1935, that contained bans on marriage between Jews and non-Jews. A paper by Katharine Faville, Associate Dean, Western Reserve University School, discussed "The need for teaching eugenics in schools of nursing".[28]

In closing remarks Henry Osborn, a founder of the Galton Society and member of the AES, noted that some aspects of German eugenics could not have been enacted without a dictator. Alta E. Dines, a leader in public health and Director of the Bureau of Nursing Education, attended the conference and wrote a report for AES, including the role of public health nurses, noting that with 220,000 nurses in the US with daily patient contact and 20,000 public health nurses, nurses were ideally situated to these tasks, provided they were adequately educated on eugenics. Curricular recommendations were included. Although the *American Journal of Nursing* routinely covered conference proceedings and meetings of interest to nursing, it did not cover this event.

4 Nurses, Family Health and Eugenics

Discourses of the eugenics movement interacted with those of several organizations and movements in which nurses actively participated, including child and family health, and prevention of sexually transmitted diseases and alcohol abuse. The eugenics movement had close ties with the American Social Hygiene Association (ASHA). This association was formed in 1914 to prevent what were then called venereal diseases, with their often-devastating impact on families. The association included nurse leaders and promoted inclusion of social hygiene content in nursing curricula. Much of the eugenic rhetoric on social hygiene was integrated with eugenic discourses based on the notion that "germ cells" of parents were damaged by alcohol, and that detailed family histories could identify those at risk for transmitting these defective genes. Nurses' roles included preventative education and gathering family histories. AJN's News and Announcements sections carried frequent items about meetings of the ASHA and eugenic components of their agendas, and curricular recommendations encouraged nursing programs to include social hygiene and eugenics together in their curricula.

Although there are no definitive statistics for infant mortality in the early 20th century, reported deaths of children under the age of one year for all registered areas in the US were 286.7/100,000 population[29] and there was general consensus that these rates were alarm-

[27] The copy of this address found in the American Philosophical Association archives gives a title of "A Eugenic Program in Operation." American Eugenics Society Records, American Philosophical Society. "Summary of Proceedings-Conference on Eugenics in Relation to Nursing", Box 17, Folder 8.

[28] See Lagerwey 2006 for a more detailed analysis of relationships between US and Nazi German Nursing.

[29] According to the Department of Commerce and Labor Bureau of the Census Mortality Statics for 1910, true infant mortality rates were difficult to estimate as births were under-reported while numbers of infant deaths rates were assumed to be more accurate. This would have resulted in reported infant mortality rates that were higher than actual rates.

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ingly high and needed to be tackled with collaboration from many sectors of society. AJN reported on meetings of the American Association for the Study and Prevention of Infant Mortality (AASPIM). Leading members included Mary Adelade Nutting, Professor and Chair of Johns Hopkins School of Nursing, as well as prominent members of eugenics associations such as Irving Fisher, founding president of the AES and Charles Davenport, Head of the Eugenics Record Office.

In his opening address at the AASPIM's first meeting in 1910, Irving Fisher spoke of preventing infant mortality as congruent with natural selection, concluding that, "this [eugenics] movement aims to remove the interferences with natural selection which modern civilization has created."[30] Annual meetings were held from 1910–1918, with eugenic sections and topics for discussion at each meeting[31] and coverage in AJN.

Although eugenic and public health discourses clearly interacted, the relationship between the two was at times ambivalent and controversial. Was heredity biological only, or did it rely on childrearing practices? Does eugenics speed up or interfere with natural selection? At the 1914 National Conference on Race Betterment, some, such as Paul Popenoe and John Harvey Kellogg, argued that public health measures such as sanitation and immunization were dysgenic in that they increased chances of survival and reproduction of the unfit. Some, such as nurse midwife Mary Breckinridge, held that good stock needed education and good health care to have a healthy environment to thrive and reproduce healthy children.[32]

Another nurse, Margaret Sanger (1879–1966), is closely associated with both birth control and eugenics. Although she shared the eugenic goal of limiting reproduction by newer immigrants from countries outside northern Europe, eugenics leaders supported neither reproductive choice nor Sanger's emphasis on the health of women, particularly mothers.[33]

Nonetheless, the birth control movement sought rational scientific and moral legitimation from the eugenics movement. Birth control activists often used the language of eugenics and appealed to the moral value of caring for the health of children and future generations. They found common ground in the belief that, "Every child has the right to be well born." [34]

Eugenic organizations such as the AES appealed to women's increasing independence and provided respectable venues for involvement in social concerns.[35] In some areas women's organizations and eugenics overlapped, but much of the collaboration between organizations for women's reforms and mainstream eugenics had dissipated by the early twentieth century

[30] American Association for Study and Prevention of Infant Mortality: Transactions of the First Annual Meeting. 1910, p. 39.
[31] American Association for Study and Prevention of Infant Mortality: Transactions of the First Annual Meeting 1910.
[32] Pernick 1997, pp. 1767–1772; Goan 2008, p. 109.
[33] Kevles 1985, p. 89; Lagerwey 1999.
[34] Kline 2005 p. 64.
[35] Kevles 1985.

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as women's reforms were excluded from eugenic platforms. AJN, however, covered and integrated infant and child health and social hygiene with eugenic discourses. Women's rights and birth control were deemed too controversial and were avoided.[36]

5 Analysis of AJN Texts

Method

It is beyond the scope of this paper to present an analysis of all US nursing publications from the time under study. However, one widely distributed nursing journal, at that time published by ANA and its predecessors, provides an exemplar of how nursing texts from the first half of the twentieth century worked to legitimize eugenics as an area for nursing knowledge and a means of improving health, and data on how eugenics was presented to and by nurses. AJN was first published on October 1, 1900, with a purpose of keeping members of the ANA "educated and informed of nursing issues and procedures and that the gospel of unselfish devotion to the care of the sick might be spread, with propaganda for securing to the profession a status whereby its usefulness should be increased."[37] AJN informed its readers, reflected wider discourses, and played a part in constructing the meaning of eugenics for its readers. Journals such as AJN have the power to shape reactions to events.[38] This study examines one forum for eugenics discourse published for a nursing readership in the United States. It explores the extent and manner in which nurses reading AJN from 1900–1950 would have been exposed to eugenics discourses.

The notion of legitimation as developed by van Leeuwen[39] was used to examine references to eugenic and related concepts in AJN. According to van Leeuwen, there are four types or bases of legitimation: authority of individuals or institutions, moral values and evaluations, rationality, and the use of stories.

AJN was chosen for its broad readership, coverage of news related to the nursing profession, and frequent articles on nursing policy, education, and practice. Each issue was read and entries that included the word eugenics, as well as the language of eugenic discourse, such as race suicide, mandatory sterilization, purity, the unfit, feeble-minded, and degenerate were analyzed. Type, length, and authorship of entries were noted. Some texts were originally written for nursing audiences, while others were reprints of papers previously published or read at conferences, meetings, or lectures. Those included in this paper were of particular relevance for illustrating legitimation of eugenics and concerns for the health of families.

6 Findings

1900–1909

The first notable mention of eugenics in AJN was in 1909 in a section titled, "Foreign Department in Charge of Lavinia Dock, R.N." This article "The Eugenics Education Society of England,"

[36] Lagerwey 1999.
[37] Riddle 1925.
[38] Lipstadt 1986, p. 3.
[39] Van Leeuwen 2007, pp. 91–110.

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lent legitimacy to the eugenic movement by placing it within contexts of scientific advancement, support by the International Council of Nurses' (ICN) president and the British Government, and association with Lavinia Dock. Further legitimacy came through language of moral goodness of fit with existing nursing care for families, and cautionary tales of the impact on families of unchecked fertility among "degenerates."

1910–1919

In the second decade of the twentieth century, specific references to eugenics and its ideologies became more prevalent, with 29 articles mentioning eugenics and three about the feeble-minded. Eugenics appeared in several "Nursing News and Announcements" sections. In the November 1911 issue, the news section was 23 pages long, and included a report from Indiana State Nurses Association's annual convention. A page from this report was devoted to eugenics.[40] Legitimizing appears in this and other news items about presentations on eugenics to nurses, emphasized the authority of science and international collaboration, and the moral duty of "educating the public."[41] An announcement in the March 1912 "Nursing News and Announcements" section recommending Public Health Lectures at the Academy of Medicine on "Sex Hygiene in Relation to Eugenics" illustrated interaction between public health and eugenics.[42]

Physicians, often in connection with eugenics organizations, lent their authority to discourses of health and eugenics. Fifteen articles specifically included eugenics and three discussed the "feeble-minded." Some articles written by physicians and eugenics leaders were re-printed or written specifically for nurses. These entries were consistent with AJN's practice of publishing informative articles meant to keep nurses current on developments in health care.

Thus we find articles that described eugenics and presented authoritative legitimation. A section titled "Editor's Miscellany" contained a long reprint of "Practical Eugenics", written by John N. Hurty, M. D. Indiana State Board of Health Secretary and avid supporter of eugenic sterilization laws.[43] The article was originally published in the January 1912 issue of *Social Diseases*, and reprinted in two parts in AJN, in February (four pages) and March (12 pages) 1912. In the February article Hurty emphasized the authority of medicine. As this is the first informational article of any length on eugenics in AJN, his use of analogies and cautionary storytelling present eugenics as commonsense and rational. He appealed to moral legitimation by drawing an analogy between physical and moral "blindness" and between breeding animals and people: "Now at last, we realize that the human race is to be improved by applying exactly the same laws to and that will perfect the breed of the lower animals."[44] Cautionary tales told of preventable burdens to society from "imbeciles" and the "unfit" allowed to reproduce, and of a talented musician who is "an imbecile and now suffers from impulsive insanity."[45]

[40] AJN 1911, pp. 155–156.
[41] AJN 1911, p. 156.
[42] AJN 1912, p. 511.
[43] Stern 2007, pp. 2–28.
[44] Hurty 1912 a, p. 451.
[45] Hurty 1912 a, p. 452.

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Reflecting on the musician, a "graduate of one of our minor colleges,"[46] he lamented that the man's grandfather had not been sterilized before he had children. Hurty concluded with appeals to moral and rational forms of legitimation. "It is certainly useless, unnecessary, cruel, bad every way, to permit the procreation of the unfit and then bear ourselves to the earth with a burden of taxation to care for them."[47]

In part two in the following month, AJN published the remainder of Hurty's article, which contained even more vivid arguments. This section began with the claim that education and religion have been unsuccessful and unable to "improve the race … decrease crime and increase morality."[48] Again, Hurty drew legitimating analogies with laudatory tales of animal breeding and cautionary tales of children in an orphan asylum.

Although Hurty wrote here of the science of eugenics, moral legitimation was strong in this article, with arguments again about eugenics being much more effective than religion or education in humanely improving civilization and preventing suffering, and in using scarce resources responsibly. Hurty also likened war to dysgenic practices, linking eugenics with peace, claiming that the Great War had claimed the lives of the men most eugenically fit to become fathers.

Arthur R. Hamilton, Director of Extension Work at the Eugenic Records Office, wrote in a similar vein of the science of eugenics but wrote specifically for nurses and AJN. His article "Science of Eugenics and the Nursing Profession" appeared in the March 1915 issue. References to a "eugenic conscience" and an appeal to future generations to be protected by eugenic practices as "a trust and responsibility"[49] formed moral legitimations for eugenics.

A couple of years later, AJN published shorter pieces by registered nurses concerning the "feeble-minded". A two-page reprint of a paper read by Lucia L Jaquith, RN and Superintendent of the Memorial Hospital in Worcester, Massachusetts, at the Massachusetts State Nurses Association meeting in October 2013, appeared in the January 1914 issue. In this paper, "The Menace of the Feeble-Minded" Jaquith encouraged nurses to gain public and family support for segregating "feeble-minded" women with appeals to moral norms of the day. Here interests of eugenics and social hygiene intersected, as Jaquith wrote of "feeble-minded" women as promiscuous and fertile. Segregation was considered preferable to sterilization because "the effect of turning 60,000 sterile feeble-minded women loose on society is too easy to forecast, the results to morals and in the spread of disease would be appalling."[50] Jaquith also relied on authoritative legitimacy by quoting physicians who were leaders in supporting eugenics.

The May 1914 issue contained a three-page response from Ellen Bertha Bradley, RN, "The Problem of the Feeble-Minded". We again see authoritative legitimacy as Bradley drew support from male eugenic leaders – physicians and an attorney. Echoing messages of the

[46] Hurty 1912 a, p. 452.
[47] Hurty 1912 b, pp. 525-536.
[48] Hurty 1912 b, p. 525.
[49] Hamilton 1915, p. 469.
[50] Jaquith 1914, pp. 268–271.

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Women's Temperance League, she made a moral appeal to nurses' duty to educate potential fathers on the eugenic dangers of any alcohol consumption. Bradley aligned eugenics with the temperance movement, citing alcohol as a leading cause of "degeneracy" among the children of those who drank.[51]

The American Association for Study and Prevention of Infant Mortality had a separate section on Nurses Associations and Social Workers. Its meetings were covered in some detail in AJN's "Nursing News and Announcements" sections. In 1912, four and a half pages were given to coverage of the third annual meeting of the Association. Of these almost an entire page was devoted to eugenics. The chair presented "The Rearing of the Human Thoroughbred,"[52] providing legitimation through the authority of traditional agricultural practices and fairs, with their Better Baby and Fitter Family contests.

1920–1929

During the 1920s, there were twelve entries in AJN about eugenics. As in the previous decade, nurses wrote about "feeble-mindedness", but the writers emphasized families' care for their children and nurses' moral duty to educate and support families in this care. In 1922 and 1926, V. M. McDonald, RN, wrote of "The feeble-minded as an Individual"[53] and "Changing Concepts of Feeble-Mindedness." McDonald legitimized her call for "defectives" to be raised in "good homes" with moral, rational, and scientific arguments. She questioned the validity of hastily trained "diagnosticians of mental defect"[54] and presented her recommendations as "the newer point of view,"[55] a correction to public misunderstanding, faulty treatment, and neglect of the needs of persons who are "feeble-minded". She concluded by quoting a medical authority from the New York State Commission for Mental Defectives, offering a moral and rational argument that challenged and delegitimized some aspects of eugenic practice. "If all defectives could be brought up in good homes they would cease to be the social menace they are now."[56] The 1926 article provided authoritative and moral scientific arguments that the danger from the "feeble-minded" and their children is rather small, and largely tied to neglect. Its author recommended specific interventions to care for the "feeble-minded".

Eugenics also was normalized by its presentation as of international interest. In October 1925, AJN included a paper by Annie W. Goodrich, Dean of the Yale Graduate School of Nursing and of the Army School of Nursing, read at the July 1925 International Council of Nurses in Helsingfors, Finland. A half-page photo shows Goodrich addressing a large crowd in an elaborate three-tiered auditorium. Goodrich spoke of increasing rates of inherited mental illness and of her hopes that the science of eugenics would eliminated these and other "evils." This could

[51] Bradley 1914, pp. 628–731.
[52] Nursing News and Announcements 1912 b, pp. 137–155.
[53] McDonald 1922, pp. 263–266.
[54] McDonald 1922, p. 264.
[55] McDonald 1926, p. 348.
[56] McDonald 1926, p. 348.

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be done, she believed, by applying agricultural knowledge to human reproduction. She appealed to the nurse's moral values, saying she "must take her part" and draw on "tradition, and personal volition … [and] instinct to the conversation of the race."[57]

Following the 1927 Buck v. Bell Supreme Court decision, AJN invited Leon Whitney, to write a "statement on the legal sterilization."[58] Whitney was Field Secretary of the American Eugenics Society and in 1934 generated controversy with public support of "Nazi Germany's sterilization program."[59] AJN described the article, "Eugenical Sterilization" published in the September 1927 issue of AJN, as "authoritative". In the article court-mandated sterilization on the basis of eugenic factors was given legitimation through authority, morals, and rationale. Whitney wrote that eugenic sterilization had been declared constitutional by U. S. Supreme Court and "now the matter is settled."[60] Further authoritative legitimation was given with an extensive quote on eugenics from Justice Holmes, and reference to the large number of states (22) with sterilization laws and the claim that many more would follow within the next year. Furthermore, he claimed the authority of medical science by describing three methods of sterilization in some detail. Moral legitimation was given by describing sterilization as "one of the kindest inventions of man"[61] and having the intent of protection of society from the dangerously "unfit."[62] Finally, relying on moral and rational legitimation, he claimed that there was no evidence of harm having been done to Carrie Buck or her family; rather her sterilization was of general benefit to society.

In a May 1929 article, "The Ills this Flesh is Heir to" Anna Wallace, who served as assistant editor for the Joint Committee of Eugenical News, appealed to scientific legitimacy with two charts demonstrating simple Mendelian inheritance of dominant and recessive genes for fur color in rats and eye color in people. She argued for the need for significantly more data.[63]

During the 1920s, texts in AJN presented eugenics as a modern science that held a promise of preventing physical and social problems, but also presented arguments delegitimizing claims of great danger from the "feeble-minded". Authoritative legitimacy was granted through book reviews and numerous news articles advertising educational lectures on eugenics for the public or nursing. Healthy families were possible only through eugenic practices, but also needed family and professional care.

1930–1939

Throughout the 1930s eugenic discourses were interwoven with language addressing nurses in public health, nursing education, infant and child health, and visiting nurse services. Nan Ewing urged nurses were to provide antepartum care with eugenics in mind.

[57] Goodrich 1925, pp. 821–826.
[58] Our Contributors 1927, p. 774.
[59] Engs 2005, pp. 7–9.
[60] Whitney 1927, p. 742.
[61] Whitney 1927, p. 743.
[62] Whitney 1927, p. 741.
[63] Wallace 1929, pp. 537–544.

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> By a careful study of the cases coming under her observation, and a comparison of the normal and the abnormal, she (the nurse) will understand better and appreciate more the importance of eugenics. … Physical inheritance will have a different meaning. She will feel more reverential toward science which made it possible for countless children to be well born.[64]

At one level, Ewing appealed to rational scientific legitimation, but the strength of her appeal relied on religious language of reverence, invoking both moral and authoritative legitimacy.

Although the National League for Nursing Education (NLNE) published its first Standard Curriculum Guidelines for Schools of Nursing 1917, it was up to individual states whether to adopt them. AJN paid most attention to their content and application to various areas of nursing in the 1930s. Eugenics seems to have found its home most clearly in social hygiene, and was recommended as part of biological, physiological, and eugenic considerations, medical nursing,[65] and social elements in nursing.[66] The NLNE guidelines recommended that eugenics be included in the section on "Modern Social and Health Movements". Content including the history and aims of the eugenics program should be taught, along with euthenics and Mendelian genetics. Ten hours should be devoted to "Modern Social Conditions", including feeble-mindedness and degeneracy, and various social ills that have an impact on families' health. These recommendations remained in the 1927 and 1932 guidelines, but in subsequent versions the social and health movements sections did not make specific reference to eugenics.

A couple of articles reflected a close affinity between the US and German eugenics movements. One echoed some of the curricular recommendations by the NLNE. Ties with Germany and its eugenic program were also reflected in a May 1939 paper by Gertrude Kroeger, a German public health nurse and researcher, who had studied at the University of Chicago. The nearly three-page article was titled "Nursing in Germany: Recent changes in organization and education." The article began: "Since 1933, important changes have taken place in Germany, first in the organization of nurses; secondly, in their education and in the practice of nursing."[67] Various religious and secular nursing organizations had been combined into "a national federation which was to include all nurses. This organization was called "Reichsfachschaft Deutscher Schwestern und Pflegerinnen" (National Professional Federation of Nurses and Attendants)."[68] Educational changes included a uniform curriculum and exclusion of non-Aryans from most schools of nursing.

In March 1930, the news section contained a short half-column announcement about an upcoming International Hygiene Exhibition in Dresden."[69] A "special unit of the 1930 exhibition will be the Hospital Exhibit in which nursing will be included … The purpose of this whole exhibit of which this one is part will be to show the need for racial hygiene and will deal with

[64] Ewing 1930, p. 414.
[65] Stewart 1934, pp. 1195–1204.
[66] Snow 1934, pp. 367–371; Frost 1934, pp. 371–373.
[67] Kroeger 1939, p. 483.
[68] Kroeger 1939, p. 483.
[69] The International Hygiene Exhibition, Dresden, 1930, p. 274.

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man in relation to his natural needs and environment."[70] "This is the International Hygiene Exhibition which will have as its nucleus the Deutsche Hygiene-Museum, an institution founded in 1911, for the purpose of teaching hygiene and health."[71] Here legitimation came from conflating hygiene as sanitation with the eugenic ideology of racial hygiene. In the US curricular guidelines, as well as the American Social Hygiene Association, likewise linked discourses of hygiene with eugenics.[72]

During the 1930s AJN items addressing eugenics reflected further developments in recommended curricula, some of which was in direct response to the recently published curricular guidelines from the NLNE. Eugenics no longer required overt legitimation from cautionary tales or as a "new science". Its legitimation was reinforced as eugenics appeared as an accepted part of the body of nursing knowledge, worthy of study and discussion, and woven into curricula and practice.

Several positive book reviews and articles were focused on eugenics content in curricula and practice. Legitimation most frequently came from the authority of the books' authors, the writer of the review, and of science. Three books reviewed argued for mandatory eugenic sterilization. A review in September 1936 concluded, "Every lay person interested in the vital problem of eugenics should own this book."[73] In an August 1938 review of *Ethics: a Textbook for Nurses*, Edith H. Smith, R.N. referred to eugenics and euthenics as being "among the ethical problems with which the young nurses of today are struggling."[74] This item is unique in presenting eugenics as an ethical problem, although the nature of that problem is not specified. It may be that legitimation of eugenics was becoming more nuanced than in prior years.

1940–1949

In the 1940s, AJN content on eugenics decreased to a handful of book reviews and articles on nursing curricula. We find three book reviews, three reports on findings of curricular surveys, and one report on an educational experience in which eugenics was a specific part of the curriculum. We find variety in the aspects of the curriculum in which eugenics is placed, obstetrics, "venereal disease integrated in pediatrics,"[75] pediatric growth and development,[76] and eye health.[77]

The most substantive entry was written by a board member of the ICN and published in May 1940. In eight pages of text and photos the author described her year-long (August 1938–July 1939) participation, along with 20 other students, in an international educational memorial to Florence Nightingale. The program was for "outstanding nurses of various countries to do

[70] The International Hygiene Exhibition, Dresden, 1930, p. 274.
[71] The International Hygiene Exhibition, Dresden, 1930, p. 274.
[72] See for example, Social Hygiene in Schools of Nursing 1930, p. 631, which speaks of "Elementary treatment of breeding; and Eugenics"; American Social Hygiene Association 1930, p. 107.
[73] Baker 1936, p. 989.
[74] Smith 1938, p. 965.
[75] Goldberg/Johnson 1941, p. 695.
[76] Romine 1940, p. 956.
[77] Toelle 1940, p. 192.

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advanced work in the field of Public Health."[78] Banworth mentioned eugenics as one of five subjects in her Administrative course. She pointedly emphasizes the "international aspect" of the program, and glossed over signs of approaching war, such as the interruption of the "September Crisis," concluding that it was solved by the Munich Settlement.[79] This article, along with the others from this decade are most notable for what was omitted. There was little argument for or explanation of eugenics, little apparent need to legitimize eugenic policies or practices.

The topic of eugenics appears normalized, an expected, if at times ignored part of nursing curricula. In an August 1940 two-column review of the 1939 *Pediatrics and Pediatric Nursing* textbook, reviewer Romine referred to the texts' "factual materials which are either essential or related to the science of pediatrics."[80] Romine included eugenics as part of the content in a unit on growth and development, noting that this unit "introduces much that is ordinarily omitted in pediatric nursing textbooks." It is a topic about "which the nurse needs ample information and which she so frequently lacks."[81] Eugenics needed no defense for inclusion, but teaching materials and instructors at times needed a nudge or reminder to cover the topic. The reference to science linked eugenics rationally to a body of scientific knowledge, and its normalization speaks to a moral form of legitimation in which something is presented as the way things are done. AJN continued its international focus, with short news items in the section "Nursing in Other Lands". Referencing a May 1936 AJN entry, one news item, titled "New State Regulations in Germany" described changes in length of education for different levels of nursing and the requirement that all nurses and nursing students belong to one of the "recognized nurses associations in Germany."[82]

As the US entered World War II, much of AJN's attention shifted to nursing's involvement in the war effort and care for patients with specific health concerns. Following World War II, the language of eugenics faded from most public and professional discourses. However, the work of legitimation was not so easily undone. As Rydell noted, "eugenics and racism are about ideology—ideas and culture enmeshed in a system of beliefs, values, and practices—that could not be easily displaced by either new scientific knowledge or by the discovery of hideous practices by the Nazis."[83] Although the term eugenics fell out of favor following the abuses of the Nazi era in which negative eugenics progressed to the murder of millions, compulsory sterilizations continued in the United States into the 1970s, with an estimate of over 19,000 involuntary legal eugenic sterilizations.[84]

[78] Banwarth 1940, p. 492.
[79] Banwarth 1940, p. 494.
[80] Romine 1940, p. 956.
[81] Romine 1940, pp. 956–957.
[82] News about Nursing: Nursing in Other Lands: 1941, p. 623.
[83] Rydell 2010, p. 670.
[84] Lombardo 2008; Schoen 2005.

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7 Discussion

In the first half of the twentieth century, eugenic discourses in AJN were prevalent enough for the average reader to conclude that eugenics was relevant for nursing. Lavinia Dock introduced eugenics in the journal in 1909 with a news article from a eugenics conference in England. In the following two decades, AJN published lengthy articles about eugenics from non-nurses who held positions of legitimizing authority as physicians, scientists, or recognized leaders of eugenic organizations. Eugenics was legitimized as a rational new science. Some of these articles included storytelling, tales warning of what had and could happen when eugenics practices were not applied to the "unfit." AJN also provided information on how nurses could apply their knowledge about eugenics in their practice: through education on the choice of a spouse, preventing reproduction by the "unfit," and teaching parents how to help their "well-born" children reach their genetic potential.

AJN began the century paying attention to the "new science of eugenics." Appeals to existing moral values of nurses helped legitimize eugenics with discourses of improving the health of future generations. By the 1920s, eugenics was on the agendas of numerous health care meetings and conferences covered by AJN, demonstrating interaction between health care and eugenic discourses. This lent moral legitimation to eugenics as beneficial and a concern of nursing. The frequent inclusion of eugenics in AJN articles on curricular development, standards, and evaluation reinforced the legitimacy of eugenics for nurses on authoritative, moral, and rational grounds. Once eugenics was established within nursing curricula and as part of organizations for infant and child health, AJN coverage of eugenics shifted to reporting on meetings, curricular development and evaluation, and book reviews.

What was not found is also important. Eugenics discourses in AJN did not contain overtly racist or anti-immigrant rhetoric. Birth control was mentioned only negatively. Although eugenics was presented as an international movement, the only countries besides the US mentioned specifically as engaging in eugenic discourses were Great Britain, Germany, and Finland. Finally, AJN never mentioned euthanasia as a eugenic measure. Consistent with broader trends, at mid-century the two had not been inexorably linked in the pages of AJN.

AJN entries that included eugenics functioned in several ways. Some were educational entries with authoritative sources and scientific rational. Some included tales of warning. Others appealed to moral values and accepted customs, illness prevention and health promotion. By the 1940s, eugenics moral legitimation relied more on normalization.

Nursing discourses in the United States and as reflected in the pages of AJN resonated with societal interaction with the eugenics movement and its organizations. Nursing leaders often had active roles in eugenic organizations and worked closely with organizations designed to improve the health of infants, women, and families. These organizations were generally supportive of eugenics as a means of reducing suffering, and social and health problems. AJN participated in the work of legitimizing eugenics to its readers and encouraging nurses to legitimize eugenics to their patients and the public. Yet AJN did not speak about eugenics with one voice. At the same time that the Bell v. Buck non-consensual sterilization case was making its way through the US Supreme Court, some nurses were questioning the legitimacy of both

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involuntary sterilization and treatment of the "feeble-minded" in institutions on moral grounds.

Eugenics was never without its critics, from within scientific communities, nursing, and the public, but neither was it a fringe movement in the United States. An understanding of the dynamics of legitimation of eugenics in a widely-read professional journal can sensitize the professions such as nursing to ethical issues of today.

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The “Curative-Protective Hospital Regime” Concept in the Medical and Nursing Practice of 1950s USSR

Kristina Popova

Abstract

The introduction of the “curative-protective hospital regime” was one of the results of the Pavlovian Session in Moscow (1950). This regime was elaborated at Makarovo Hospital (a small hospital near Kiev) and then introduced into hospitals all over in the USSR and in Eastern Bloc countries. It was propagated as a great achievement of Soviet medicine in contrast to the old Western “Virchovian” medicine. The regime was based on the explanation of disease as caused by an imbalance between the cortex processes of excitement and inhibition. The aim of the regime was to provoke “protective inhibition” as a tool to minimise this imbalance. This concept led to the widespread implementation of both sleep therapy and the elaboration of the “curative-protective hospital regime”, which changed hospital organisation in the early 1950s. Although the new regime was explained in physiological terms, its dissemination and implementation were never politically neutral; instead, they were always were placed in a set of party-political and health-policy relationships as well as the general epistemological framework of a materialistic understanding of nature. Changes in hospital care began in 1950 and intensified after the Seventh Session of the USSR Academy of Medical Sciences in May 1952, which stressed the need to transform clinical work.

The introduction of the “curative-protective hospital regime” was a general measure to transform practical work according to Pavlov’s doctrine. Nurses were tasked with implementing the new regime into daily hospital routine. This paper aims to present the implementation of the Pavlovian Session from the perspective of nursing history. It places the topic of the Pavlovian Session and the “curative-protective hospital regime” within the official narrative of the time in relation to the “two sciences”: the “proletarian” (Soviet) and the “bourgeois” (Western). The paper also aims to discover how the “curative-protective regime” was propagated and introduced into everyday professional hospital work. The main sources for the research are official medical periodicals (Medical Nurse [Meditsinskaya sestra] and Medical Worker [Meditsinskiy rabotnik]) and publications from the 1950s as well as various memoirs and novels in which the introduction of the “curative-protective regime” is described.

1 Introduction

The initiative of Makarovo Hospital in the USSR to introduce the “curative-protective hospital regime” in the early 1950s was one of the most important and most visible projects in the reorganisation of medical institutions’ work. It began following the political decisions of the Pavlovian Session at the USSR Academy of Medical Sciences and the USSR Academy of Sciences in Moscow in 1950, and was accompanied by the wide-scale introduction of sleep therapy. While the sleep therapy was introduced to treat certain diseases in Soviet hospitals (including hypertension, ulcers, nervous and mental illnesses), the “curative-protective regime” was imposed on all medical institutions – ambulatory care facilities, sanatoriums and hospitals. Both the new hospital regime and sleep therapy were founded on a general theoretical basis in Ivan Petrovich Pavlov’s physiological doctrine. This basis comprised both “protective inhibition” and the more general materialistic philosophical idea of the unity

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between the living organism and the environment that was proclaimed in Soviet natural sciences. According to these general considerations, the "curative-protective regime" aimed to transform the hospital environment in order to restore the balance of the nervous system by removing irritant factors in the environment. It was recognised as an important condition of therapy.

Medical sciences, medical treatment and techniques in the Soviet Bloc incorporated explicit ideological elements. Such elements were also very important in the medical training of doctors, nurses and other medical staff. Medical knowledge and techniques introduced during the socialist era were not outside the system of ideological indoctrination but an essential part of it (especially in the 1950s) and were explicitly emphasised. The ideological impact related both to the ideological and materialistic philosophical justification as well as to the way in which such techniques were propagated, introduced, implemented and changed. The importance of dialectical materialism for the medical and biological sciences was emphasised, as was the superiority of Soviet science and medical practice to those of the West.[1]

The decisions of the Pavlovian Session were implemented both in scientific institutions and medical practice. Changes in hospital care began in 1950 and became more intensive after the Seventh Session of the Soviet Academy for Medical Sciences in May 1952, which stressed the need to transform clinical work and proclaimed the need for new methods based on the "legitimate union between physiology and clinic".[2] The introduction of the "curative-protective regime" was recognised as a general measure to transform practical work according to Pavlovian doctrine. Nurses were given the task of implementing the new regime into the practical organisation of hospital care and so special attention was paid to their preparation for these work tasks. This paper analyses the implementation of the Pavlovian Session from the point of view of nursing history and presents the "curative-protective regime" as propagated as a Soviet achievement in the early 1950s within the framework of the scientific reconstruction of Soviet medicine following the decisions of the Pavlovian Session.

2 The "two sciences"

The Pavlovian Session of the USSR Academy of Sciences and the USSR Academy of Medical Sciences was an important part of a series of events in the late 1940s and early 1950s that placed science under closer political control. The session of the All-Union Academy of Agricultural Sciences of the Soviet Union in 1948 had a huge impact on the natural sciences in the USSR: "Mendel-Morgan-Weissman" genetics was defeated and the Michurin-Lysenko model, which gave priority to the impact of the environment, was confirmed.[3] The Pavlovian Session, which followed this session, coincided with campaigns against cosmopolitanism in science and "admiration of foreign scholarship", a campaign to subject scholars to "courts of honour"[4] and a campaign against "formalism in art". It also coincided with the publication of

[1] В. Болховитинов и др., под общей редакцией В. Орлова, Рассказы о русском первенстве, Издательство ЦК ВЛКСМ „Молодая гвардия", Москва 1950.
[2] Медицинский работник, 38/39, май 1952.
[3] Trofim Denisovich Lysenko (1898–1976).
[4] See Сонин 2011; Чернышева 2014, pp. 80–100.

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Stalin's series of articles on linguistics in the summer of 1950. The Pavlovian Session was therefore not an isolated phenomenon limited to the field of medical science; together with the decisions of the Academy of Agricultural Sciences session, it endorsed the thesis of the determining importance of the environment over the development of living organisms and strongly influenced the official materialistic and philosophical views, the institutional impact of which extended to the entire scientific and educational infrastructure.[5] Some of Pavlov's most prominent adherents and students – Levon (Leon) Orbeli (1882–1958), Lina Stern (1875–1968), Ivan Beritashvili (1884–1974) – were officially criticised during the session. Other physiologists – Konstantin Bykov (1886–1859), Anatoliy Ivanov-Smolenski (1895–1982), Nikolay Krasnogorski (1882–1961) – were proclaimed as adherents of the true Pavlovian doctrine. The session also marked the beginning of a complete reconstruction of scientific and practical work in medical and biological education, sciences and institutions. Pavlovian committees were established to realise this reorganisation.

The Pavlovian doctrine was placed in opposition to "Virchovianism" in medicine: Rudolf Virchow (1821–1902) was declared to be a reactionary bourgeois scientist and Virchovianism to be analogous to Mendel-Morgan genetics.[6] The struggle against Virchovianism began in the spring of 1950. The reorganisation of natural science based on Michurin-Lysenko and Pavlovian teachings were marked by the rising confrontation between "Soviet science" and "Western science", and underlined the prioritisation of "Soviet science".

The concept of the superiority of "Soviet science" to "Western Science" became very important in the late 1940s and early 1950s, especially during the initial years of the Cold War. It deepened the opposition of the "two sciences" – the concepts of "proletarian science" and "bourgeois science" that had been established in the USSR in the late 1920s.

This transformation was researched by science historians in order to reveal the role of the confrontation with "Western science" in the process of growing political and ideological control over Soviet scientific institutions. In the 1970s, Dominique Lecourt analysed the concepts of the "two sciences" with regard to the struggle against genetics in the USSR and the case of Lysenko.[7] Loren R. Graham points out that political control over science and scientific theories did not yet exist in the initial post-revolutionary years in Soviet Russia.[8] Party leaders did not plan to approve or support certain scientific views; such a possibility was denied by prominent party figures. Most researchers tried to avoid philosophical and political discourse. However, the intervention of the communist party in scientific institutions deepened during the Stalin era and culminated in a series of political decisions on science in the late 1940s.[9]

In their book on "proletarian science" the Russian authors V. Glasko and V. Cheshko analyse the process of creating the ideas of "proletarian science".[10] First formulated by Alexander Bogdanov (1873–1928) at the beginning of the 20th century, the concept of "proletarian science" and "proletarian culture" was transformed and established as the official theory in

[5] Цветаева, Нина 1999.
[6] Глазко/Чешко 2013, p. 312.
[7] Lecourt 1977.
[8] Graham 1987.
[9] Graham 1987.
[10] Глазко/Чешко 2013.

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the USSR during the 1920s. Glasko and Chesko identify the various factors for this process as being the philosophy of Marxism, central state control over science and the mythologization of the social role of science. N. Krementzov has commented that when great revolutions take place, science carries out its own revolutions – from individual activities to large industrial-scale enterprises.[11] The Russian Revolution also coincided with a scientific revolution within experimental medicine and experimental biology that encouraged various visions of the ability of science to control life span, death and disease in the future. The captivation with this "visionary biology" led to a large number of new journals, societies, conferences, research institutes and teaching departments being founded. New disciplines began in this area, including endocrinology, genetics, haematology, immunology, zoopsychology, experimental cytology and embryology, biochemistry, eugenics, dietetics, the physiology of "higher nervous processes", social hygiene, "psychotechnology", biophysics and paedology.

Revolutionary dreamers like the medical doctor Alexander Bogdanov were closed to "visionary biology". Bogdanov saw the proletariat as holding the power and responsibility to create a new science based on the philosophy of the dialectical materialism, on Marxism as a worldview. He believed that this new "proletarian science" would have to be an expression of workers' thinking and be rooted in their collective labour, their collective-working way of life and their spontaneous monism.[12] According to Bogdanov, although the idea of the new "proletarian science" did not oppose the former science,[13] it had by the end of the 1920s become clear that the "peaceful coexistence [of Soviet science] with the bourgeois science" had come to its end and the need for "the natural sciences to be transformed on the basis of the materialist dialectics"[14] became official doctrine. The Communist party introduced control mechanisms to the organisation of science and emphasised the strong relationship with social practice.[15]

At the time the political dictation of science ran parallel to the infiltration of scientific institutions by patterns from the organisational life of the communist party:[16] formal rules of conduct and communication were introduced. These included discussions, critique, self-criticism and rituals of Stalinist political culture, such as assemblies, meetings and sessions. "Creative discussions" were established as an important part of academic culture in which scientists engaged in various academic conflicts.

The decisions of the Pavlovian Session were implemented within the context of the complex relationship between politics and science. The Pavlovian committees formed as a result of the session were designed to fulfil a particular political role in the scientific world. In recent years, a number of papers and memories have been published in Russia that highlight the repressive activity of the Pavlovian committees in the USSR and other socialist countries between 1950 and 1955. It is pointed out that the damage caused by the Pavlovian Session in 1950 in the field of natural sciences was even greater than the session at the Academy of Agricultural Sciences in 1948. The published documents shed light on the repressive methods of the

[11] Krementsov 2011, pp. 6–9.
[12] Гловели 1991, p. 7.
[13] Ягодинский 2006, p. 143.
[14] Глазко/Чешко 2013, p. 145.
[15] Глазко/Чешко 2013, p. 146.
[16] Kojevnikov 2000, pp. 142–176.

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Pavlovian committee led by Konstantin Bykov and the authority he exercised in implementing the session's decisions.

The Pavlovian Session proclaimed a general transformation of the curricula in biological and medical disciplines at medical universities and institutes as well as re-training of all medical scientists (professors, assistants, etc.) and hospital staff (doctors, nurses and sanitary staff). New educational programmes were developed under the supervision of the Pavlovian committees. Special textbooks were prepared for further qualification of doctors.[17] Even the content of foreign language courses for medical students was changed in order to present Pavlov's theory.[18] The research programmes of the medical and biological institutes for 1951–1955 were developed in accordance with the prescriptions of a Pavlovian committee.

Applied healing aspects of Pavlovian doctrine were also explored and introduced in practice at the same time as this transformation of education and science programmes. The aim of introducing these aspects was wide-ranging and included both ideological and therapeutic goals. Another aim concerned the struggle between materialism and idealism: it was necessary to prove the supremacy of materialism as well as the dominant role of the environment on the living organism and its therapeutic power in medical practice. It was also very important to demonstrate that the supremacy of Soviet science and Soviet medicine was scientifically-based, developed on native soil, inspired by genuine health care, rooted in Soviet care for people and as such free from considerations such as the material benefit of hospitals, pharmaceutical companies, doctors or staff. It was necessary to demonstrate that this practice released important creative energies for all doctors and nurses, that Pavlovian doctrine released creative energies in the practical work of medical staff in hospitals and clinics, and that this constituted a catalyst for innovative interpretations and innovations. This was the case with the introduction of the "curative-protective hospital regime" that became part of the process of post-war reconstruction for both scientific and medical institutions during the period between 1948 and 1955.

The practical implications of therapy innovation in accordance with the Pavlovian Session contained some key innovations. These were based on the notion of "protective inhibition", which became a key element in explaining the aetiology of diseases and treatment options.[19] It was assumed that an important cause of disease was the imbalance between the processes of excitation and inhibition of the nervous system. The theory was that the imbalance led to a local stagnation of excitement in the cortex, which became the basis for various pathological phenomena. The term "protective inhibition" was introduced in an attempt to emphasise that this "protective inhibition" could provide or restore balance in the nervous system and as such prevent or treat diseases. Inhibition was seen as not only protective, but also as an important healing tool.[20]

[17] Лебедева В. П. 1953.

[18] See for example the German Language Textbook for Soviet Medical Students, prepared by Sophia Naumovna Bondar (1913–1994), which began with a text on the importance of Pavlov's teachings for the theory and practice in medicine and continued with a text on the healing power of sleep: Die Bedeutung der Lehre Pawlows fuer die Theorie und Praxis der Medizin; Schlaf des Gehirns bringt Heilung. In: Бондарь 1958, pp. 5–16.

[19] Smith 1992.

[20] Усиевич 1953, pp. 37–130; Стрельчук 1953, pp. 531–548.

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Sleep therapy was widely recommended. This recommendation was based on Pavlov's understanding of the sleep process as an important phase in the inhibition of nerve processes in the cerebral cortex and as protective inhibition.

Sleep therapy was not a new approach in clinical practice. It had been introduced at the end of the 19th century by the Swiss doctor and scientist Jakob Klasi (1883–1980) and had also been tested and practised in other countries. The new element in the USSR was the justification of sleep and sleep therapy based on Pavlov's theory and the attempt to make it a universal treatment for a wide spectrum of diseases. This interpretation transformed the practice of sleep therapy into a medical innovation of the Soviet Union. A few Soviet doctors – mostly students of Ivan P. Pavlov (Anatoliy Ivanov-Smolenski and others) – had introduced sleep therapy before 1950 (especially during the Second World War) and used it to treat psychiatric and nervous diseases as well as hypertension, ulcer, surgical cases and other diseases. Treatment also considered the nervous activity type of the patient in accordance with Pavlov's theory, the "excitable nervous type" being interpreted as particularly difficult to treat.[21]

The other direction taken by the "Pavlovization" of the medical practice based on "protective inhibition" was the "curative-protective hospital regime". The regime of modern institutions (hospitals, schools, social homes) was considered to be an important disciplinary tool. The Pavlovian Session and the "Pavlovization" of pedagogy, medicine and sports intensified the attention to the physiological aspects of the regime, especially with regard to the theory of conditional reflex. In the "curative-protective regime", however, Pavlov's insights into the elaboration of conditional reflexes were not decisive; instead, the regime was to become part of the therapy by removing irritant factors and restoring the balance of the nervous system. This was based on its physiological explanation: the impact of the environment on the whole organism and preventive sleep retention as a "normal approach to the physiological struggle against disease-causing agents (I. P. Pavlov)".[22] The regime was manifested in the transformation of the hospital environment, in continuation of the physiological sleep, in protecting the patient from negative emotions and pain.[23]

This paper focuses on the establishment of the "curative-protective regime" in the medical institutions in the period from 1950 to 1955. Its application affected the entire network of medical institutions in the USSR and the countries of the Soviet Bloc and characterised the organisation of general everyday hospital life, especially the activities of nurses and other hospital staff. Its realisation was designed to create a kind of a hospital utopia based on Pavlov's teachings.

Several Soviet medical journals from the period 1950–1955 ("Medical Worker", "Clinical Medicine" and especially "Medical Nurse"), a number of scientific books as well as several popular books and memoirs were examined for the purpose of this study. Certain literary

[21] For medical and pedagogical science as well as for clinical practice in the first half of the 20th century and especially between the two world wars, the nervous-excited type, his/her control and therapy were of great interest to scientists in many countries. In this regard, this classification in the medicine of the USSR was no exception. Here, Pavlov's theory was used to explain and classify the types of nervous activity in order to apply the appropriate medical techniques.

[22] Вогралик/Иорданский 1961.

[23] Вогралик/Иорданский 1961.

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works from this period that reflect the experience of the invention of the "curative-protective regime" and its introduction through the transformation of hospital work are also of particular interest. These books, especially the novels by the physician and writer Pavel Beylin[24] and famous Soviet novelist Yuri German,[25] played an important role in the dissemination of these practices.

The introduction of the "healing regime" was a typical example of Soviet innovation as a combination of administrative measures and propaganda efforts. It was particularly common in the Stalin era and followed a propaganda pattern according to which its introduction was the result of common collective practical work and everyday creative activity on the part of modest Soviet people, who did not occupy positions of power. Many such innovations began in agriculture, education and medical practice, and marked the practical work of collectives in the 1950s. They managed to reach party institutions and were acknowledged and implemented.

This was what happened in the case of the new hospital regime. Invented in a small hospital in the village of Kopilovo, 9 km from the regional centre of Makarovo, near Kiev in Ukraine, it became known as the "Makarovo Hospital innovation" and was propagated as an important part of the reconstruction imposed by the Pavlovian Session in 1950. The implementation of the "Makarovo Hospital innovation" was acknowledged and regulated by the Ministry of Health and made a norm for the hospital regime.

In March 1952, the USSR Ministry of Health elaborated guidelines based on Makarov Hospital's work in order to apply the new regime in medical institutions. Its introduction became the primary example and provided the main criteria for the reorganisation of the activities of medical institutions following the Pavlovian Session. Along with the wide-scale introduction of sleep therapy, it was incorporated into the programmes of educational courses for scientists, doctors and nurses in studying Pavlov's theory, presenting the practical aspect of this reconstruction. The regime became a visible indicator of the reorganisation, significantly changing the hospital space and the work of the staff in a way that could be monitored and reported. It was not enough for the government that scientists, practitioners, nurses and other staff attended Pavlov's theory classes; they also needed to know how to apply the theory in hospital practice.

3 Makarovo Hospital and the concept of the "protective-curative regime"

The name of the new hospital regime referred to the concept of "protective inhibition". According to its inventor, Dr Pavel Beylin, the idea of the new regime originated in a conversation between himself – at that time serving as a medical consultant for Makarovo hospital – and the local Communist Party Secretary, Roschin, who had explained to the doctor the practical significance of the Pavlovian Session and its decisions.[26] This important

[24] Бейлин 1953, Герман 1965.
[25] Герман 1965.
[26] Бейлин 1953, p. 8.

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conversation with the party secretary provoked Beylin to start his experimental work, in which he was supported by the head doctor of the local hospital. Makarovo Hospital was small, with a staff of 6 doctors and around 70 patients. The medical staff was encouraged to study the works of Pavlov. Beylin also initiated a survey on hospital work. Patients from various medical establishments in Kiev were questioned in order to identify the factors that inhibited the healing process. The patients mentioned the hospital noise, the hospital odour and the painful diagnostic procedures. Following Pavlov's interpretation of the irritant factors, Beylin wanted to reform the hospital environment by reducing irritants (beginning with noise) in order to ensure the peace of patients as an important prerequisite for their recovery. Beylin recalls that this is how the "struggle for silence" began.[27] In the course of this "struggle for silence" a "whispering regime" was introduced in the hospital: members of staff were obliged to speak only in whispers. It was also emphasised that whispering improves discipline and was capable of reducing conflict and providing discipline for medical staff.

Although the new regime was explained in physiological terms, its dissemination and implementation were never politically neutral; instead they always took place within a network of party and health-policy relationships as well as within the general epistemological framework of a materialistic understanding of nature. Beylin, who initiated the new experiment, was a military surgeon, a war veteran and an author of books and essays. His novels on the Makarovo Hospital innovation gained him considerable fame, especially among younger readers. His innovation in medicine at the time was compared to the influence of Anton Makarenko on pedagogy.[28] Beylin's novels "The Big Family" and the "The Most Valuable", which were dedicated to Makarovo Hospital's innovation, were well received by readers in the 1950s. In them, Beylin described how the initiators of the new hospital regime struggled with the traditional thinking of their colleagues as well as with the followers of the old Western "Virchovian" concept, which was seen as opposite of the Pavlovian concept in medicine.[29] He described the introduction of the new healing regime in a number of articles and essays. In 1951, he presented his innovation in "Medical Worker", the official newspaper of the Soviet Ministry of Health. His literary works contributed to the cultural context of the reception of Pavlovian doctrine not only by doctors, nurses and other medical workers, but by a wide range of people.

The Makarovo Hospital innovation soon attracted the attention of and personally convinced the Health Minister, E. Smirnov, who made positive comments about the new regime principles.[30] He officially supported the "curative-protective hospital regime" as a practical implementation of Pavlovian physiology. In order to support its innovation, he told an anecdote about his stay in the Kremlin Hospital, explaining that he was unable to get any sleep because of the level of noise: people yelling, washing dishes, doors creaking loudly. "In the past, order and silence in the hospital was mere empiricism", he said. "But now that can be based on science and that, of course, follows from the basis of Pavlovian physiology."[31]

[27] Гамбарян/Сазонтов 1952, p. 25.
[28] Новиченко 1970, pp. 229–239.
[29] Бейлин 1953, p. 35.
[30] „Vystuplenie ministra zdravookhraneniia tov. Smirnova o dal'neishem razvitii Pavlovskogo ucheniia" [1951]. GARF f. r-8009, op. 1, d. 984, ll., pp. 7–8.
[31] GARF f. r-8009, op. 1, d. 984, l., p. 7.

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In the post-war environment of the early 1950s, with its everyday difficulties, after huge human losses (especially in Ukraine), war trauma, widespread tuberculosis and other social diseases, the healing possibilities of such simple means as silence, sleep and improved hospital environment attracted readers. The writer Yuri Vilensky, who was born in 1931 and later became a doctor, was a student at the time. He remembers the context in which Beylin's books on the Makarovo Hospital regime appeared:

> I was still studying my final secondary school classes when I heard the name of this writer, and I had seen his book for sale several times. It was Pavel Efimovich's [Beylin] response to Pavlov's teaching that gained popularity. Although the popularity of this theory was in a certain sense a top-down phenomenon, its importance could nevertheless be justified in practical medicine [...]. Dr Beylin responded to the signs of his time honestly, seeing in it a source of healing, even without drugs. In the early 1950s, he unexpectedly became a head of the provincial hospital in Makarovo near Kiev and turned it into an amazing place of healing. His book has clearly shown that many non-standard innovations, such as silence, can be useful and successful.[32]

The experience of Makarovo Hospital was carefully examined by the Scientific Council for Ivan Petrovich Pavlov's theory studies (the Pavlovian Committee) and the Soviet Ministry of Health.[33] In 1951, the Scientific Council sent two physiologists (L. Gambaryan and V. Sazontov) to study Makarovo Hospital's work, and to become acquainted with the work of the staff.[34] They observed the work and publications of Beylin as a leader of this initiative and finally provided a positive evaluation of the Makarovo experiment.

The Makarovo Hospital experiment involved political struggles between physiologists. Gambaryan[35] and Sazontov were two close collaborators of Professor Konstantin Bykov, Head of the Pavlovian Committee. Gambaryan was later sent to the Physiology Institute in Yerevan[36] in order to ensure that the Pavlovian Committee line was implemented in order to counter adherents of Levon Orbeli, such as the Head of the Physiology Institute, Alexanyan. Orbeli's adherents complained that Gambaryan provoked a large number of personal conflicts there and was responsible for "nefarious activities".[37]

The following year, Gambaryan and Sazontov summarised the observations they had made regarding the Makarovo "curative-protective hospital regime" in a short book, stressing that the reorganisation of the work of medical institutions according to the principles of Pavlov's physiological doctrine was paramount in the struggle for preserving the life and health of the Soviet man. [38]

While hospital staff studied Pavlov's theory in order to support practical work in the hospital, Beylin also wrote a popular lecture for the patients that the doctors could use to explain the

[32] Виленский 2017.
[33] Гамбарян/ Сазонтов 1952, p. 26.
[34] Гамбарян/ Сазонтов 1952, p. 4.
[35] Levon Gambaryan (1923–1990).
[36] The Institute of Physiology in Yerevan started in 1943.
[37] Григорьян 2002, p. 301.
[38] Гамбарян/Сазонтов 1952, p. 3.

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new hospital regime.[39] In this lecture, he explained the meaning of silence, the reason why doctors, nurses and sanitary staff whispered and the healing effect of sleep. He explained that sleeping protected health and that it was the responsibility of staff to create the conditions for sleep. He explained how Pavlov had demonstrated that "human forces" were restored during sleep and that it was necessary to play music in hospital rooms to improve recovery. Pictures were used to make the environment more attractive and appeals were made to the patients to look at wall paintings, which had been donated by Kiev Art Institute for the purpose of the "curative-protective hospital regime".[40]

As part of the healing regime, the duration of sleep in the Makarovo hospital was increased to nine hours and an obligatory afternoon sleep was introduced. Separate rooms were provided for sleep therapy. Although sleep was a central element in the regime, Beylin insisted on physiological sleep. He was sceptical about sleeping medicines and argued that they made patients "dizzy" and caused them to "stagger". A hospital nurse was obliged to document the sleep behaviour of every patient and to keep his/her "individual account" of sleep.[41]

In their report, Gambaryan and Sazontov emphasised that a significant number of institutions had implemented the new regime, including Moscow Hospital № 34, the Institute of Traumatology in Leningrad, Yerevan Medical Clinic. Gambaryan and Sazontov stated that every doctor, nurse and member of the sanitary staff in these institutions made his/her contribution to this process.[42]

The experience of Moscow Hospital № 34 was summarised in the book "The Curative-Protective Regime in the Hospital" by Galperin, Muzichenko and Podolni. This book was published in 1953 and edited by Professor N. A. Vinogradov, Head of the Department of Public Health at the Central Institute for Doctoral Qualification.[43] In the preface, Vinogradov advises the reorganisation of medical work based on the Pavlov's teachings. "Rules of the Internal Order of Medical Staff" were elaborated[44] and uniform organisation of sleep was introduced in hospitals.[45]

Thirteen rules were recommended for staff.[46] They related to communication with the patient (he/she should not be called using the impersonal term "patient" but using his/her first name and surname; the patient should not be allowed to read the history of the disease; the diagnosis should not be communicated). Special attention was paid to the ninth rule, which addressed sleep, especially afternoon sleep.[47] In addition to the rules, there were recommendations to place slogans in hospitals. The recommended texts of the slogans also revealed the connection between the "curative-protective hospital regime" and the spread of sleep therapy:[48]

[39] Бейлин 1952, pp. 28–29.
[40] Бейлин 1952, pp. 28–29.
[41] Бейлин 1953, pp. 62–63.
[42] Бейлин 1953, p. 44.
[43] Гальперин/Музыченко/Подольный 1953.
[44] Гальперин/Музыченко/Подольный 1953, p. 4.
[45] Гальперин/Музыченко/ Подольный 1953, p. 59
[46] Гальперин/Музыченко/ Подольный 1953, pp. 17–31.
[47] Гальперин/Музыченко/ Подольный 1953, p. 26.
[48] Гальперин/Музыченко/Подольный 1953, pp. 81–86.

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"Prolonged and relaxed sleep – the best remedy for many diseases.

Follow the doctor's advice to ensure a long, healthy sleep!"

"The rules of the internal order of the sick aim to preserve peace and to help a fast recovery.

Get to know the rules and keep them!"

A methodological letter from the USSR Ministry of Health (№ 04-22/23) under the title "On the organization of the work of hospitals based on the physiological teachings of the Academician I. P. Pavlov" was distributed to all hospitals in March 1952.[49] It stated that the Pavlov's teachings were not only the basis of the modern Soviet theoretical medical science, but also a powerful factor in the reorganisation of the practical work of Soviet health institutions.[50] Although the decisions of the Sixth Session of the Pavlovian Committee in November 1951, which approved the Makarovo Hospital regime, were cited, the slow reorganisation of this experience was criticised.[51] The letter of March 1952 gave instructions for the hospital regime and recommended combatting noise in hospitals and hanging pictures in order to make the environment more attractive. It also stipulated the elimination of irritants and negative psychological experiences such as fear as well as the prolongation of physiological sleep.[52]

Many of the elements of the "curative-protective hospital regime", such as those that required medical staff to arrange wards more attractively or to maintain silence and be polite to patients, were not new or strange as official rules for public spaces. Many of them were part of the programmes of the late 1930s to make the environment better and human relations more civilised: to be more "cultured". There was pressure to make homes, workers' dormitories, places of trade and institutions more attractive by introducing interior elements such as flowers, curtains and music. These elements had a symbolic meaning as a part of the Stalinist political culture: the alignment of real and symbolic achievements with overall social progress.[53] The great turning point was a "return to normality" and referred to some of the symbols of the old regime and the values of the middle class – whereby private values were reversed to public values. Volkov examines the structural dynamics of the struggle for 'kul'turnost' (culturedness) and comes to the conclusion that it was never a clearly defined concept but combined techniques of individualisation and totalisation of procedures.[54] Hygiene and orderliness were identified as important attributes of "culturedness", as were interior elements such as curtains, flowers and lampshades. Volkov identifies another important point as speech control, citing pressure to eliminate swearing from

[49] Pis'mo „Ob organizatsii raboty bol'nits na osnove fiziologicheskogo ucheniia akademika I.P. Pavlova", GARF (State Archive of the Russian Federation) f. r-8009, op. 1, d. 1094, ll. 36–39ob.
[50] Гальперин/Музыченко/Подольный 1953, p. 7.
[51] Pis'mo „Ob organizatsii raboty bol'nits na osnove fiziologicheskogo ucheniia akademika I.P. Pavlova", GARF (State Archive of the Russian Federation) f. r-8009, op. 1, d. 1094, ll. 36–39ob.
[52] Pis'mo „Ob organizatsii raboty bol'nits na osnove fiziologicheskogo ucheniia akademika I.P. Pavlova", GARF (State Archive of the Russian Federation) f. r-8009, op. 1, d. 1094, ll. 36–39ob.
[53] Volkov 2000, pp. 210–231.
[54] Volkov 2000, pp. 210–231.

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communication.[55] Similar prescriptions for the staff were introduced in the relationship to clients in trade institutions.[56]

The new point of the "curative-protective regime" was that the hospital rules, which took into account medical staff and the arrangement of the environment, were scientifically explained in accordance with the Pavlovian physiological doctrine. Once practical implementation of Pavlovian teachings began in the hospital, it was not difficult for the regime to translate the elements of 'kul'turnost', which had been propagated since the 1930s, into a scientific interpretation. As such they were transformed for the aims of the hospital regime, which were interpreted in terms of both protective inhibition and healing procedures.

The key element of the "curative-protective hospital regime" for patients was the control of sleep. The "curative-protective regime" expanded the limits of such control. The Soviet Ministry of Health ordered the rules for the general implementation of medical sleep in hospital practice.[57] Maintaining the rules of collective sleep in the hospital wards was considered important both for staff and patients.

In his article about the genre of lullaby during the Stalin era, Konstantin Bogdanov discusses the importance of sleep control in totalitarian culture and the importance of sleep research in Soviet science.[58] While analysing the sleep research of the Pavlovian school and the implementation of sleep therapy, he emphasises the element of collectiveness.[59] Bogdanov combines the totalitarian concept of sleep with the folkloric traditions of the lullaby, which emphasises the tendency towards uniformity and collectiveness. According to him, the Pavlovian doctrine of sleep as inhibition prevented the exploration of individual dreams in Soviet psychiatry, while dream analysis became important in Western psychoanalysis. Bogdanov believed that the general context that united the rhetoric of Pavlovian physiology and discursive practices of the Stalin era was the idea of "sleep/dream control".[60]

4 The nurse's place in organising the "curative-protective regime" in the Soviet journal "Medical Nurse"

The main responsibility of implementing the "curative-protective hospital regime" with regard to the maintenance of order, silence and other element regime lay with nurses. Nursing training in Soviet Russia in the early years after the October Revolution entirely rejected the pre-revolutionary model of the "merciful nurse" that was elaborated in the second half of the 19th century. Compassionate principles were rejected, as were the organisational patterns of nursing communities based on religious, aristocratic and philanthropic traditions.[61] Nevertheless, for some time in the early 1920s, some of the traditions in the work of nurses

[55] Volkov 2000, pp. 210–231.
[56] Hessler 2000, pp. 182–209.
[57] Temporary instruction of the curative implementation of the medical sleep, K. medicina, 6, 1951.
[58] Богданов 2008.
[59] Богданов 2008.
[60] Богданов 2008.
[61] Grant 2017, p. 57.

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survived.[62] From the second half of the 1920s, technical schools (technicums) were organised for vocational training, including nursing training. Training was primarily subordinated to the acquisition of technical and practical skills. This new concept also required a more technical attitude towards the patient.[63] The huge need for medical staff in the processes of industrialisation and urbanisation required nurses to be trained very quickly. Various new training courses opened for factories, universities and various other institutions and organisations, primarily offered by the Red Cross. In 1936, the Ministry of Health attempted to unify the requirements for educational standards in the education of nursing staff, but a variety of courses remained. In the years that followed, training was connected to military needs: thousands of nurses were needed between 1941 and 1945. Training focused on surgery and trauma care.[64] After the end of the war, the ministry introduced new curricula: practical training was improved and more theoretical subjects were introduced. In 1942, the magazine "Medical Nurse" began to be published – it was the first periodical for nurses after long decades without professional media. Nursing conferences began to be organised and "nursing councils" were initiated as platforms for professional discussion. Consequently, a limited degree of professional autonomy began to emerge in the early 1940s.[65] In this context, the introduction of the "curative-protective hospital regime" provided the framework for the topics of the nursing conferences and discussions answering questions on the practical implementation of Pavlovian teachings by the medical staff.

In his article on the practice of introducing the new hospital regime in "Medical Nurse", P. Obnorski identifies the central position of nurses in the organisation and underlines the immense importance of the environment for the central nervous system.[66] He believed it was necessary for nurses to be the leading figures in this organisation and explained that in Moscow, as in Makarovo Hospital, the reorganisation of work began by educating doctors and nurses on how to implement Pavlov's teachings in practice.[67]

As medical staff who were central to the organisation of everyday hospital life, nurses were closely involved in the project to introduce the "curative-protective regime". After 1950, "Medical Nurse" explained Pavlov's concepts in a series of theoretical articles. The journal contained information on the seminars and conferences organised in various local hospitals, as well as the personal promises of doctors and nurses to study Pavlov's teachings. The journal included reviews of medical books and textbooks for nurses, which were criticised is they did not use Pavlov's concepts. The most widely used reference for nurses, a textbook on general care of patients by R. M. Shapiro (published in 1951), was criticised for providing insufficient information on Pavlov's teachings and for not underlining the important role of sleep therapy.[68] "Medical Nurse" also emphasised the supremacy of Soviet over "Western" hospital care. As in other periodicals, Pavlov's theory and its implementation were one of the main arguments for this superiority.

[62] Лопатина 2012.
[63] Grant 2017.
[64] Grant 2017.
[65] Grant 2017.
[66] Обнорский 1953, pp. 7–11.
[67] Обнорский 1953, pp. 7–11.
[68] Кушнир, 1952, pp. 29–31.

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In numerous publications in the journal, nurses from various hospitals shared their experience of studying Pavlov's concepts and applying them in practice. Many of the articles were by senior nurses, who were mainly responsible for the organisation of everyday hospital work. As such, their articles are likely to give an impression of the real reorganisation of hospital life after 1950.

In her article on sleep as a healing factor, senior nurse A. S. Stepchenko summarises that "the immortal teachings of I. P. Pavlov must be available to every medical worker, to every nurse."[69] According to senior nurse N. L. Bedeker, overloading the nervous system leads to problems in the functioning of internal organs, during sleep the cerebral cortex rests and returns to its normal function, and if the patient has sleep disorders, he/she should be helped using medication.[70] Bedeker summarises that nurses should understand the requirements of the modern medicine and practice the teachings of the "great I. P. Pavlov".[71]

T. A. Nevzorova from Moscow's First City Psychiatric Hospital also demonstrates what she has learnt about protective inhibition. According to Nevzorova, if irritation lasts for a long period or is excessive, it exceeds the endurance of the nerve cells, which then fall into a state of inhibition. She claims that this defence mechanism "saves them from doom" and that in this sense detention is protective and curative.[72]

In her article on the introduction of a regime according to Pavlov's ideas in a children's hospital, senior nurse T. D. Bistrova points out that this implementation is based on the principles of the interaction of the organism with the external environment. Bistrova emphasises the leading role of the nurse and states that a nurse should be able to identify the influence of the high nervous activity on physiological processes in organism. Bistrova also stresses the need for a nurse to be aware of the fact that she is the main organiser of the external environment of the patients. She identifies purity, flowers, paintings in the rooms as improving emotional conditions and supporting the healing process. [73] Bistrova also states that a nurse who is aware of the curative effect of inhibition and its importance for the correct regulation of the recovery processes in a sick organism would endeavour not to disturb the relaxation of the patient. Convinced that preventive inhibition is an effective method of treating certain diseases, Bistrova highlights the importance of natural sleep as a healing tool for children.[74]

E. G. Svechina, a nurse from Leningrad also reports that work in the hospital was reorganised in accordance with Pavlov.[75] She states that the interior of the physiotherapy facilities were changed by hanging pink curtains on the windows, providing books, magazines, newspapers, playing light music in the rooms and accompanying all these innovations with a loving attitude towards the patients.[76]

[69] Кушнир 1952, pp. 29–31.
[70] Бедекер 1951, pp. 24–27.
[71] Бедекер 1951, pp. 24–27.
[72] Невзорова, 1951, pp.19–24.
[73] Невзорова 1951, pp.19–24.
[74] Невзорова 1951, pp.19–24.
[75] Свечина 1952, pp. 22–24.
[76] Свечина 1952, pp. 22–24.

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The topic of the "curative-protective hospital regime" became central in the nurses' conferences in the 1950s. In the period from 1948 to 1951, 21 scientific and practical conferences were held in Gorki district alone. Nurses discussed the biography and scientific achievements of Pavlov, the ideological and political education of the medical staff, the application of the sleep therapy, the role of nurses in the organisation of the hospital regime according to the teachings of Pavlov.[77] On 28 February 28 1952, a nurses' conference of the physiotherapeutic units was held in Leningrad in order to discuss the reorganisation of work.[78] In December 1951, a nurses' conference was held in Poltava and a report on the implementation of Pavlov's doctrine on patient care was presented. The conference also highlighted the political importance of this implementation.[79] A series of workshops were organised for nurses. These workshops highlighted both the impact of the environment and the healing impact of sleep.[80]

The Makarovo Hospital model spread through various hospital departments, including ophthalmologic departments.[81] Considerable success in practical use of the model was reported at the nurses' conferences in the towns of Zhdanov, Kharkov and many other places.[82] The children's ward of the hospital in Lviv in Western Ukraine reported that it had implemented the "curative-protective regime". It was reported that complete silence was provided during sleep and that this contributed to successful treatment and quick recovery.[83] Similar information on the application of the healing hospital regime came from Astrakhan in South Russia[84] and from West Belarus.[85]

In an article on the culture of service, nurse O. D. Kolibina emphasises how much work nurses invested in redesigning the wards in the hospitals, creating cosiness and silence, ensuring the normal and prolonged sleep of the sick in order to compensate for their higher nervous activity.[86] Thin needles for injections were recommended in order to preserve the nervous system and the guarantee rest for the patient. In Ulyanovsk, a group of 115 nurses continued to study Pavlov and the application of sleep therapy. Reports of its implementation in everyday work also came from cities such as Kiev and Dnepropetrovsk.[87]

In 1953 and 1954, the reports on the application of the "curative-protective regime" became increasingly uniform. These reports became more frequent, but then began to decrease after the dissolution of the Pavlov Committee in the spring of 1955.

[77] Свечина 1952, pp. 22–24.
[78] Свечина 1952, pp. 22–24.
[79] Левченко 1952, p. 27.
[80] Левченко 1952, p. 27.
[81] Гринберг 1952, pp. 31–32.
[82] Миц 1953, p. 20.
[83] Тарасова 1953, pp. 25–28.
[84] Лебедева 1953, pp. 23–24.
[85] Церенциян 1953, pp. 24–26.
[86] Колыбина 1954, pp. 21–24.
[87] МЕДИЦИНСКАЯ СЕСТРА, 1954, p. 31.

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5 Conclusions

In his memoirs as a psychotherapist from the early 1950s, the Soviet scientist and psychiatrist J. N. Vorobeychik gives a positive assessment of the innovation of Makarovo Hospital, stressing that the main pursuit of the "curative-protective regime" was to use long periods of sleep in patients to achieve a form of "protective inhibition".[88] He identifies another important positive effects as being intensive research on the use of sleep therapy and the improvement of the hospital environment.[89] According to him, the only disadvantage was the introduction of whispering. His memoirs show that a large number of medical experts failed to develop a critical attitude towards the application of the concept of "protective inhibition" and accepted it without discussion, even after the dissolution of the Pavlovian committee in 1955 and in the following decades.

Among the very few critical views of "protective inhibition" that provoked the reorganisation of the work of medical practice in the early 1950s was the position of Kharkov psychotherapist I. Z. Velvovsky, who published the article "The Second Principle of I.P. Pavlov Therapy" in 1952. In it he argues that the protective regime was not productive and was not correctly based on Pavlov's principles. A. L. Groyssmann is critical of the "protective inhibition" theory because of the general implementation of sleep medicines.[90] He also criticises "pacification" of the patients by the "curative-protective regime", which he believed made it difficult for them to adapt to the external world after leaving the hospital.[91]

The famous Soviet scientist Alexander Myasnikov (1897–1972), who was one of Stalin's personal doctors in his final years, addresses the significance of the Pavlovian Session of 1950 and mentions "protective inhibition" in his memoir "I Healed Stalin":

> From Pavlov's theory followed the conclusion that sleep as an inhibition process eliminated imbalances of higher nervous activity. And as they [the imbalances] were seen as a common cause of all pathological processes (and we used to be monists – there was always one main reason), sleep therapy was also seen as a universal method for the treatment of diseases. The practical "contribution" of this famous session in medicine was sleep therapy.[92]

He goes on to say the following:

> Sleep therapy was implemented in many clinics and hospitals – special rooms for sleep therapy were organised. A number of conferences were held on the results of the new Pavlovian methods of treatment, including the Universal Therapeutic Conference in Leningrad in 1952, the session of the Department of Clinical Medicine at the Academy of Medical Sciences in Rjazan and many others. Hospitals attempted to introduce a "protective regime" – silence, "whispering"; nurses and doctors had to wear slippers so as not to make noise with their shoes. Actually, this was a useful measure – it was usually noisy in our hospitals. Unfortunately,

[88] Воробейчик, http://www.medlinks.ru/article.php?sid=70566, accessed April 26, 2019.
[89] Воробейчик, http://www.medlinks.ru/article.php?sid=70566, accessed April 26, 2019.
[90] Гройсман 1995.
[91] Гройсман 1995.
[92] Мясников 2011, pp. 117–121.

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> when they started to be more relaxed about "Pavlov's medical doctrine", the staff immediately started screaming and being noisy.[93]

Alexander Myasnikov points that the introduction of the "curative-protective hospital regime" as a mass practice was realised in an entirely administrative fashion as part of a widespread propaganda campaign that was not only limited to medical circles but also affected the wider public. The aim of this propaganda was to convince people that the regime was a medical achievement of Soviet scientists, doctors and nurses that opened up new healing possibilities in Soviet medicine. Myasnikov states that although its introduction raised a number of questions regarding deontology, such questions were not discussed, despite isolated critical voices.

In his utopia of silence, the initiator of the hospital reorganisation, Beylin, was searching for an alternative for the patients to the outside post-war world, which he believed lacked kindness and was brutal, noisy and full of irritants. He wanted to introduce peace, tranquillity and more beauty into the hospital settings and to make the relationship between staff and patients more humane. He strove to realise this in accordance with the official political and ideological instructions of the decisions of the Pavlovian Session. His efforts to improve the situation and the ethical problems he identified were therefore formulated in terms of physiology and neurology. The healing power of silence, which Beylin tested at Makarovo Hospital and then spread throughout the country, became the subject of a propaganda campaign. Another result was the widespread use of sleep therapy in Soviet health institutions and then in Eastern Bloc countries. The "curative-protective regime" increased sleeping time in hospitals and sanatoriums; patients' sleep was monitored and controlled by staff. In this way, the new hospital regime opened the dangerous path for the use and abuse of narcotics. By educating and convincing doctors, nurses and patients of the ideological explanation of the healing regime and by controlling their behaviour, public health officials did not allow any expression of opinion or a critical attitude of staff or patients and forced everyone to accept and apply the experience of Makarovo Hospital unconditionally.

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[93] Мясников 2011, pp. 117–121.

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Material Configurations of Nursing and their Ethical Implications. The Prolonged Bath Treatment in Psychiatry

Monika Ankele

Abstract:

When "prolonged" or "permanent" baths were introduced as a treatment in psychiatric institutions around 1900, special treatment rooms had to be created that utilised medical knowledge of the time (hydrotherapy) and technically progressive features (running water). The nurses, who were co-agents in the treatment regimens, had a high level of responsibility for the patients, as serious accidents repeatedly occurred in the prolonged baths. Technical apparatus was gradually installed and material adaptations were made to the rooms that served to lighten the nurses' workload. This article examines the influence the material configuration of the bathroom had on nursing practice and also explores which insights can be drawn for current issues in nursing ethics.

1 Introduction

On 9 July 1919, the 29-year old patient Anna Schönstein died in the Werneck asylum. The day before, she had suffered scalds during her prolonged bath treatment, a treatment during which patients could spend anything from a few hours, a few days or even weeks in a tub filled with water. A nurse was held responsible for this incident because she had added hot water to the tub while the patient was still sitting in it and having an epileptic seizure at the same time. The nurse's attempts to lift the patient out of the tub were in vain and none of the other nurses heard her calls for help. When she finally noticed that she had not turned off the hot water it was too late. The patient had slipped with her feet into the running water and it had already caused life-threatening scalds on both of her lower legs and also her thighs and buttocks.[1]

Anna Schönstein, who suffered from epilepsy, had lived continuously in the asylum since 1910 with only a short break of a few months. After her death the directors of the asylum reported the accident both to the district court at Werneck and the Chamber of the Interior for the state government at Würzburg. In their draft for the letter to the Chamber of the Interior the directors described why accidents during the treatment in the prolonged bath were nearly unavoidable.[2] The explanations referred both to shortcomings of the technical equipment to

[1] To reconstruct the accident, see the notes in the clinical history of Anna Schönstein and the letter of 10 July 1919 (included in the clinical record) from the Werneck Asylum to the government of Unterfranken and Aschaffenburg, Chamber of the Interior at Würzburg. Schönstein, Anna (1889–1919): Clinical record of the Asylum Werneck, Kingdom of Bavaria, photocopy in the collection Prinzhorn Heidelberg, original at the Hospital for Neurology of the district Unterfranken, Werneck Castle, No. 7709.

[2] The explanations were taken from the letter by the asylum Werneck to the government of Unterfranken and Aschaffenburg, Chamber of the Interior from 10 July 1919.

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mix hot and cold water and to the negligence of the nurses who often ignored regulations that had been created for the prolonged bath treatment. The accident that cost Anna Schönstein her life was no isolated case and the respective reports were not only documented in the clinical files but also published in medical journals.[3]

Mixer taps that allowed the adding of water at the desired temperature and to help minimising the risk of scalding were only occasionally used at the time of the accident and the nurses were often unfamiliar with handling this new device. Furthermore, mixer taps were not always reliable: even though the Werneck asylum had installed a mixer tap, the chalky water rendered the equipment unusable.[4] To avoid scalds the nurses were hence forbidden to add hot water to the tub as long as the patient was still sitting in it. The nurse who had to answer for Anna Schönstein's death and was punished with disciplinary action, had not followed the doctors' standard instructions. Instead of removing the patient from the tub, she had simply moved her to the other end of the bath while the hot water was running. The nurse stated that she had been shown this method by a senior nurse who was now no longer working at the asylum. The directors of the asylum explained that the regulation on how to conduct the prolonged bath shared "the same destiny as all regulations that are laborious and hard to fulfil [...], namely they are handled in a more relaxed manner."[5] They also expressed their sympathy for the actions of the nurse who had not followed the doctors' orders. As the directors of the asylum observed, "it is often very difficult to remove an agitated patient who is finally sitting happily in the tub from it for a few minutes and return him or her quickly afterwards."[6]

Scalds of the skin caused by adding unmixed (hot) water were the negative side effects of a treatment that was introduced together with bed treatment, that is, a medically indicated bed rest, at the end of the nineteenth century. Its goal was to calm the patient. Doctors argued that this new treatment would have both internal and external effects. It was supposed to lighten the nurses' workload and lead to significantly more peace in the wards because restless patients in the bathroom could be separated from their fellow patients. In addition, escaping from a tub was more complicated than escaping from a bed. Patients treated with the prolonged bath were not just stowed away, but were to be subjected to modern medical insights of the time, such as hydrotherapy aided by the technology of running water. These psychiatric departments were no longer spaces to simply contain people throwing fits, there were no cells and privies smeared with faeces, no sheets that had been ripped apart, no

[3] "Berichte über den Tod einer Patientin im Dauerbad" (Reports on the death of a female patient in a prolonged bath), Staatsarchiv Hamburg, Asylum Langenhorn, Holdings 352-8/7, Sig. 146. See also "Verbrühung im Dauerbad," cited after Breslauer Zeitung, in: Psychiatrisch-Neurologische Wochenschrift 8/1906, p. 71.

[4] Reports on the death of a female patient in a prolonged bath, Staatsarchiv Hamburg, Asylum Langenhorn, Holdings 352-8/7, Sig. 146. Franz Nissl, head of the Psychiatric University Hospital, Heidelberg, also hoped in 1910 that usable mixer taps would be installed. See Nissl, Die psychiatrische Klinik, Heidelberg, 18 November 1910, p. 8, Universitätsarchiv Heidelberg, Sig. H-III, 682/1.

[5] Reports on the death of a female patient in a prolonged bath, Staatsarchiv Hamburg, Asylum Langenhorn, Holdings 352-8/7, Sig. 146.

[6] Reports on the death of a female patient in a prolonged bath, Staatsarchiv Hamburg, Asylum Langenhorn, Holdings 352-8/7, Sig. 146.

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dresses made out of tear-proof fabrics, no more straw mats or shoes with screws for a heel, nor any foul smells.[7] All of this became dispensable or even extinct through the setting up bathrooms and the use of the prolonged bath. Instead of placing highly agitated patients in isolation cells they were to find peace in lukewarm water according to the doctors, even if this meant accepting the potential of significant risk to the patient – as the example of Anna Schönstein illustrates. The treatment also involved a higher level of responsibility for the nurses.

2 The Issue

In the accident report on the death of Anna Schönstein the directors of the asylum noted that nurses often ignored the regulations that had been created for giving prolonged baths and pointed to the technical equipment that was necessary to conduct the treatment. Even if the reasons for ignoring regulations or for handling them in a "lax" way may have been manifold, the example directs the attention to the material configuration or material arrangement of the treatment. Using the term 'material arrangement' I draw on the sociologist Theodore Schatzki, who in the context of his social ontology and with regards to the question on social phenomena, links material dimensions to dimensions of action: "Indeed almost all practices would not exist or would take different forms were it not for the presence in them of particular material entities. The reverse also holds."[8] For Schatzki, material arrangements are "a set of interconnected material entities" that he divides into four types: "humans, artifacts [sic!], organisms and things of nature."[9] Practices "are carried on amid and determinative of, while also dependent and altered by, material arrangements."[10] In this sense, practices and their respective arrangements are co-constitutive. This approach can be applied to practices of nursing and the arrangements or configurations in which these are performed and, as I subsequently show using the practice of the prolonged bath, can be expanded by the dimension of ethics. While ethical actions in nursing are mainly discussed as interactive actions between nurse and patient, drawing on the material configuration of the treatment can mediate between room, practice and ethics.

The psychiatric asylums followed the model of general hospitals when they established wards for treatments in bed and bathrooms for the prolonged baths.[11] With these "nursing-intensive

[7] Kraepelin 1909, p. 583; see also Würth 1902, p. 682.
[8] Schatzki 2010, p. 140.
[9] Schatzki 2010, p. 129.
[10] Schatzki 2010, p. 130.
[11] Since the 1880s prolonged baths or permanent baths were also used in the surgical departments in hospitals. "For patients with visible diseases [...] the surgical departments will provide prolonged baths or waterbeds that will either be placed in a special room or the general ward as the last row of beds" (Ruppel 1899 a, p. 804). At the General Hospital Hamburg-Eppendorf, opened in 1889, a special bath house was built for the various hydrotherapeutic treatments and "permanent water baths". The waterbeds that were installed in these bathrooms were built in such a way that the water constantly renewed itself because fresh water was continuously added. The tubs were equipped with a lifting device in order to be able to lift and

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forms of therapy"[12] they established for the first time medical treatment rooms in psychiatry that fell under the nurses' responsibility. In both the German Empire and Austria nursing underwent a restructuring of its training by introducing training programmes and a first phase of professionalisation during this time. Using the example of these two treatment methods that depended on the set-up of specific rooms and required training in specific nursing techniques, we can nicely illustrate the interplay between room and nursing practice and uncover their ethical implications. The paper closely describes the material configuration of the prolonged bath treatment before delineating the practical instructions the nurses were supposed to follow when applying it. It concludes with some reflections on the perspectives that might arise from these arrangements for current ethical questions.

With the introduction of prolonged bath treatments psychiatry developed its own (and new) material culture at the interface of objects[13], rooms, and groups of agents. It required objects (bath tubs) and a material substance (water), rooms (bathrooms) and a technical infrastructure (supply of sufficient amounts of warm water, connection to the water supply system). The treatment could not be reduced to dealing with a single object but, from the nurses' perspective, straddled the "management" of a complex material arrangement (consisting of objects, substances, materials, technical apparatuses etc.), an arrangement which was the result of the particular physical characteristics of water. The nurses had to "master"[14] the treatment in order to apply it to the patients according to the doctor's orders, and they learnt from the implicit knowledge of more experienced nurses, from training courses and service instructions. Yet, they also had some room for action that the material-physical arrangements prescribed. Water was the central element that had to be controlled and tamed to use it for therapeutic purposes. The treatment rooms, and indeed the whole material arrangement, had to be constructed to enable the therapeutic characteristics of water to be harnessed. The nurses had to familiarise themselves with the qualities of water and the technical devices that were installed both to maximise its therapeutic benefits but also to reduce the potential risks during therapy.

lower the stretcher on which the patient was lying. This stretcher was covered with a canvas that had been soaked in oil (Ruppel 1899, p. 804; Zuschlag 1897, p. 115). The length of the treatment varied. Gustav Zuschlag, doctor at the surgical department in Hamburg-Eppendorf, talked about a patient who spent 15 months without a break in a waterbed. The treatment was used in a wide variety of ailments, especially in general decubitus, diseases of the central nervous system and marasmus senilis, for inoperable carcinoma of the genitourinary system and the rectu [...], for extended bone and joint tuberculosis, phlegmons, purulence of surgical wounds, tissue necrosis and sepsis, for second and third degree burns, fistulas of the urine and faeces, urinary infiltrations and for ileostomies. The effects of the waterbed were perceived as positive and included weight gain, decrease of pain and improved wound healing. Cf. Zuschlag 1897.

[12] Schott/Tölle 2006, p. 440, cited after Urbach 2017, p. 68.

[13] On this cf. Kalthoff/Cress/Röhl 2016, p. 12. The authors argue for understanding materiality more broadly and to include in the material dimensions of the social sphere signs, writing, graphic systems, physical phenomena, organisms, artefacts and substances such as air and water.

[14] Artner/Atzl/Depner/Heitmann-Möller/Kollewe 2017, p. 7.

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3 Overview over Current Research

Water has been used from the early 19th century in its different states and temperatures to treat psychologically ill people, including as a cold affusion, dousing, splash bath and immersion bath. However, research into water therapy in German speaking countries is limited and the topic is often only marginally addressed. Similarly, research into prolonged bath treatments is also paltry, as historian Elisabeth Dietrich-Daum pointed out in 2013 in one of the few articles that explicitly addresses this treatment method.[15] There are some short explanations of the prolonged bath therapy in general overviews of the history of psychiatry,[16] in publications on the history of institutions[17] and in a small number of doctoral dissertations,[18] but the descriptions are rather generic. One thesis on water treatments in psychiatric institutions in the 19th century that includes some remarks on the practice of the prolonged bath was submitted in 2009 by the medical doctor Friedgard Rohnert-Koch.[19] She describes the prolonged bath system as practiced at Riedstadt-Goddelau by senior physician Karl Osswald, who published them in 1904 in the "Psychiatrisch-Neurologische Wochenschrift". Using six clinical records from the archive of the former mental institution Rohnert-Koch also provides an albeit small insight into the treatment. She demonstrates that prolonged baths were quite frequently performed for twelve consecutive days without a break. In 2004, she published a book chapter on the subject, where she located the prolonged bath somewhere between punishment and therapy.[20] Art historians Ingrid von Beyme and Sabine Hohnholz have illustrated how patients themselves reflected on the treatment in the prolonged bath, using personal testimonies from the Prinzhorn collection.[21]

Since the use of prolonged bath treatments was not restricted to German-speaking countries, publications on the history of psychiatry in other countries also contain some descriptions of the technique, mainly in the field of nursing history.[22] One example is a study on the development of psychiatric nursing in the Netherlands between 1890 and 1920, published by Geertje Boschma in 2003. She describes in detail the implementation of the prolonged bath treatment and the high level of responsibility that it devolved to nurses.[23] In an article published in 2000, Gunnel Svedberg and Gunilla Bjerén used the nurses' perspective of the prolonged bath in psychiatric institutions to explore the use of the therapy in Sweden.[24] They draw on interviews with nurses who worked between 1930 and 1963 in psychiatry and had

[15] Dietrich-Daum 2013, pp. 117–119. Some of the following notes on publications are taken from Dietrich-Daum's article.
[16] Haenel 1982.
[17] Engelbracht 2004; Putzke 2003.
[18] Wernli 2014; Braunschweig 2013, pp. 72–74; Hermes 2012; Ankele 2009; Grießenböck 2009.
[19] Rohnert-Koch 2009, pp. 131–135.
[20] Rohnert-Koch 2004.
[21] The Prinzhorn collection evolved from a former teaching collection of the Psychiatric University Hospital Heidelberg that had collected from the early 20th century a broad array of works by psychiatric patients (drawings, writings, textile works, objects, etc.). Von Beyme/Hohnholz 2018, pp. 67–69.
[22] My selection of publications is limited to those in English and French.
[23] Boschma 2003, pp. 72–73.
[24] Svedberg/Bjerén 2000.

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not received any training. The nurses' memories reveal that their work with patients in prolonged baths was determined by both fear and boredom. Similar views from the nurses' perspective can also be found in Claude Cantini's and Jérôme Pedroletti's book on the Hôpital sur Cery near Lausanne.[25] They also focus on the nurses' fear and work overload due to the numerous tasks that had to be considered and managed during the treatment. The German publication on the St. Jürgen Asylum in Bremen contains a brief excerpt of an interview with a nurse who had started her service there in 1929 and who did not have the best memories of working with the prolonged bath. "That was dangerous, and I never liked thinking about it."[26] In many of the interviews, patients treated with prolonged baths were agitated, bedwetting or suicidal. Benoît Majerus takes on a different perspective, using the example of the Belgian Hôpital Brugmann he analyses the "social life" of the bed, the door and also the bathtub and its transformation into a therapeutic object.[27] He also explains the treatment in his book "Parmi les fous".[28]

Since my article uses the prolonged bath treatment to enquire about the interplay between material culture and nursing (practices), it draws on newer research approaches that were established during the *material turn* and *practice turn* and utilises them for the fields of history of psychiatry and history of nursing.

4 The Installation of Bathrooms

Since the 1890s, psychiatrists in German Empire had been discussing the use of prolonged bath treatment (lasting several hours) to address states of agitation, and only a few years later this treatment method – combined with bed rest – acquired a leading position in psychiatric institutions and clinics and drastically changed them both in terms of their architecture and their social aspects.[29] The uptake of hydrotherapy at the end of the 19th century[30] paved the way for the prolonged bath treatment to enter psychiatry even though hydrotherapeutic measures had already been used before.[31] During the First World War and the post-war period prolonged bath treatment was less frequently used due to the lack of coal, lack of staff and the increased price of water. If reports of the institutions are to be believed, prolonged baths continued to be used during the 1920s and 1930s, albeit in rather restricted circumstances, and seemed to be applied even beyond that time.[32] This is similar to the practice in other

[25] Cantini/Pedroletti 2000, pp. 75–77.
[26] Tischer/Engelbracht 1990, pp. 42–47, here: 46.
[27] Majerus 2011, pp. 100–105.
[28] Majerus 2013.
[29] Boschma 2003.
[30] In 1899 the first Chair for Hydrotherapy was created at the University of Vienna and Wilhelm Winternitz was appointed.
[31] Rohnert-Koch 2009.
[32] [NOS], Bäderbehandlung in den Irrenanstalten (1921/22). Cf. also the descriptions of Dorothea Buck who was admitted in 1936 to the v. Bodelschwingh Institutions in Bethel and spent 23 hours in a prolonged bath

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countries.[33] At least for a while, in general treatment they were not replaced by somatic therapies.

After the introduction of the prolonged bath treatment doctors in the asylums communicated intensively about the new treatment method, drawing on their (and the nurses') experiences. In journals they explained the technical, spatial and material features of their prolonged bath settings, published technical drawings and photographs, explained the usage, pointed out problems that emerged during the application of the treatment, described suggestions for solutions and provided recommendations for spatial, material and technical adaptations which simultaneously illuminated the deficiencies and susceptibility to errors that were inherent to the treatment. "At the centre of the modern therapy [...] is the systematic treatment with bed rest and baths and there does not seem to be a single institution anymore that is not using them", according to a report on the "Fortschritte des Irrenwesens" (Progress of Mental Institutions) from 1903 which emphasised the significance of the new treatment methods.[34] The psychiatrist Emil Kraeplin was credited with combining bed treatments that had been promoted by his colleague Clemens Neisser[35] with baths of multiple hours, and later even days, weeks and months, and with having created a spatial ensemble consisting of a large ward or monitored room for the bed treatments with an adjacent bathroom for the prolonged bath treatments. His student Heinrich Dehio[36] wrote in 1904:

> The essentially new part of Kraepelin's actions is the effort to treat all conditions of agitation that pose a problem for bed treatment with a full bath of nearly unlimited duration. Secondly there is the technical execution of this concept in that the baths are provided under continuous monitoring in a larger room equipped with multiple bathtubs located next to the surveillance wards.[37]

Franz Nissl who succeeded Kraepelin as head of the Psychiatric University Hospital Heidelberg in 1904 pointed out that the prolonged baths which his predecessor had set up had been the first ones that had been used for the regular treatments of patients who were bedwetting or had bed sores. Such rooms, he claimed, were a model for other institutions.[38]

The combination of bed therapy and prolonged bath treatment, and the concomitant architectural innovations required, provided psychiatrists like Kraepelin and Neisser with the opportunity to make psychiatric institutions more like general hospitals where both treatment methods were already used. Max Löwy writes: "In addition to the surveillance wards, the

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as she described in her autobiographical book "Auf der Spur des Morgensterns" (Tracing the Morning Star). Zerchin 1990, p. 67.

[33] Svedberg/Bjerén 2000; Cantini/Pedroletti 2000.

[34] Deiters 1903, p. 133.

[35] On the installation of bed treatments cf. Ankele 2018.

[36] Heinrich Dehio earned his doctorate under Kraepelin in 1997 at the Psychiatric Hospital Dorpat, where he also worked as a doctor. When Kraeplin was the head of the Psychiatric University Hospital in Heidelberg, Dehio was granted a leave of absence to work in Kraepelin's lab at that hospital. Cf. Kreuter 1996, p. 245.

[37] Dehio 1904, p. 482.

[38] Nissl, Die psychiatrische Klinik, Heidelberg, 18 November 1910, p. 8, Universitätsarchiv Heidelberg, Sig. H-III-682/1.

installation of prolonged baths has given the wards for agitated patients of the modern mental asylum a much better image."[39] The idea was that through both bed and prolonged bath treatment a psychiatric ward was created that, based on a new material culture and subsequently a changed nursing practice (monitoring instead of isolating), would mark the beginning of a "modern" and "humane" psychiatry. Using force during the treatment of mental patients, epitomized through the image of a straightjacket and solitary cell, was replaced by the principle of continuous monitoring. The nurses were able to do this through the newly set-up wards (bedrooms) and bathrooms: and the method was supposed to affect the patients differently but not less effectively than the straightjacket and the isolation cell. While doctors had before felt forced to isolate severely agitated patients in solitary cells, the bed and prolonged bath treatment was meant to enable the return of these patients into the wider patient community, as long as permanent monitoring by nurses was provided.[40] The newly created rooms (ward and bathroom) which were signed over to the nurses had to match this condition.

To set up the new ensemble of ward and prolonged bath room, the separating walls of the isolation cells had to be gently demolished so that the former cells could be turned into larger rooms or changed into bathrooms. The sickbed and the bathtub were introduced as therapeutic agents, and they served as co-nurses. Thus, the basics were created to comply with the principle of continuous monitoring, reconfiguring the relationship between nurse and patient. Franz Nissl reported that in 1900 the "cells [...] were changed according to the progressive views on the treatment of the patients into a ward with monitoring facilities for agitated patients [...] with a so-called prolonged bath" at the Psychiatric Hospital Heidelberg.[41] By removing the hallways, the small rooms for patients and the room for the warden were transformed into three larger wards for patients with an adjacent bathroom containing four bathtubs. Similarly, at the asylum in Emmendingen the walls were taken out of the isolation cells in the wards for agitated patients in order to set up facilities for prolonged bath therapy.[42] (Fig. 1)

[39] Löwy 1926, p. 90.

[40] On the effects of the community with regards to the bed treatment cf. Ankele 2018, on the interplay of psychiatric concepts of the rooms and the nurses' task of monitoring cf Ankele 2019. Sabine Jenzer, Willi Keller, and Thomas Meier show in their interviews that they collected for their book "Eingeschlossen. Alltag und Aufbruch in der psychiatrischen Klinik zur Zeit der Brandkatastrophe von 1971" (Trapped. Daily routine and departure in the psychiatric hospital at the time of the fire disaster of 1971) that the new orientation of psychiatric institutions in Switzerland during the 1970s went hand in hand with a reform of their material culture. Jenzer/Keller/Maier 2017.

[41] Here and subsequently: Nissl, Die psychiatrische Klinik. Heidelberg, 18 November 1910, Universitätsarchiv Heidelberg, Sig. H-III-682/1.

[42] Haardt 1912, p. 5.

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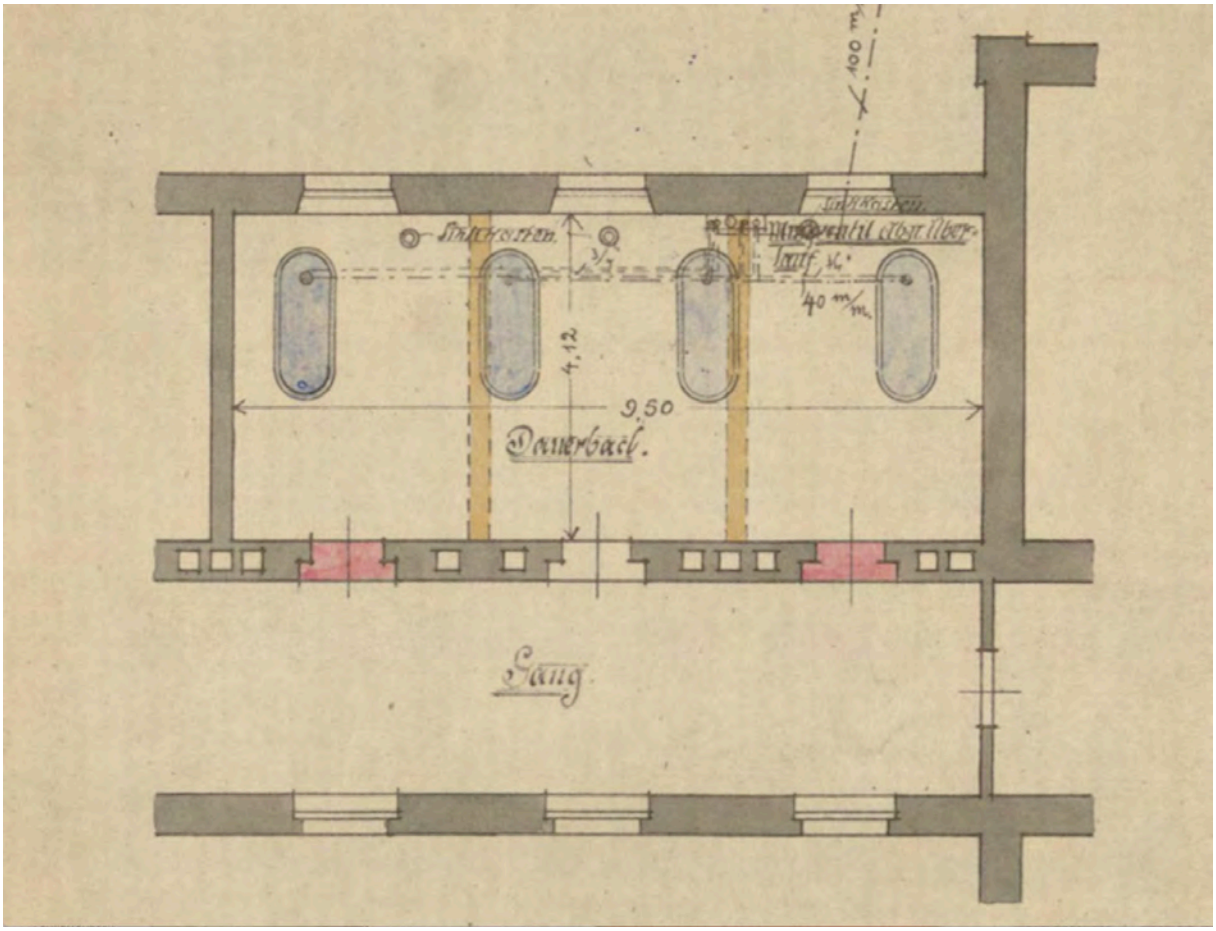

Fig. 1: Plan for the facilities for prolonged bath therapy on the ward for agitated women at the Emmendingen asylum. The lighter colour marks the two walls that were to be removed. August 1910, Staatsarchiv Freiburg, Holdings B 698/5, No. 5057.

The location of the bathrooms was central. Since they served to calm down "acutely and chronically, but also particularly agitated and partially bedwetting patients,"[43] they were supposed to be separate, but still in close proximity to the bedrooms where the aforementioned patients were housed. Connecting the bedroom to the bathroom had the advantage that the nurses could move the patients more easily from one room into the other, that is, "directly from the bed into the bathtub."[44] Furthermore, the nurses who were often on call by themselves in the bathroom had the opportunity to call for a nurse from a neighbouring surveillance ward in case they needed help.[45] As Doctor Tomaschny pointed out in his 1905 report on prolonged bath facilities in German and Austrian asylums, well equipped bathrooms were rarely used when they were too far away from the surveillance wards.[46] The location of

[43] Osswald 1904, p. 166.
[44] Dehio 1904, p. 482.
[45] Wachsmuth 1909/10, p. 192; Dehio 1904, p. 482; Tintemann 1907.
[46] Tomaschny 1905, p. 461.

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the rooms had an immediate impact on both the work of the nurses and on whether a treatment was applied or not. The practicability of implementing a treatment seemed to have been more crucial than the potential necessity of it. If the ward and the bathroom were located next to each other, patients could be given a prolonged bath even at night when they were not to disturb the peace in the ward.[47] At the Leipzig-Dösen asylum, the superior nurse was able to prescribe a prolonged bath without the prior consent of a doctor as it had "proven itself to be useful" during agitated phases at night, "and especially because it was hard and time consuming to reach a doctor in the middle of the night."[48]

The set-up of bespoke rooms for prolonged bath treatments was also the result of the expansion of the infrastructure in the institutions. The extension of the water pipe system happened at the same time as the prolonged bath treatment was introduced, facilitating the connection to a (central or local) hot water supply. This opened up new avenues for hydrotherapeutic treatment concepts because, as Tomaschny pointed out, the installation of bathrooms for prolonged baths required the continuous availability of hot water both during the day and at night.[49] Originally, the bathtub was a nomadic piece of furniture. It had rubber wheels (Fig. 2) or a movable wheel frame (Fig. 3) and could be placed in different rooms where the nurses filled it from buckets. With the extension of the water supply system, the bathtub became a fixed piece of furniture[50] that could and (had to) be installed at a specific place.

Fig. 2: Badewannenräder (Bathtub wheels). In: Medicinisches Waarenhaus (ed.): Ausrüstungs-Gegenstände, Krankenpflege-Artikel für Heilstätten, Liste No. XV. Berlin 1905, p. 61.

[47] Ganser 1912, p. 638. Dehio reports that in the asylum Leipzig-Dösen the nocturnal prolonged baths had been exclusively conducted in the women's ward up to that point because there had been no corresponding "need" for it on the men's ward. Dehio 1904, p. 482; Würth commented in 1902 that due to a lack of nursing staff prolonged baths could not be performed at night at the Hofheim asylum. Würth 1902, p. 679.

[48] Dehio 1904, p. 482.

[49] Tomaschny 1905, p. 461.

[50] Giedion 1988, p. 738.

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28675 **Fahrvorrichtung** für Badewannen, speziell geeignet für Krankenanstalten. Ganz aus Eisen konstruiert, Räder eventuell mit Gummireifen . . . . . Mk. 45,—
Bei Bestellung Schablone des Wannenbodens erforderlich.

Fig. 3: "Fahrvorrichtung für Badewannen, speziell geeignet für Krankenanstalten" (Undercarriages for bathtubs, especially suitable for hospitals). In: Medicinisches Waarenhaus (ed.): Ausrüstungs-Gegenstände, Krankenpflege-Artikel für Heilstätten, Liste No. XV. Berlin 1905, p. 61.

5 The Material Configuration of the Bathrooms

Fig. 4: Room for permanent baths at the Langenhorn mental asylum, 1909. Staatsarchiv Hamburg, StAHH 141-19, Sig. 06-195-p1398a.

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"Apart from the bathtubs, the room should be sparsely furnished to avoid any opportunity for destruction or risk of accidents," Kraepelin recommended in his manual in 1909.[51] A photograph of a "room for permanent baths" from the Langenhorn mental asylum from 1909 captured his instructions. The photograph shows a light and nearly empty room giving the nurse the highest level of overview and visibility, and from her standing position she can overlook the whole room and monitor the patients. The floor and the walls of the room are tiled; to avoid injuries, the radiators were boxed in. The four bathtubs filled with water are placed with ample space between them in the middle of the room, such that the patients can only touch each other by stretching out their arms. In the photograph the patients are wearing shirts, and one tub is lined with a sheet to prevent the patient from drowning. The inflow pipes for the water that were connected to the tubs are clearly visible in the photo, which also shows that the taps to regulate the addition or draining of the water are located in a wall-cupboard, to prevent patients from using the taps themselves; only the nurse could handle the device. In this image, she stands next to the wall cupboard from where she can regulate both the water supply and the temperature. In this facility, the use of buckets to fill and refill the tubs has been rendered obsolete because of the technical equipment that had been placed between patient(s) and nurse. The sign directly above the wall cupboard states the bath rules.

The physical arrangement of the prolonged bath treatment prescribed the relationship between nurses and patients. It became "live" once the agents stepped into the room and went to the location prescribed to them by the arrangement. Through the material configuration of lying (tub/patient) versus standing (room/nurse), the treatment allocated both groups of agents their own places in the room, which provided them with a different perception and distinctive forms of communication, perspective and points of view, ranges of motion and levels of action. The juxtaposition of the standing nurse and the patient either sitting or lying in the tub in the picture illustrates this difference, as the patients were restricted in their movements both by the tub and the water. In 1904 the psychiatrist Heinrich Dehio pointed out that the patient lying in water "was habitually in much more need of help" and "is in a much bigger relationship of dependency with the nursing staff which, if utilised correctly, can make the patient significantly more willing and responsive."[52] In contrast to isolation in a cell that both the nurses and the patients could perceive as punishment, "patients and nurses alike " were supposed to recognise "the use of the bath as a beneficial medical measure."[53]

The particular physical qualities of water, the requirements of its processing to be suitable for the treatment, and the patient group that was supposed to be treated – often agitated, self-harming or harming others – required adaptations of the room which affected the work of the nurse. Water as the central element of the treatment made it necessary that the walls of the bathrooms were painted (at least to reaching height) with a water-resistant oil or enamel paint. Tomaschny recommended that all elements made of wood, such as doors and doorframes, should be coated with the same water resistant paint because wood was prone

[51] Kraepelin 1909, p. 580.
[52] Dehio 1904, p. 485.
[53] Kraepelin 1909, p. 583.

to rot quickly due to the high humidity in the room.[54] A waterproof and ideally warm floor was meant to protect the bathing patients from the cold. "[I]n the interest of the staff in the bathroom" the floor was supposed to be slightly slanted "to ensure a quick drainage of the water that would be on the floor mainly due to the patients' splashing."[55] This served to prevent nurses and patients slipping on the wet floor. Osswald recommended that the room should be "big enough, full of air, light and equipped with high ceilings [...]; a rectangular shape would possibly be the most functional form." Such a room would make it easier for the nurses to monitor the patients as this was their main task during the bed and prolonged bath treatment.[56]

When installing the tubs, their positions should take into account the need "to facilitate the monitoring of patients in the baths and to ensure that the occupants of the tubs are able to bother each other as little as possible." Tomaschny did not think it necessary to place walls between the tubs as was custom in some asylums because these made it more difficult "to keep an eye on the bathing patients."[57] His recommendation for setting up a room for prolonged baths were guided by the tasks and the responsibilities that the nurses had to assume while conducting the treatment.[58] Appropriate arrangement of the room should enable nurses to better manage the requirements that the work in the prolonged bath entailed. Room and nursing practices correlated. As a co-agent of the treatment, the room and its material arrangement (position of the tubs, non-slip safety of the floor etc.) could make the work either easier or harder.

6 The Technique of Bathing

Even though the photographs of the bathrooms for prolonged baths provide an insight into the ideal treatment, they show nonetheless rooms that had to be "played" by the nurses.

For the nurses, the prolonged bath treatment did not only require numerous new tasks that required a different level of attention and new knowledge, they also took on an increased level of responsibility for the patients. They had to familiarise themselves with the medium "water" and its specific impact on the room (humidity, steam etc.) and on the body and the psyche of the patients. Finally, there were the (often rather dangerous) actions that the medium triggered (submerging, swallowing, splashing etc.). Nurses had to know how to use the technical equipment to process the water and learn certain routines and techniques for the application of the treatment. With service regulations or specifically created bathing rules that

[54] Tomaschny 1905, p. 463.
[55] Here and subsequently: Osswald 1904, pp. 166–168.
[56] On monitoring as the central task of nurses in the bathroom for prolonged baths cf. Svedberg/Bjerén 2000 and Boschma 2003.
[57] Tomaschny 1905, p. 462.
[58] Tomaschny 1905, p. 462.

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were hanging[59] or lying[60] in the bathrooms, the mental hospital provided its staff with a guideline for the application of a prolonged bath. In addition nurses received some training, as in the Wiesloch asylum where "at the beginning of the shift in the bath they receive detailed instructions from the bathing rules."[61] The manuals, service regulations and bathing rules particularly emphasised the potential dangers that the treatment could cause: patients could drown when falling asleep (the warm water was meant to have a soothing effect after all), or they might suffer scalds of their skin when the added water was too hot. "There are nowhere as many accidents as in the bath," the Swiss psychiatrist Walter Morgenthaler stated in his nursing manual and categorised them into four groups: "drowning," "scalding," "catching colds" and "harm and self-harm through objects that are lying around or have been torn off."[62]

The nurses' tasks when working in the bathroom were not limited to placing the patients in the tub, letting in the water, regulating the water temperature and monitoring the bathing patients. The nurses had to handle of all aspects that were created by this novel material-spatial arrangement, this ensemble of co-agents: cleaning and airing of the bathroom, cleaning and drying the tubs with the appropriate detergents, mopping the wet floors, drying sheets, opening the windows after the treatment and preventing drafts during the treatment, undressing or changing the patient, at times also inserting the sheets in the tubs to keep the patients in the water or to place patients on them when there was a danger of drowning and – as far as this was planned – lubricating the skin with Vaseline[63] or Lanoline[64] to protect it from the damaging qualities of the water. The nurses themselves were recommended to frequently cream their forearms and hands with oil, as for instance in the Leipzig-Dösen asylum.[65] One of the side-effects of the prolonged bath treatment that equally affected patient and nurse were infections that could spread in the water and were transmitted by it: boils, phlegmons, fungal infection and inflammatory diseases such as eczema were all potential sources of infection.[66] To protect the nurses from the moisture some institutions provided them with functional clothing for the work in the bath. While in Hofheim, the nurses received "bathrobes made of Billroth-batiste,"[67] in the hospital in Freiburg they were given "linen dresses" under which "they (the female nurses, M.A.) should wear a waterproof apron at the front."[68]

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[59] Photograph of the room for the prolonged bath treatment at the Philippshospital, 1930. LWV-Archiv und Museum Philippshospital, photo collection, without signature, printed in: Rohnert-Koch 2004, p. 162.
[60] Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.
[61] Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.
[62] Here and subsequently: Morgenthaler 1930, p. 141.
[63] Tomaschny 1905, p. 462.
[64] The protective creaming with Lanoline was used for instance at the Asylum for Lunatics and Epileptics in Frankfurt a. M. (Anstalt für Irre und Epileptische), cf. Wachsmuth 1909/10, p. 194. Kraepelin also recommended this to prevent skin diseases, cf. Kraepelin 1915, p. 585.
[65] Dehio 1904, p. 484.
[66] The state asylum Goddelau Würth reported a spreading of furunculosis that affected the forearms of mainly those nurses who were "monitored furunculous patients in the prolonged bath", cf. Würth 1905, p. 290.
[67] Würth 1902, p. 678. "Billroth-batiste" is a waterproof fabric that was named after its inventor, the surgeon Theodor Billroth.
[68] Deiters 1905, 387–388.

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Before the patients were taken to the bathroom, the nurses had to run the bath with water at a temperature of 36 degrees Celsius, unless otherwise prescribed by the doctor. According to the bath rules in Wiesloch, the patients were allowed to get in the tub only after the male or female nurse[69] had measured the water temperature with the bath thermometer. He or she was not allowed to measure the temperature "by touch with the hand or the arm" or to rely on instinct.[70] Once the patient was in the tub the nurse had to check the water temperature every half an hour with a thermometer. For the nurses, keeping a (relative) consistent water temperature proved to be a particular challenge during the prolonged bath treatment. Even though some materials that were used to make the tubs kept the heat better than others – it was recommended to use tubs made of tin-glazed earthenware[71] – the water cooled down with time and refills with warm water were necessary.

> If the temperature falls below 34 degrees the nurse (in German: Wärter, M.A.) drains half of the tub (approximately one hand width) and adds warm water (by switching on first the tap for cold water and then the tap for hot water) of at most 42 degrees (according to the thermometer of the mixer tap) until the bath water has reached the correct temperature of 36 degrees again.[72]

Since it became clear that the risk of accidents was very high when hot water was added, many institutions established the rule that the patients had to be removed from the tub while water was added to it.

> Using the mixer tap requires a high focus. The nurse must repeatedly reassure himself that the thermometer is working, that no tap [...] and in particular not that tap with hot water [...] leaks after it has been turned off, nor that the mercury rises to the top of the thermometer.[73]

Furthermore, looking at the thermometer and reading the temperature quickly and to interpret the display correctly required training. As soon as the patients became sleepy or

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[69] The respective bath rules only use the male form of the term "Wärter" (transl. as "nurse").

[70] Here and subsequently: Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.

[71] For this reason, the Langenhorn asylum was supposed to have tin-glazed earthenware tubs. Cf. information by the senate to the citizenry 1909, 25 June, Antrag, betreffend dritte Erweiterung der Irrenanstalt Langenhorn (Application concerning the third expansion of the asylum Langenhorn), Staatsarchiv Hamburg, Holdings 364-3/1, Sig. 57. When the Winnenthal asylum planned to refurbish the cells of the old department and transform them into a bathroom for prolonged baths, it was noted on 30/10/1905 that the purchase of tin-glazed earthenware tubs "was far too expensive for prolonged baths for patients who were agitated or tended to demolish things." At times the tubs would not last very long – and if they were to be purchased a warranty had to be given. Staatsarchiv Ludwigsburg, E 163, Sig. Bü64. The Viennese Medizinische Wochenschrift (Weekly Medical Journal) reported that the Viennese company Bondi & Comp. had developed a bathtub that "avoided differences in temperature [...] because it was made out of a poor heat conductor. This means that the bath heats up quickly and the bath water does not cool down so rapidly." Berichte aus den wissenschaftlichen Vereinen. Gesellschaft für physikalische Medizin, Meeting on 18 March 1908.

[72] Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.

[73] Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.

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when the prescribed bathing time was up, they were supposed to be taken out of the tub, dried, dressed and put to bed.[74] Putting the patients back to bed at night presented a particular challenge, when – as for instance in the asylum in Frankfurt on the Main – there was only one nurse on duty in the prolonged bath.[75] However, he or she could "call for a nurse for support from a neighbouring ward," as Wachsmuth conceded.[76] The lack of staff was the biggest source of risk: On 15 November 1930 a patient died in the Langenhorn state asylum after a nurse had taken her to the bathroom because she had soiled herself. The nurse, who had been on night-duty and was caring for another 20 bedridden patients, briefly left the patient in the bath and went back to "the room to check on things", as she stated herself.[77] When she returned to the bathroom after fifteen minutes, the patient's head had sunk under the water and she could not be saved. Due to the structural framework, the nurse was prevented from acting ethically in the sense of non-maleficence.

7 The Technical Apparatus

The introduction of the prolonged bath treatment accompanied the installation of mixer taps that were supposed to ensure water entered the tub at a constant temperature, because scalding of the skin was a huge risk during the treatment. Nurses had to familiarise themselves with this technical apparatus, that is they had to practice using the lever or crank that served to regulate the flow of cold or warm water and they had to learn how to interpret the display of the thermometer. Haymann writes in his manual: "The assistant in the bath must be fully familiar with the mixer taps before starting to work there",[78] while Wachsmuth pointed out that "highest demands must be placed on the reliability of the staff and the usability of technical operation."[79] In the asylum in Frankfurt on the Main both a mixer tap with a lever and one with a crank were used. When the nurse turned the crank, cold water was let into the tub first while the hot water valve was still closed. When he or she continued to turn the crank, the valve for hot water opened as well and when he or she turned even more, the cold water valve closed and only hot water was flowing into the tub: by "setting two nuts by moving them along a valve spindle [...] every desired maximum temperature" could be determined and "scalding of the bathing patient could definitely be avoided."[80] A display with a scale of "closed – medium – warm" and a thermometer allowed the nurse to evaluate the temperature of the bath. Yet, this model was prone to the risk that the nurse would "turn the [valve in the] wrong direction in a moment of shock and thus instead of turning off the water completely, he or she would only turn off the cold water and open the hot water valve." The lever system was meant to prevent this risk because one glance at the position of the lever was supposed to be

[74] Bathing rules of the asylum Wiesloch, 1910, Generallandesarchiv Karlsruhe GLA Abt. 463 Wiesloch. No. 722.
[75] During the day two nurses looked after six patients in the prolonged bath, "in very difficult cases even three." Wachsmuth 1909/10, p. 192.
[76] Wachsmuth 1909/10, p. 192.
[77] Handwritten reports on the death of a female patient in a prolonged bath, Staatsarchiv Hamburg, Holdings Staatskrankenanstalt Langenhorn, 352-8/7, Sig. 146.
[78] Haymann 1922, p. 118.
[79] Wachsmuth 1909/10, pp. 192–193.
[80] Here and subsequently: Wachsmuth 1909/10, pp. 192–193.

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enough to check the water temperature. As Wachsmuth illustrated, however, the constant water temperature did not only depend on the respective mixer tap but also on an even water pressure in the pipes.

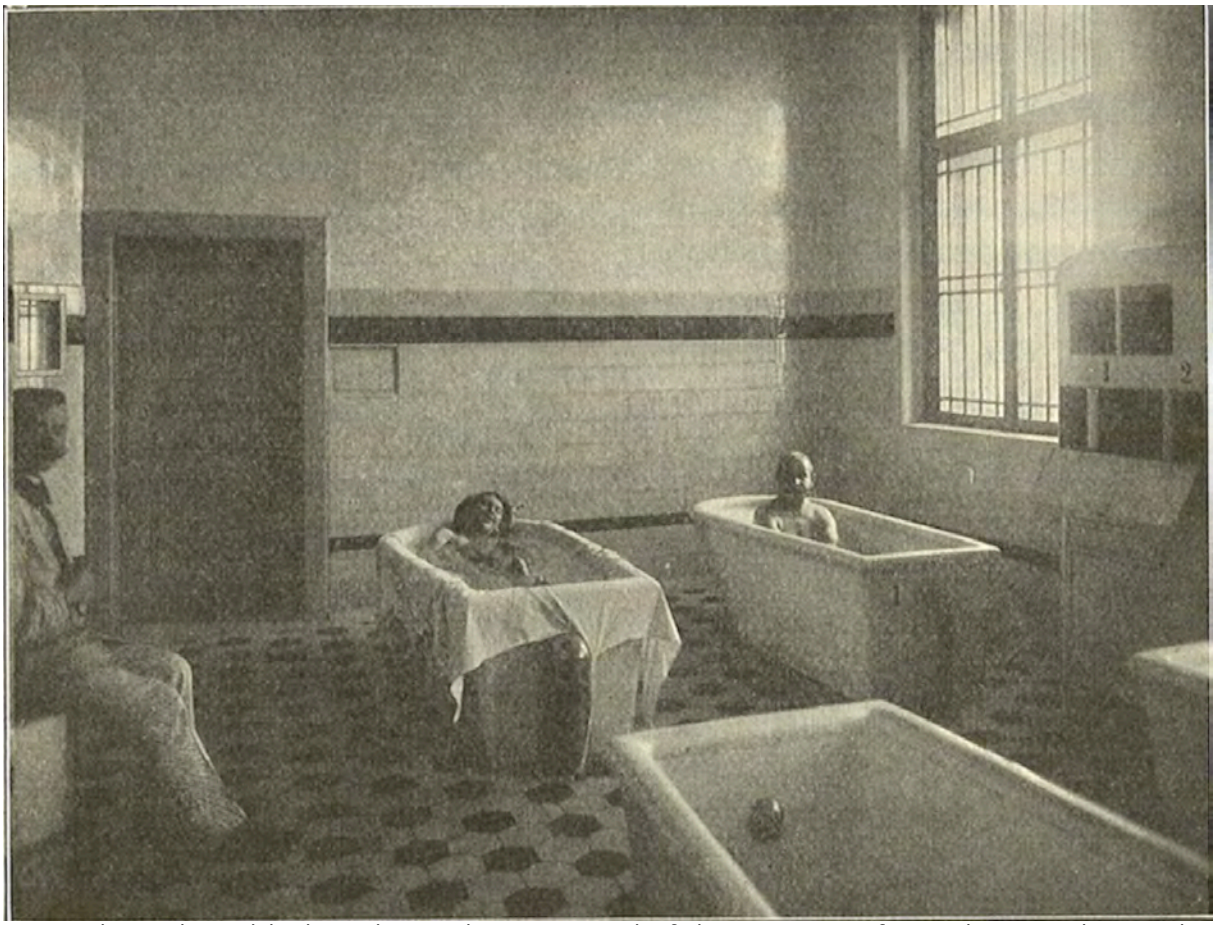

Fig. 5: The prolonged bath at the Psychiatric Hospital of the University of Munich. In: Emil Kraepelin: Psychiatrie. Ein Lehrbuch 1909, p. 582.

While the technical apparatus for the prolonged bath was supposed to reduce accidents and help the nurses to delegate some of their tasks to the equipment, in reality the mixer taps repeatedly proved to be unreliable and accidents happened despite their use. For this reason, the Psychiatric Hospital in Munich used an electric system to regulate the temperature.

> It automatically ensures that the water temperature in the large storage vessels never rises above 60 degrees and it signals a red light as soon and for as long as the water that is let in the tub is warmer than 40 degrees. The temperature can always be checked on the thermometer.[81]

As we can see on a photograph from the hospital in Munich (Fig. 5), the bathroom there – similar to the one at the Langenhorn asylum – had an open-plan layout, was light and neatly

[81] Kraepelin 1909, p. 581.

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arranged. The male nurse is overlooking the room from a bench that has been inserted into one of the walls. He is not positioned right next to the technical equipment as was the case in the image from Langenhorn but opposite to it. Yet, this slightly raised position provided him with an overview over the bathing patients, provided that none of the patients was standing in the water, was getting out of the tub or was splashing water around, or was submerging himself. Any such incident would have changed the situation and required the nurse's attention so that he could no longer focus on the overall picture. Under ideal circumstances this viewpoint allowed the nurse also to keep an eye on the equipment for adding and draining water – located in the open cupboard across from him. The thick glass panes made it possible to observe "the thermometer that was located in the inflow pipe."[82] If water that was warmer than 40 degrees was flowing in, the red light came on that he could also see from across the room.

8 Room – practice – ethics

When providing a prolonged bath, the nurses' tasks straddled far more than the handling of a single object. Here, a whole arrangement of tasks had to be managed and mastered. In the writings of physicians, providing a prolonged bath treatment emerges as an interplay between technical equipment and nursing staff. Each "player" was given specific tasks, each of them was prone to make mistakes and could cause huge damage in case of failure. While the technical apparatus to mix water was installed to make the treatment safer for the patients, it was highly susceptible to errors. This was one reason why the hospital in Munich installed a warning light. Such adaptations were reactions to experiences that had been made during the treatment. Similarly, the bathroom was adapted to reduce the opportunities for patients to hurt themselves or others. All of these interventions in the bathroom served to enable nurses to run the treatments safely. Hence, they were designed on the whole to take the practice of nursing into account. Bathroom and nursing practice – and consequently also the ability for ethical treatment – were configured from a material point of view. They were in close proximity to each other, that is they depended on each other. The configuration of the room affected the nurse's actions more than bath rules or service regulations. Water, as the central medium of the treatment, illustrated to the nurse what could happen if he or she was inattentive or lost focus. It forced the nurses to be attentive.

From a historical perspective, this article raises contemporary ethical questions in nursing regarding the effectiveness of spatial and material arrangements and the interactions between nurses and patients. A material analysis of the prolonged bath treatment, enriched through a focus on practice, visualises the complexity of the situation with which nurses were confronted when they provided the treatment. This perspective reveals that treatment practices and ethical questions cannot be reduced to an analysis of face-to-face-situations because the interaction of nurses and patients, that is how nurses treated the patients, was also influenced by the spatial and material arrangements with which they were confronted.

[82] Kraepelin 1909, p. 582.

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Last but not least, the material configuration of the prolonged bath treatment shows that– despite some attempts to install appropriate equipment such as technical apparatus and adapting the room through installation of mixer taps, warning lights, covering the radiators, arrangement of the tubs, use of linen sheets etc. – it was impossible to make the work easier for the nurses and at the same time increase safety for the patient, even though the experiences had an impact on how the arrangement was adapted. Ethical action in nursing does not start with the direct encounter of patient and nurse. Rather, their meeting and their subsequent relationship are largely arranged by the material configuration of the respective treatment setting. This historical analysis of the prolonged bath treatment is intended to direct the focus towards the ethical implications that are inscribed and contained in the setting. Thus, this article underlines the significance of a material cultural analysis with regards to questions in nursing ethics by highlighting the dependency that exists between ethical actions (not to cause harm) and the material configurations, the concrete (physical) setting that conditions a treatment. This does not imply that nurses are to be released from their responsibility for their patients but it is a plea to also include the structural framework of a treatment (here the room, medium and materials) into the analysis when studying nursing ethics.

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Dealing with Scarcity of Resources in Nursing. The Scope and Limits of Individual Responsibility

Nadia Primc

Abstract

Empirical studies show that nursing staff are often unable to perform all the nursing tasks they consider necessary. The phenomenon of incompletely performed nursing tasks is a consequence of the scarcity of resources in patient care and represents a form of rationing of nursing care. Although nursing staff cannot be held responsible for the lack of resources, an approach that has considered ethical aspects is necessary for decisions regarding prioritisation and rationing, as well as for considerations regarding efficiency in nursing care for patients. The phenomenon of incompletely performed nursing care should be addressed not only in the context of nursing science and health economics, but also in the context of ethical interpretation. Within the latter context, it is also possible to define in broad terms the scope and limits of individual responsibility of nursing staff under conditions of scarcity.

1 Introduction

> It's been a long while since I was a clinical nurse juggling competing demands on a busy medical ward. Fighting down the sense of panic, with a growing realisation that what needs doing is more than I can get done. Hoping that somehow, by luck or judgement, the amount of harm caused by what I leave undone is minimal. Leaving a shift with a nagging doubt, and finding it increasingly difficult to imagine staying in nursing.[1]

Under the terms "care left undone", "unfinished care", "missed care", "unmet nursing care" and "implicit rationing of care", a particular phenomenon in professional nursing care is examined: the fact that, due to a lack of time or other resources, nurses are regularly unable to perform all the nursing tasks that are considered necessary or are unable to perform tasks to the extent intended.[2] The individual investigations vary in terms of focus. Some studies focus on the causes or consequences of incomplete care,[3] while others focus on the decision-making processes themselves.[4] The extent of incompletely performed nursing tasks is regarded as a possible indicator of the risk to patient safety, as well as an indication of the overburdening of nursing staff, which in turn is regarded as one of the causes of the shortage of nursing staff. This shortage is a phenomenon that is not only observed in Germany.[5]

[1] Ball 2017, p. 1.
[2] Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.
[3] Ball et al. 2016; Recio-Saucedo et al. 2018; Schubert et al. 2013; Zander et al. 2014; Zúñiga et al. 2015.
[4] Kalisch 2006.
[5] Ball 2017, p. 25, 66; Kutschke 2014; Papastavrou et al. 2014, p. 5, 22.

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The aforementioned studies address incompletely performed nursing care as a form of treatment error.[6] These are errors that are due to the failure to provide nursing care, rather than the incorrect provision of nursing care or provision of the incorrect nursing care. Although it is a form of undertreatment rather than overtreatment, it is a failure that can be equally dangerous for patient safety and patient well-being.[7] The empirical studies discuss incompletely performed nursing care primarily in the context of professional standards and their incomplete implementation in nursing practice.

As will be shown below, however, the phenomenon of incompletely performed nursing care is also associated with a number of ethical issues that are not adequately described by the inadequate implementation of professional standards. It is only against this background that questions of responsibility for incompletely performed nursing care can be addressed. The phenomenon of incompletely performed nursing care should be addressed not only—as has been the case to date—in the context of nursing science and health economics, but also in the context of ethical interpretation.

The following elaborates on the fundamental ethical issues associated with the phenomenon of incomplete nursing care. The first section provides an overview of those empirical findings that are of greatest importance to the ethical discussion. This is followed by a clarification of some of the terms used in the field of allocation ethics. In this context, it is also necessary to address the extent to which issues of rationing nursing care are typical of the increasing opening of the healthcare system to the principles of the market economy and are determined by the overarching structural conditions. Against this background it is possible to determine in broad terms the scope and limits of the individual responsibility of nursing staff in dealing with scarcity of resources in nursing.

2 The Phenomenon of Incompletely Performed Nursing Tasks in Empirical Research

There are now not only numerous empirical studies, but also several reviews and systematic reviews covering the nature and extent, as well as the causes and consequences of incompletely performed nursing tasks in professional nursing.[8] The following will therefore not provide any further systematic overview of the empirical findings; instead it will present those aspects that are of relevance for further ethical analysis.

The majority of existing studies were conducted in acute hospitals. A few were also conducted in the field of long-term inpatient and outpatient care.[9] Both quantitative and qualitative research methods were used.[10] Most of the studies followed a methodological approach in which nursing staff were presented with a questionnaire containing a number of nursing tasks. In this questionnaire they were asked to retrospectively assess for a defined period in

[6] Scott et al. 2019, p. 1529; Suhonen/Scott 2018, p. 549; Jones et al. 2015, p. 1122.
[7] WHO 2009, p. 16, 106, 148.
[8] Ball 2017; Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.
[9] Zúñiga et al. 2015; Tønnessen et al. 2011.
[10] Jones et al. 2015; Papastavrou et al. 2014.

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the past which nursing tasks they had been unable to perform and how often, despite having themselves identified these tasks as necessary. Questions were asked, where relevant, regarding work environment (e.g. nurse-to-patient ratio, workload, work atmosphere), effects on patient safety (negative patient outcomes such as falls, decubital ulcers, infections) and/or employee satisfaction. Some information was taken from other data sets (e.g. administrative data). Some studies have also used patient questionnaires to survey the quality of care or the extent to which nursing tasks are incompletely performed.[11]

The individual studies show great differences in form and content, e.g. with regard to the collection and evaluation methods used, as well as the contexts in which the data were collected (e.g. surgery, internal medicine, gynaecology). This variability places certain limits on the comparability of the study results. In general, the results of the individual studies suggest that incompletely performed nursing tasks have a negative impact on patient and staff satisfaction.[12] Although several studies link the level of neglected tasks to the nurse-to-patient ratio, as well as the experience and training of the nursing staff (known as the "grade and skill mix")[13], they are very different in terms of results.[14] Negative patient outcomes were also used to measure the effects of incompletely performed nursing tasks on patient well-being and safety. There was evidence of corresponding correlations between incompletely performed nursing tasks and the occurrence of nosocomial infections and urinary infections, falls, decubital ulcers and medication errors. An effect on patient mortality is also discussed.[15] The individual studies make no explicit distinction between the concept of incompletely performed nursing care and incompletely performed nursing tasks; instead the two are sometimes used as synonyms. From a systematic perspective, the relationship between the two terms can be summarised in such a way that nursing care that is considered necessary (e.g. oral and dental care) can be divided into specific individual nursing tasks. These can vary depending on the patient and his/her health requirements. Depending on the patient, oral and dental care may require cleaning the teeth and interdental spaces with a toothbrush, or cleaning the denture in the sink. Nursing care is considered to have been incompletely performed if the nursing tasks stipulated for this purpose in the expert and care standards have not been performed in full.

The extent of incompletely performed nursing tasks identified in the studies varies greatly due to factors including the aforementioned differences in the survey and evaluation methods and the survey location. Nevertheless, it is possible to identify some similarities in dealing with time and other resource constraints using the example of two studies.[16]

[11] Jones et al. 2015; Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

[12] Ball et al. 2014; Jones et al. 2015; Schubert et al. 2008; Schubert et al. 2009; Papastavrou et al. 2014; Recio-Saucedo et al. 2018; Zúñiga et al. 2015.

[13] "Grade and skill mix" refers to the specific composition of the personnel who make up the nursing team and their various levels of qualification, individual job-specific skills and specialist professional knowledge.

[14] Jones et al. 2015; Papastavrou et al. 2014; Kalisch 2006.

[15] Schubert et al. 2008; Schubert et al. 2009; Schubert et al. 2013, Papastavrou et al. 2014; Recio-Saucedo et al. 2018.

[16] Since this paper deals with the framework conditions for nursing care in Germany, studies from Germany and neighbouring Switzerland will be used as examples.

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A study[17] conducted in Germany, asked 1511 nursing professionals how many of the nursing tasks listed in a questionnaire it had been necessary for them to neglect during their most recent shift. On average, this was 4.7 out of a total of 13 nursing tasks. 92.6% of the nursing professionals surveyed stated that they had been unable to perform at least one of the tasks listed in the last shift. Among the most frequently mentioned nursing tasks were "time to give the patient attention/talk to the patient" (82%), "developing and updating nursing care plans/nursing care pathways" (54%), "counselling/instruction" (54%), and "planning nursing tasks" (43%). However, "patient monitoring" was also mentioned as a neglected nursing task in 37% of cases. In contrast, "treatments and procedures" (15%) were mentioned least frequently, followed by "pain management" (19%), "timely medication" (21%) and "regular repositioning" (22%).[18]

In a study conducted in Switzerland, Schubert and colleagues used a list of 32 nursing tasks and asked a total of 1633 nursing professionals how many of these tasks they had been unable to perform during the previous seven working days.[19] In contrast to the German study mentioned above, the Swiss study specified in each case whether these tasks were "never", "rarely", "sometimes" or "often" neglected. A total of 98% of respondents reported that they had been unable to perform at least one of the aforementioned tasks in the previous seven working days. The items "set up care plans", "assessment of newly admitted patient", "emotional and psychological support" were mentioned with frequencies of 12.3%, 11.5% and 10.6% respectively in the category of "often" neglected nursing tasks. In the "sometimes" neglected category the nursing tasks mentioned most often were "emotional and psychological support" (30.8%), "mobilization" (28%), "necessary conversation" (27.3%) and "assessment of newly admitted patient" (26.6%). The most rarely neglected tasks were "change of the bed linen" (65.2%), "necessary disinfection measures" (61.7%), "partial sponge bath" (56.2%), "change of wound dressings" (54.7%), "preparation for test and therapies" (53.3%) and "continence training (insert catheter)" (52.5%).[20]

These examples illustrate a general trend observed in the available evidence, which is that aspects of social, psychological care and counselling, as well as tasks related to nursing planning and documentation, are most often neglected when nursing professionals are unable to perform all the nursing tasks deemed necessary due to a lack of time or other resources. The least frequently neglected tasks tend to be those in the field of treatment care, measures delegated by doctors, and assisting tasks in diagnostic and therapeutic measures. The same applies to tasks that do not take up much time (e.g. changing bedding, medication) or whose duration is easier to estimate, e.g. regular repositioning, as opposed to more time-consuming measures such as mobilisation and activating care. This raises the question of whether these trends can be used to identify an informal system that has emerged in times of resource scarcity and according to which nurses decide to neglect certain nursing tasks while others are not neglected wherever possible.[21]

[17] Zander et al. 2014.
[18] Zander et al. 2014, p. 731.
[19] Schubert et al. 2013.
[20] Schubert et al. 2013, p. 235.
[21] Jones et al. 2015, p. 1131; Schubert et al. 2013, pp. 236–37; Zander et al. 2014, p. 731.

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This informal system could be seen as an attempt by nursing staff to neglect those nursing tasks that have a less direct influence on the health of patients and residents, i.e. those which are not expected to have negative effects in the immediate term (e.g. social and psychological care and counselling for patients and their relatives) but could tend to have negative effects during the later course of care, e.g. after discharge from hospital.[22] These tendencies can also be seen as an expression of increasing trend towards other occupational groups determining the tasks of nursing staff, in that nursing staff seldom neglect areas of responsibility that are based on delegation by doctors or consist of direct assistance to doctors. This determination of nursing tasks by other occupational groups leads to the fact that nursing staff neglect primarily those tasks over which they themselves can decide and which are regarded as the intrinsic tasks of nursing, i.e. social and psychological care.[23] Furthermore, this could also be a sign of a changing self-image of the nursing profession, moving away from a more holistic understanding of nursing based on denominational nursing (see Section 3) to a biomedically abbreviated, but at the same time biomedically deeper understanding of professional nursing that places the social and psychological care of patients on the periphery of their professional self-image and how their profession is viewed by the public.[24]

With regard to the available findings, it should be added that a major point of criticism is directed against the survey methods used. Almost all the studies were based on self-reporting by the nursing staff (and in some cases the patients) when collecting data on neglected nursing tasks and negative patient outcomes. In this form of retrospective survey, it is necessary to consider possible recall bias and that the concept of "necessary nursing tasks" is likely to be understood and used very differently by the individual nursing professionals (and patients). This issue of definition will be discussed later.

Due to these methodological shortcomings, the studies explicitly point out that none of the studies mentioned is, strictly speaking, capable of proving a causal relationship between neglected nursing tasks and negative patient outcomes. Nevertheless, the phenomenon of incompletely performed nursing tasks is seen as an essential component of a theoretical model that should be able to explain an aspect that has been discussed in many international studies: the connection between nurse-to-patient ratio (or "skill and grade mix") and negative patient outcomes, which can include a higher mortality rate.[25] Especially, as a correlation between incompletely performed nursing tasks and negative patient outcomes has already been demonstrated in case of a small amount of neglected nursing tasks.[26]

Irrespective of the methodological shortcomings described above, from an ethical point of view, the question arises of how nursing staff should responsibly deal with a lack of time and other resources, as well as which responsibilities are associated with the phenomenon of incompletely performed nursing tasks in the various levels of the healthcare system.

[22] Jones et al. 2015, p. 1131; Schubert et al. 2013, pp. 236–37; Zander et al. 2014, p. 731.
[23] Papastavrou et al. 2014, p. 18.
[24] Papastavrou et al. 2014, p. 23; Suhonen/Scott 2018, p. 550.
[25] Ball 2017, pp. 20–22; Recio-Saucedo et al. 2018, p. 2250; Schubert et al. 2008, p. 227; Schubert et al. 2013, p. 232; Griffiths et al. 2018; Twigg et al. 2016; Aiken et al. 2012; Schwab et al. 2012.
[26] Schubert et al. 2009.

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3 Allocation, Prioritisation, Rationing, Rationalisation and Efficiency of Healthcare Services

As previously mentioned, the literature describing the phenomenon of incompletely performed nursing care due to resource scarcity uses various terms. The term "implicit rationing of care" makes it clear that both nursing staff and doctors function as "gatekeepers" for the healthcare system and control access to healthcare services. Nursing staff carry out medical interventions delegated by doctors. As part of nursing planning, they themselves determine the need for care (e.g. in the form of nursing diagnoses) and independently initiate appropriate nursing measures. "Therefore, few care processes reach patients without first passing through the hands of nurses."[27]

Nurses are constantly busy allocating healthcare services[28], as they have to allocate the time and material resources available to them between patients and therefore decide which healthcare services should be made available to individual patients and which should not. They also have to decide when and how these services should be made available.[29] This is achieved in the form of prioritisation: nursing staff arrange their tasks according to the degree of importance and work through them one after the other. Prioritisation becomes rationing when, due to lack of time or other resources, it is no longer possible to fulfil certain tasks or only possible to fulfil them incompletely.

Although the terms "allocation", "prioritisation", "rationing" and "rationalisation" are closely related, they have different meanings. These are explained below using the example of incompletely performed nursing tasks.

Allocation

In the following, the term "allocation" is generally understood to mean the distribution of limited resources among various recipients (persons, institutions, tasks, etc.). The allocation can be performed on the basis of implicit or explicitly specified objectives or criteria.[30] For example, the German Transplantation Act explicitly stipulates that post-mortem donor organs must be distributed primarily according to the urgency and prospects of success of an organ transplant.[31] In contrast, the allocation of nursing care on wards or in the residential sector described in the previous section is based on implicit criteria, which are therefore not explicitly formulated in the form of generally binding guidelines or directives. In this case, the criteria and allocation rules are not specified above the individual relationship between nursing staff and patient, i.e. at a higher level of the healthcare system.

[27] Jones et al. 2015, p. 1122.

[28] The terms "healthcare service" and "healthcare resource" are used in the following in a comprehensive sense and include both tangible and intangible goods. The designation of a resource or service as "healthcare" means that they are designed to protect, strengthen or restore health, or to alleviate or prevent suffering or dysfunction.

[29] Scott et al. 2019; Suhonen/Scott 2018.

[30] Marckmann 2006, p. 195–196.

[31] German Transplantation Act § 12 para. 3.

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Prioritisation

According to the proposed definition presented here, the term "prioritisation" should be understood as the classification of nursing care or the recipients of nursing care according to their degree of importance, which is determined by the application of the implicit or explicit allocation criteria.[32] A frequent and ethically well-founded example of prioritisation in the healthcare system is that of prioritising patients with acute, life-threatening conditions as opposed to those with mild illnesses. In the emergency room or waiting room, for example, such patients have preference over patients who have been waiting longer (triage), as it is assumed that a longer waiting period is associated with the risk of serious health problems for these patients. This largely corresponds to the first possible interpretation of the informal prioritisation system in nursing described above, i.e. that in times of resource scarcity, nursing staff prioritise those nursing tasks for which a time delay is associated with the concrete and acute risk of serious damage to health.

The second possible interpretation of the informal prioritisation system in nursing is more questionable from an ethical point of view, i.e. that nursing staff primarily prioritise those tasks that have been delegated to them by other professional groups, especially doctors, because in this case the prioritisation is not per se based on detriment to patient health. In some cases, there may well be an overlap between these two systems of prioritisation, i.e. when tasks delegated by doctors are also those whose postponement is associated with a potential health risk. However, these overlaps are contingent and the two informal prioritisation systems must be strictly distinguished from an ethical point of view.

Rationing

The term "rationing" should only be used if patients are deprived of healthcare services that are in principle suitable for prolonging their lives or for alleviating or compensating health-related dysfunctions or preventing further health impairments.[33] Accordingly, the withholding of nursing care that is not indicated from the perspective of nursing science cannot be described as rationing of nursing services. In Germany, the guiding principles for determining the current state of nursing science are expert standards developed by the Deutsches Netzwerk für Qualitätsentwicklung in der Pflege (German Network for Quality Development in Nursing). These expert standards formulate evidence-based standards for various tasks in nursing care (decubital ulcer prophylaxis, discharge management, pain management, etc.), which serve as a benchmark for high-quality nursing care and are designed to be implemented in the individual facilities by means of nursing standards.[34]

Rationing becomes necessary when the available resources are limited and not all potential recipients can be given access to these resources. The phenomenon of incompletely performed nursing tasks is primarily a consequence of resource scarcity. For this reason, it seems that using the term "allocation" to describe the recurrent phenomenon of incompletely performed nursing care obscures the central ethical problem and that the term "rationing" is more appropriate. In such cases, patients are at least partially denied access to nursing care

[32] Marckmann 2006, pp. 193–199.
[33] Scott et al. 2019, pp. 1530–1531; Marckmann 2006, pp. 193–194.
[34] § 113a of the German Social Code (SGB) XI.

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that is in principle suitable for alleviating health-related limitations (e.g. by providing needs-based support for personal hygiene instead of the time-saving complete assumption of personal hygiene by nursing staff), or for preventing further health impairments (e.g. by adequate patient monitoring or mobilisation). This constitutes nursing support to which patients (similar to medically indicated treatments) have a legitimate prima facie ethical right, especially in a publicly financed healthcare system that is based on the aforementioned expert standards.[35] Since patients must forego nursing care in favour of other persons, justification must always be provided for such rationing. The extent to which individual patients can actually be granted an ethical right to individual nursing care must be determined as part of nursing process planning. The current state of nursing science and the standards of care prescribed in the institutions provide the external framework within which the individual support needs of patients can be determined and planned.[36]

Like allocation, rationing, i.e. healthcare limitations, can take either an explicit or implicit form. Explicit healthcare limits are set above the individual relationship between the doctor/nurse and the patient.[37] Implicit rationing, on the other hand, "is not carried out according to generally binding rules, but rather by the healthcare providers in each individual case".[38] This form of healthcare limitation is also known as "bedside rationing".[39] From an ethical point of view, the explicit and implicit forms of rationing each have different advantages and disadvantages. Explicit healthcare limitations have the decisive advantage that they improve the transparency and consistency of allocation decisions and that patients with comparable health impairments receive the same healthcare services everywhere.[40] Explicit allocation decisions can also provide positive relief for the relationship of trust between the persons providing the healthcare and the patients, since the former do not have to decide for themselves which of their patients should have access to the scarce resource and which should not; instead this decision is made at a higher level within the healthcare system.

A decisive advantage of implicit rationing from an ethical point of view, however, is that the individual health needs and personal preferences of the patients can be addressed more flexibly. This does, however, involve the risk that this may lead to unequal treatment of patients, which from the perspective of allocation ethics should be regarded as questionable and threatens to disadvantage vulnerable patient groups in particular.[41] In principle, implicit rationing has the advantage that nursing staff can react individually to an increase in workload and decide which nursing tasks to curtail or neglect.

[35] § 113a of the German Social Code (SGB) XI.

[36] This does not affect the wider ethical question of the extent to which patients should or even must be granted the right to personal attention and individual adaptation of care services to personal needs and preferences over and above the standardised care services defined in the expert and care standards. The application of expert and care standards is a minimum requirement from the point of view of the patients' needs.

[37] Marckmann 2006, pp. 195–196.

[38] Marckmann 2006, p. 196.

[39] Ubel/Goold 1997.

[40] Marckmann 2006, p. 196.

[41] Marckmann 2006, p. 198.

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Rationalisation

From an ethical point of view, rationing of healthcare services is only legitimate if all options for rationalisation, i.e. increasing efficiency, have been exhausted.[42] In principle, options for increasing efficiency exist wherever it is possible to achieve the same goal (e.g. a specific nursing goal) with fewer resources and wherever it is possible to achieve more with the same application of resources (e.g. more patients can be cared for). Measures to increase efficiency can certainly be in the interest of patient well-being, e.g. when evidence-based care is used to offer the patient the most effective nursing measure for achieving a specific nursing goal. Rationalisation should be regarded as ethically questionable if the quality of care is reduced as a result or if it is no longer possible to offer the necessary nursing measures, e.g. as a result of the nurse-to-patient ratio being too low.[43]

Whether restructuring can in practice be regarded as improving efficiency is sometimes disputed, since the assessment of efficiency is partly dependent on overriding principles and normative models. The organisational form of functional care has the advantage over holistic and patient-oriented care models that the individual nursing tasks can, under certain circumstances, also be carried out with a smaller number of carers. From the perspective of a principle of holistic care, however, functional care cannot simply be described as a more efficient form of organisation, as this means that the principle of holistic care is abandoned in favour of another higher-level care principle, i.e. functional care. Similarly, the complete assumption of personal hygiene by nursing staff cannot be described as efficient if this means that the actual nursing goal, i.e. that a patient receives instruction on regaining the partial ability to wash himself/herself, must be abandoned due to a shortage of staff and time. In this case, the nursing goal is no longer realised at all.

Accordingly, a more technical understanding of professional nursing – one that is oriented towards a narrow biomedical model that places the nature and quality of nursing care in the assumption of defined tasks of basic and treatment care, and assistance in medical tasks – would not necessarily define the aforementioned frequent neglect of social and psychological care as rationing of a nursing task that is necessary per se, or perhaps only would if it was possible to establish a causal connection to objectively ascertainable negative patient outcomes. Dealing with scarcity of resources and healthcare limitations in professional nursing in a manner that takes into account ethical aspects cannot therefore be separated from the overarching social ethical question of what normative ideal of professional nursing is targeted within a healthcare system and what individual patient needs a community based on the principle of mutual solidarity wishes to see fulfilled in nursing care.

Efficiency

When talking about rationalisation in the healthcare system, it is necessary, from an ethical point of view, to critically examine the meaning of the term “efficiency”. As will be argued according to the proposed definition presented here, the concept of efficiency can be framed in very different ways; either by focusing on saving resources or on the goals targeted. In the former case, care must be organised in such a way that the minimum number of nursing staff

[42] Scott et al. 2019.
[43] Marckmann 2006, p. 192.

are deployed and the maximum number of patients are cared for. Although it is possible to justify such an orientation towards efficiency (especially from a utilitarian point of view), there is a danger that seriously ill and high-maintenance patients in particular will be disadvantaged. In the case of a strictly timed daily routine in the ward, older and disoriented patients in particular run the risk of not receiving the support they need, especially if there are no relatives on site to make up for the lack of personal care.

In the second case, the term "efficiency" refers to the most efficient possible realisation of the specified goals, i.e. "efficiency" would be defined here primarily in terms of the nursing goals targeted. In such a case, the efficiency of care measures is determined by the actual care needs of the patients. From such a point of view, if the need for nursing support (e.g. regular walks in the hallway after orthopaedic surgery) identified by nursing staff during the course of nursing process planning cannot be met due to a lack of time or other resources,[44] this does not constitute efficient use of the "nursing resource". Instead it constitutes a failure to fulfil lege artis, the patients' right to certain nursing care services as established by nursing staff on the basis of professional standards.

4 Structural Framework and Overarching Responsibilities in Dealing with Scarcity of Resources in Nursing

Although nurses have a responsibility for how they prioritise and ration nursing tasks in direct patient care, they cannot be held equally responsible for this scarcity of resources. This scarcity of resources is determined to a far greater extent by decisions and responsibilities at higher levels of the healthcare system. Allocation decisions are made at all levels of the healthcare system and have a direct influence on allocation decisions at lower levels. Insofar as these allocation decisions at the upper levels are subject to both national differences and changes over time, it is to be expected that this will also result in differences in the understanding of what is regarded as a necessary nursing task in direct patient care and what demands must be made of nurses in dealing with resource scarcity. Using the allocation decisions at individual levels, it is possible to reconstruct the ideal of professional care within a healthcare system and how it should be ethically evaluated and implemented in direct patient care in the form of prioritisation and rationing systems.

This paper cannot provide a comprehensive systematic reconstruction; it can only provide a brief outline of the development of the structural conditions in Germany, as it is these conditions that determine the extent and handling of resource scarcity in nursing care.

The Reform of Nursing in Germany in the Post-war Period[45]

[44] Kalisch 2006, p. 307.

[45] The explanations provided in this section refer to Kreutzer (2005), which is still the authoritative work on the reform of nursing in Germany after 1945. A general overview of the developments in nursing and other healthcare professions after 1945 can be found in the anthology by Hähner-Rombach and Pfütsch (2018).

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Nursing care in German hospitals was primarily characterised by denominational care until the 1950s. The sisters sent by the motherhouse understood their activity not as a profession but as a vocation, not as work but as service.[46] The sisters were expected to devote their lives entirely to the service of denominational care, i.e. to the care of the physical and spiritual well-being of the patients. This understanding of service was linked to compulsory board and lodging, i.e. the unmarried sisters lived in the hospitals, or at least in the immediate vicinity of them, which meant that the nurses were available to care for their patients virtually around the clock.[47] Accordingly, the sisters were not paid a performance-related salary; instead they received a non-monetary compensation.[48] The high availability of the nurses made it possible to design nursing primarily as holistic care, i.e. the nurses usually worked in two shifts (day and night shift), fully caring for the patients assigned to them in each shift. The hierarchisation of nursing into basic and treatment care, which is still common in Germany today, was only established with the reform of nursing into a modern, performance-related paid profession.[49] The model of holistic care was also adopted by the so-called free, i.e. non-denominational sisterhoods that emerged at the beginning of the 20th century as an alternative to the orders.[50]

One major difference to the current situation of nursing professionals in Germany is that under the model of holistic care outlined above, periods of high workload were mainly absorbed by the sisters simply extending their shifts according to the amount of work required. Under the model of denominational care, this might also have been understood (to a certain extent) as a legitimate ethical requirement for the sisters in dealing with the scarce time resources. Nevertheless, even then, the nursing staff had to make allocation decisions on a daily basis. It was also necessary to prioritise nursing tasks according to their importance and to share them between several patients. Even rationing of nursing measures cannot be ruled out. Due to the declining attractiveness of the nursing profession, the motherhouses struggled with an increasing shortage of staff since the mid-1950s. It was therefore necessary to decide at the level of the motherhouses to which institutions the remaining sisters were to be sent, or which institutions it was necessary to abandon completely.[51] Due to the lack of staff, however, it was not possible to provide nursing care as recommended or desired even in direct patient care. Rationing was therefore necessary in this case too[52]—even if it was only that the sisters did not have the desired time for personal, "spiritual" care of the patients. Just as today, rationing in direct patient care probably primarily took the form of implicit rationing, i.e. without the use of guidelines for action that had been explicitly formulated or that took into account the relevant ethical aspects.

The anthology by Kreutzer and Nolte (2016) goes beyond Germany and the 20th century. The anthology by Kreutzer (2010) contains a contribution by Kreutzer on the radical changes that took place in nursing in Germany after 1960 and again takes up essential points made in Kreutzer (2005).

[46] Kreutzer 2005, p. 7.
[47] Kreutzer 2005, p. 18.
[48] Kreutzer 2005, p. 206.
[49] Kreutzer 2005, p. 18, 27.
[50] Kreutzer 2005, p. 8.
[51] Kreutzer 2005, pp. 22–25.
[52] Kreutzer 2005, p. 22.

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A major difference, however, is that under the concept of holistic care it was not necessary to coordinate allocation decisions equally across different areas of nursing and nursing staff. While the nurses in Germany at that time were still granted a great deal of autonomy in planning and coordinating the nursing care of their patients, the nursing care to be provided today also include nursing measures that are based on doctors' orders and delegation (e.g. wound care, administration of medication, blood pressure and blood sugar measurement, etc.). As constituent parts of "treatment care", these are still often separated from "basic care" in Germany. The reform of nursing has also created new allocation conflicts, insofar as nursing staff must decide how to divide the scarce resource of time between these two areas.[53] As seen above, one suspected consequence of the more hierarchical relationship between doctors and nurses is that in current nursing care, tasks delegated by doctors are generally prioritised to the disadvantage of nursing measures that are more heavily geared towards personal care for patients or are separate from care by a doctor.

Insofar as patients are cared for by several nurses at the same time, there is a need today for far greater coordination and communication of allocation and rationing decisions among nurses. This represents an additional challenge within patient care. The associated need for teamwork, communication and coordination is one of the factors identified by nursing staff as partly responsible for the neglect of nursing tasks.[54]

The Restructuring of the German Healthcare System since the 1990s

The reform of nursing into a modern and performance-related paid profession laid the foundation for subjecting nursing to considerations of economic efficiency to a previously unknown extent. Since the 1990s, several restructuring measures (e.g. increasing privatisation, introduction of the G-DRG system[55], creation of competitive structures) in Germany have left healthcare providers in the healthcare system increasingly exposed to cost pressure, i.e. being forced to provide care for their patients as cost-effectively as possible.[56] The opening up of patient care to the principles of the market economy was primarily intended to increase the efficiency of the healthcare system. One of the aims of this was to prevent "overcare" for patients (e.g. unnecessarily long stays, unnecessary diagnostic or therapeutic measures) and to reduce the presumed overcapacity of staff. The aim was to reduce consumption of human, material and time resources without reducing quality of care.[57] Considerations of efficiency in nursing care should not be regarded as ethically questionable, provided that efficiency is defined by nursing goals, as mentioned above. If, however, considerations of efficiency are paired with the economic interests of profit maximisation, they run the risk of becoming strategies of overall benefit maximisation, so that the patient's need for nursing care as identified in the context of nursing process planning is

[53] Zander et al. 2017, pp. 135–136.
[54] Papastavrou et al. 2014, p. 21.
[55] German diagnostic related groups. The G-DRG system is a pricing system for hospitals that uses an algorithm to determine more or less fixed prices for medical procedures and inpatient care. The algorithm is updated on an annual basis and uses different diagnostic groups to calculate the prices of inpatient care.
[56] Mohan 2019, pp. 160–165, pp. 197–209; Slotala/Bauer 2009, pp. 55–56.
[57] Slotala/Bauer 2009, p. 59.

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no longer at the forefront of staff and nursing care planning, or, as the empirical findings show, it is no longer possible to perform appropriate nursing care planning at all. Increases in efficiency should be regarded as ethically questionable if the reduction of overcare threatens to become undercare for individual patients.

In professional care, which today covers areas as diverse as hospital care, outpatient care and long-term inpatient care, there has been an increasing concentration of nursing work. Between 1990 and 2010, patients' length of stay in general hospitals fell from 14.7 to 7.3 days. In the same period, the number of hospitalisations increased from 14,080,589 to 17,485,806. According to the study, around a fifth more patients are treated in hospital in half the time than around 20 years ago. This alone has more than doubled the workload of hospital nursing staff. This does not take into account the additional burden of assuming additional tasks usually performed by doctors, instruction of service and auxiliary staff and greater bureaucratic expenditure.[58]

Not only are there more patients that need to be treated, as a result of the established German legal principle of outpatient before inpatient care, those patients on the ward and in long-term inpatient care are mainly patients with severe physical and cognitive impairments, who require increased care. From an ethical point of view, it would be necessary to adjust the nurse-to-patient ratio accordingly in order to meet the patients' need for professional nursing care. In contrast to this, the number of nursing staff has been reduced in various sectors (as was originally intended) with the result that today fewer nursing staff tend to provide care for a larger number of patients with a greater need for care.[59] It should be emphasised that in the hospital sector, the number of doctors has been continuously increased at the same time as the number of nurses has been reduced. This suggests that the reduction in nursing staff as a result of the switch to the G-DRG system is not only due to the reduction of overcapacity in the nursing sector, but also to a redistribution of financial resources within the hospital in favour of doctors.[60] If we look at the ratio of nurses to patients to be cared for (nurse-to-patient ratio), Germany occupies one of the last places in an international comparison.[61] It is assumed that this is one of the reasons for the frequent rationing of care tasks that are considered necessary.

5 Summary and Outlook

As a look at the structural conditions and the changes therein makes clear, nursing professionals cannot be held responsible for conditions of scarcity. Nevertheless, in the context of professional ethical requirements, nursing professionals must be expected to deal with scarcity of resources in a responsible manner. Dealing with scarcity of resources takes place primarily in the form of implicit rationing, which creates the risk that the criteria applied in this case may not have been specifically considered by nursing staff. Integrating the

[58] Kutschke 2014, p. 55.
[59] Kutschke 2014, p. 55.
[60] Simon 2009.
[61] Zander/Busse 2017, pp. 132–133; Aiken et al. 2012.

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consideration of allocation ethics in the rationing of nursing care into training and practice allows nursing staff to act with greater certainty in dealing with scarcity of resources. It also ensures that the patients' right to nursing care that meets their needs is dealt with as responsibly as possible.[62] The explanation of terms developed in Section 3 provides an important basis for further ethical consideration of dealing with scarcity of resources in nursing care.

Today, professional nursing care takes place in very different areas. Ethical requirements for nursing staff should be determined in each case by the specific nursing needs of the patients they care for, so that it is only possible to outline general principles for handling scarcity of resources in nursing care that are ethically informed. As seen above, the term "rationing" refers to the withholding of nursing care services that are of inherent necessity. Which nursing care services are considered necessary should ideally be determined with reference to evidence-based expert and nursing standards as part of nursing process planning. From an ethical point of view, the concept of necessity should not be interpreted in a narrow sense in this case. In a narrower sense, nursing care services would only be considered necessary if withholding them entailed the risk of acute deterioration in the health of the patients to be cared for. The concept of the indication of nursing care services, which refers to the suitability of a nursing task to achieve a specific nursing goal (e.g. independent personal hygiene), seems more appropriate in this case. Accordingly, expert and nursing standards constitute tools for making such nursing indications.

If, due to scarcity of time or other resources, it is not possible to provide all the nursing care services designated as indicated, preference should be given to those nursing tasks whose postponement is associated with the risk of serious damage to health. This largely corresponds to the first possible interpretation of the informal prioritisation system in nursing described above, i.e. that in times of resource scarcity, nursing staff prioritise those nursing tasks for which a time delay is associated with the concrete and acute risk of serious damage to health. One methodological problem in dealing with resource scarcity in nursing is that ethically informed prioritisation and rationing of nursing care require professional assessment and evaluation of nursing needs, but nursing planning is now precisely one of those tasks that, as seen above, is most frequently rationed. An approach to the scarcity of resources in nursing care that has considered ethical aspects is only possible if we are aware of the individual nursing needs and the short- and long-term effects of neglected nursing tasks on patient health.

However, even an approach to rationing decisions in patient care that has considered ethical aspects can only provide management of (rather than a solution to) the scarcity of resources, which is partly determined by the structural conditions in the higher-level areas of responsibility within the healthcare system. In response to the observed discrepancy between patients' right to nursing care and the identified scarcity of resources in direct nursing care, a series of regulations have been introduced in Germany to counteract the phenomenon of incompletely performed nursing tasks.

[62] Jones et al. 2015, p. 1134.

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The Minimum Staffing Limits for Nursing Staff Ordinance (Pflegepersonaluntergrenzen-Verordnung), for example, sets a minimum limit for the number of nursing staff (specialist nursing staff and nursing assistants) in "care-sensitive areas", such as intensive care, geriatric, cardiology and accident surgery units. This regulation came into force in Germany in January 2019. Another piece of legislation relevant to the hospital care sector is the Improved Working Conditions for Nursing Staff Act (Pflegepersonal-Stärkungsgesetz), which was passed in November 2018. One of its provisions is the separation of staff costs from the G-DRG system. In Germany, the G-DRG system regulates the remuneration of healthcare services provided in hospitals. This change in the law was the German legislature's reaction to the long-standing criticism that the G-DRGs do not adequately reflect individual nursing care needs. Nursing care provided in hospitals were previously considered to be included in the doctoral diagnosis, without taking sufficient account of the fact that the same doctoral diagnosis can be associated with very different nursing care requirements and nursing care levels depending on the patient's general condition. With regard to the field of long-term care, mention should be made of the introduction of the levels of care (Pflegegrade) concept in Germany in 2017. This, together with the concept of need for care (Pflegebedürftigkeit), outline the essential tasks of long-term care as well as the scope and limits of legitimate patient rights in Germany.

Academics in the field of nursing science and nursing professionals in the various levels of the healthcare system must be involved in the relevant allocation decisions in order to ensure adequate nursing care. The reference to the methodological shortcomings of the studies as regards the effects of the nurse-to-patient ratio and the "grade and skill mix" on patient safety must be countered by financing corresponding studies. It is not the responsibility of the patient to prove that his/her right to needs-based nursing care cannot currently be realised in an adequate manner. This creates a further obligation for nursing staff to submit to their superiors an official notification of overload (Überlastungsanzeige) if they cannot guarantee patient safety.

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