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European Nursing Traditions and Global Experiences

An Entangled History

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Abstract

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

1 Introduction

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

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

[1] Arndt/Häberlen/Reinecke 2011, p. 26; Raphael 2012.
[2] Bauernkämper 2011.

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

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

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

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

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

[3] Rafferty 2014.
[4] Nelson 2001.
[5] Budde 2006; Conrad 2007; Kaelble 1998 and 1999; Kaelble/Schriewer 2003; Osterhammel 2008; cf. also the articles in H-Soz-and-Kult-Forum on "Transnational History".
[6] Middell 2000, p. 18.
[7] Conrad/Randeria 2013; Werner/Zimmermann 2002 and 2006.
[8] Arndt/Häberlen/Reinecke 2011; Bauernkämper 2011.
[9] Oguisso/de Freitas 2015.

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

2 The History of Nursing as Entangled History

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

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

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

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

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

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

[10] Habermas 2008, p. 641.
[11] O'Brien 1997, p. 154–156.
[12] Euphrasia Pelletier, cited after O'Brien 1997, p. 159.
[13] Habermas 2008, p. 660.
[14] Coors/Grützmann/Peters 2014.

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2.1 Deaconesses as Protagonists of an Entangled History of Nursing

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

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

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

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

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[15] Habermas 2008, p. 655; Köser 2006, pp. 55–60 and pp. 86–87.
[16] Nolte 2016, p. 74.
[17] Kreutzer/Nolte 2010.

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

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

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

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

2.2 Deaconesses in the Outer Mission

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

[18] Schmuhl 2003.
[19] Dross 2008, p. 177.
[20] Kreutzer 2014, pp. 90–91.
[21] Kaminsky 2010, p. 14 and pp. 27–36.
[22] Cf. also the anthology on the transfer history of the deaconesses, Kreutzer/Nolte 2016.

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

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

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

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

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

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[23] Lissner 2005, p. 243.

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

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

[26] Lissner 2005, pp. 254–256.

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

[28] Nolte 2016, p. 205.

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

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

2.3 Working Abroad and the Communities of Deaconesses

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

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

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

[29] Schweig 2012, pp. 93–101; Sweet/Hawkins 2015, pp. 4–6.
[30] Beauchamp/Childress 2013, pp. 17–19 and Coors 2014, pp. 9–10.
[31] Hauser 2011; Köser 2006, pp. 300–302; Lissner 2005, pp. 249–252 and pp. 259–264. On the deaconesses of the Moravian Church in Jerusalem cf. Wexler 2016.
[32] This was also true for the secular nurses who were sent to the German colonies. In contrast to other migrants of the time, nurses did not follow other family members who had travelled ahead but had their own dedicated networks available because of their profession and gender. Cf. Schweig 2012, p. 14, see also: Loosen 2014, pp. 98–132.
[33] Köser 2006, p. 474.

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

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

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

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

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

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

[34] Lissner 2005, pp. 256–258 and pp. 269–271.
[35] Lissner 2005, pp. 271–273.
[36] Kaminsky 2010, pp. 47–50; Kaminsky 2016, pp. 86–87.
[37] Kaminsky 2010, p. 48; Köser 2006, p. 472.
[38] Kaminsky 2010, p. 51.

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

3 New Founding of Deaconess Motherhouses Abroad: Sweden

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

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

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

[39] Farhat-Naser 2013, pp. 52–56.
[40] Armstrong-Reid 2015.
[41] Mangion 2016; Riemann 2016 and Zerull 2010.
[42] For Denmark, see: Malchau Dietz 2013 and 2016, for Finland see: Markkola 2016, for Norway see: Martinsen 1984 and Okkenhaug 2013. In Scandinavia, the deaconess motherhouses were so successful that their example can serve to analyse a double transfer. The Scandinavian immigrant communities founded their own deaconess motherhouses in the United States. Thus, in the US there were German, Norwegian, Swedish and Danish deaconess motherhouses, cf. Malchau Dietz 2016, p. 124.
[43] Green 2011, pp. 38–39.

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

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

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

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

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

[44] Andersson 2002, pp. 65–67 and p. 71; Christiansson 2006, p. 72; Green 2011, pp. 39–40.
[45] Christiansson 2006, p. 71; Green 2011, p. 40.
[46] Christiansson 2006, pp. 71–72.
[47] Green 2011, pp. 41–48.
[48] Green 2011, p. 123 and pp. 128–138.

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

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

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

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

[49] Andersson 2002, pp. 78–102; Bohm 1972, p. 37.
[50] Bohm 1972, pp. 153–154.
[51] Weber-Reich 2003.
[52] Fritschi 1990, p. 58.
[53] Kreutzer 2005, p. 207.
[54] The "Nightingale System" allowed for two types of training: in addition to the training for practical nursing women from the upper classes could qualify for leading positions. The nursing school was supposed to be run independent of the hospital.
[55] Schweikardt 2008, pp. 76–78.
[56] Nolte 2016, pp. 30–31.

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

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

In this German context, independent self-employed nurses also adopted the denominational concepts. In principle we can say that until the 1950s there was no organisational structure apart from the sisterhood model for nurses in West Germany. Even nurses who had organised themselves into a trade union founded a sisterhood that lasted until 1968.[59] Because of the dominance of the sisterhood principle the term "Sister" – which was originally reserved for religious communities – became the general term for nurses in Germany.

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

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

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

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[57] Schultheiss 2001, pp. 85–95.
[58] Kreutzer 2005, pp. 33–34; Schmidbaur 2002.
[59] Kreutzer 2005, pp. 46–57.
[60] Emanuelsson 1990, p. 98.
[61] Bohm 1972, p. 213.

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

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

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

5 Perspectives of a European History of Nursing

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

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

[62] Markkola 2000, pp. 113–114.
[63] Schmuhl 2010, p. 162.

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

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

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

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

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