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Suicide as a Challenge in Psychiatric Nursing

Marcia Blaessle (1956-1983)
Guache over Pencil

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Editorial – Suicide as a Challenge in Psychiatric Nursing

Susanne Kreutzer and Karen Nolte

The focus of the 2023 issue is on suicide as a challenge for psychiatric nursing. The idea for the theme is based on the international conference „Suicide and its Prevention: Contemporary and Historical Perspectives in Nursing, 1880–2020“, which took place from 19-21 May 2022 in Leiden, the Netherlands, and was conceived by Cecile aan de Stegge and Manon Parry and organized in cooperation with the „European Association for the History of Nursing". We would like to thank the organizers for allowing us to incorporate the three papers in the „European Journal for Nursing History and Ethics“. The articles focus on how suicide was addressed in the context of psychiatric institutions in the 19th and 20th centuries and the challenges faced by nursing staff in dealing with suicides.

In her contribution, Eva Yampolsky shows how the academic discipline of psychiatry, which emerged in France around 1800, took up the decriminalization of suicide in order to conceptualize the tendency to commit suicide as a medical problem. Referring to the „moral treatment“ developed by Pinel, Yampolsky reconstructs the therapeutic treatment of suicides and shows the role of nursing staff. Sabine Braunschweig analyzes the treatment of suicides in a psychiatric clinic in Basel, Switzerland, in the tense relationship between psychiatry as a coercive and regulatory institution and the progressive therapeutic approaches of the early 20th century, which aimed to give patients the greatest possible freedom and were based on a trusting relationship between nurses and patients. Catharina Th. Bakker's contribution deals with the perception of suicides by their fellow patients in psychiatric clinics between 1920 and 2020. Her analyses are based on autobiographical novels in which the authors describe their personal impressions of everyday psychiatric life from the perspective of patients. Bakker thus also provides insights into how the nursing staff were perceived by patients – a perspective that has rarely been included in nursing history research to date.

The cover picture of issue 5/2023 is by the artist Marcia Blaessle (1956–1983) and was made available to us by the „Prinzhorn Collection Heidelberg” in Germany. The “Prinzhorn Collection Heidelberg” is a museum for art by people with exceptional mental experiences. Its known historical holdings include around 8,000 drawings, watercolors, paintings, sculptures, textiles and texts created by inmates of psychiatric institutions between 1840 and 1945. Marcia Blaessle took LSD for the first time at the age of sixteen, like many young people at the time. She hoped to use the psychoactive substance to reduce or even deal with her fear of others and her own auto-aggressive tendencies. Therapies and living in communes followed. She began to study philosophy at the University of Frankfurt/Main. In 1981, Blaessle went to the Poona ashram in India for six months. However, all this work on herself did not help her. At the age of twenty-seven, she took her own life in a parachute jump. Her drawings, watercolors and paintings, created in the early 1970s and early 1980s, provide insight into the intrinsic laws of intoxicated perception and altered states of consciousness, ranging from visionary to

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hallucinatory. They reflect the dreams and longings, worries and fears of their creator, who often portrays herself. Marcia Blaessle's work was donated to the „Prinzhorn Collection Heidelberg" by her mother in 2002.

We would like to thank Thomas Röske, director of the Prinzhorn Collection Heidelberg, for his permission to use Blaessle's artwork as the cover picture and for the accompanying text.

We are pleased to present an article on object history, two Lost & Found papers and a forum contribution in the open section of this issue. Mienecke te Hennepe deals with objects that are commonly perceived as medical objects, but which first passed through the expert hands of nursing staff before being used by doctors – in this sense, te Hennepe takes a new nursing-historical perspective on surgical instruments, which she analyzes as „boundary objects" between nursing and medicine. Iris van Versendaal and Hugo Schalkwijk focus on unusual finds from the museum collection of the Florence Nightingale Institute, namely objects that are closely entwined with protest actions by nurses in the Netherlands in the early 20th century and the 1970s, 1980s and 1990s. Buttons, medals, song lyrics, gray literature and photographs are taken as the starting point for a history of nursing activism. Pierre Pfütsch presents a newly acquired collection from the Robert Bosch Foundation's Institute for the History of Medicine in Stuttgart, Germany, namely that of nursing expert and critic Claus Fussek. It is an extensive collection of folders filled to the brim with around 50,000 letters from private individuals reporting on grievances, acts of violence and problems in German nursing homes from the 1990s to 2021. Finally, Christoph Schwamm presents the state of research and research questions on the history of pediatric nursing in Germany.

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Nurses and the Moral Treatment of Suicidal Patients in 19th-Century France

Eva Yampolsky

Abstract

With the decriminalization of suicide and its reconceptualization as a psychiatric problem in 19th-century France, nurses were recognized as playing an important role in its prevention and treatment. Focusing primarily on 19th-century psychiatric studies on suicide and on psychiatric nursing staff, the objective of this article is twofold: 1) to examine early treatment and prevention methods in the emerging medical branch of psychiatry; and 2) to situate the role of nursing staff in early 19th-century French asylums in implementing these methods. More specifically, I will focus on the nurses' crucial role in the moral treatment of suicidal patients and the application of the non-restraint method, as it was developed by Philippe Pinel (1745–1826) in France and John Conolly (1794–1866) in England. I will argue that these non-coercive reforms in the treatment of psychiatric and suicidal patients contributed to discussions among alienists about the model profile of a nurse and to the progressive development of the nursing profession (before its official recognition as such and the establishment of formal training programs at the end of the 19th century in France).

Keywords: Nursing, suicide prevention, psychiatry, moral treatment

1 Introduction

The decriminalization of suicide in France in 1791 and its reconceptualization as a psychiatric problem occurred at the same time that new approaches were being developed to treat mental illness. Shifting, at least in part, from coercive measures to the "moral treatment" of the insane, the new medical branch of psychiatry (*médecine mentale*) took on the vast project not only of redefining mental illness as a treatable disease,[1] but also of devising new therapeutic methods and of reconceptualizing the asylum itself as a medical institution. This same period saw the rise of public health, with the establishment of committees and specialized publications dedicated, among other things, to improving living conditions and preventing social and moral causes of mental distress and illness. Within this context, nursing staff were seen as playing an increasingly important role in caring for mentally ill patients and in preventing destructive behaviours such as suicide attempts. The identity and roles of nurses became points of reflexion and redefinition in numerous early 19th-century texts, specifically those written by alienists.

Focusing primarily on 19th-century psychiatric studies on suicide and on psychiatric nursing staff, the objective of this article is twofold: 1) to examine early treatment and prevention methods in the emerging medical branch of psychiatry; and 2) to situate the role of nursing staff in early 19th-century French asylums in implementing these methods. More specifically, I will focus on the nurses' crucial role in the moral treatment of suicidal patients and the application of the non-restraint method, as it was developed by the alienists Philippe Pinel (1745–1826) in France and John Conolly (1794–1866) in England. I will argue that these non-coercive reforms in the treatment of psychiatric and suicidal patients contributed significantly to the

[1] Swain 1994, p. 86.

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discussions among physicians about the model profile of a nurse and to the progressive development of the nursing profession (before its official recognition as such and the establishment of formal training programs at the end of the 19th century in France).[2]

This article deals specifically with this earlier period of the 19th century in France, which saw the emergence of a secular precursor of the nursing profession. In contrast to the vibrant editorial work conducted by nurses themselves toward the end of the century, due in part to professionalization objectives, most sources addressing the role of psychiatric hospital personnel during the first half of the century were written by alienists. As several researchers have remarked, psychiatric nursing has not been explored sufficiently from the historical perspective,[3] though numerous recent studies have focused and worked extensively on this subject.[4] Several recent studies in the history of nursing have explored the attempts to professionalize nursing practice during the 18th century in France, which centred on the calls for formal training for the *garde-malades* and the publication of *garde-malade* manuals.[5]

These developments at the end of the 18th century resulted in both a secular shift among the earlier nursing figures, and a progressive differentiation from domestic workers. Studies on these early 19th-century figures have yet to be explored in depth from the perspective of this personnel,[6] especially in the French context, so there is a need for future archival research.[7] Nonetheless, the rich medical literature from this period on suicide as a pathology, written from the perspective of physicians, can shed light on their conception of the "ideal" identity of nurses, as a model of healthy moral behaviour and character, capable of restoring balance in the psyche of insane patients.[8]

2 19th-Century Psychiatric Theories on Suicide

Decriminalized in France in 1791, suicide became a major issue of debate among alienists and other physicians. This debate resulted in numerous medical treatises, doctoral dissertations, journal articles and medical dictionary entries on suicide, examining its causes, symptoms, its relation to mental illness, as well as possible methods of prevention and treatment.[9] Placed firmly within the parameters of psychopathology, suicidality called for a medical and public health approach. In this context, *moral treatment*, as it was theorized and put into practice by the French alienist Philippe Pinel, became the primary therapeutic approach to suicidal behaviour. Rejecting the harsh, punitive methods of the past, this approach focused on consolation, gentleness, kindness, but also on firm moral authority. It is directed not only toward the body, but also the mind, or *le moral* in French. While this term was distinguished from morality,

2 On the role of qualified nurses on the implementation of therapeutic reforms, see Ledebur 2015.
3 Hähner-Rombach/Nolte 2017 b, pp. 7–8.
4 Boschma 2003; Hähner-Rombach/Nolte 2017 a; Braunschweig 2013; Klein 2018; Thifault/Desmeules 2012; Thifault 2010; Thifault 2011.
5 Coquillard 2019. For the 18th and 19th-century Swiss context, see Francillon 2000.
6 For the Swiss context, see Braunschweig 2013.
7 We could nonetheless cite several important studies on the collaboration between Pinel and Pussin: Weiner 1979; Caire 1993; Weiner 1994.
8 It is indeed a question of an ideal from the perspective of the physicians, namely of those who recruited and retained nursing staff. See Sabine Braunschweig's (2017) interesting research on the consequences, faced by some nurses, of deviating from these expectations.
9 Yampolsky 2019.

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or *la morale*, its use in this context maintained nonetheless a certain level of ambiguity, in French and especially so in English.[10]

For Pinel, the moral treatment of mentally ill and suicidal patients was inseparable from the parameters of the asylum as a "therapeutic" apparatus that took charge of all aspects of a patient's life.[11] For Jean-Etienne-Dominique Esquirol (1772–1840), one of Pinel's main disciples, the psychiatric hospital constituted "the most powerful therapeutic agent against mental illness"[12] or, in the words of the surgeon Jacques Tenon, a "healing machine".[13] The psychiatric hospital was thereafter considered as a society within society, with its own structure, hierarchy, codes, occupations and activities. For suicidal patients, the hospital became a place of protection and prevention, designed for effective surveillance, the minimization of risk and temporary isolation.[14]

Even though suicide as a social problem had fallen under increasing medical scrutiny since the 17th century, whereby medical expertise could allow suicide victims and their families to avoid harsh legal punishment,[15] it did not become a truly medical issue until the beginning of the 19th century. Medicine, and psychiatry in particular, became the primary authorities on suicide. However, a close examination of medical theories on suicide throughout the century shows that the alienists' position on the causes, treatment and prevention, and even on the pathology of suicide, was not monolithic. The earliest period in the medicalization of suicide concerns the first alienists, such as Pinel, but also French physicians Jean Chevrey, Pierre Py and François-Emmanuel Fodéré (1764–1835). While the publications by Chevrey and Py are important in that they focus exclusively, for the first time in French medical history, on suicide as a psychiatric problem,[16] the works of Pinel and Fodéré are particularly significant here for their specific interest in the therapeutic process and the role of nurses (*surveillants* or *garde-malades*) in the treatment of suicidal patients. Unlike subsequent generations of alienists, for Pinel, suicide constituted an act of insanity only "in the rarest of cases".[17] Despite this, according to Pinel, only physicians had the necessary knowledge and diagnostic skills to distinguish pathological suicide from non-pathological suicide:

> Of all the threats of suicide, the Physician must develop ways to distinguish those that can be produced by a state of despair, or by an exaggerated imagination, from

[10] Charland 2008. This ambiguity is particularly evident in the anglophone context, where the term "moral" does not have a double meaning, as it does in French of referring to mental functions (le moral) and to morality (la morale). This has led to certain misinterpretations, or at least an excessive insistence on morality, when referring to French uses of the term in the adjective form. For instance, the English translation of Pierre-Jean-Georges Cabanis's famous work on the reciprocal influence of "the moral" (le moral) and "the physical", interprets the dichotomy between "l'homme moral" and "l'homme physique", as "the ethical man" and "the physical man". Cabanis 1981, pp. 7–8.

[11] Postel 1981, p. 192.

[12] Esquirol 1838 b, p. 398. This and all subsequent quotes in French have been translated into English by the author.

[13] See Foucault/Barret Kriegel/Thalamy/Béguin/Fortier 1976. For the German context, see Bueltzingsloewen 1997.

[14] Falret 1822, p. 242; Esquirol 1838 c, p. 659. See York 2009, pp. 231–233.

[15] MacDonald 1992; Lederer 2006.

[16] Py 1815; Chevrey 1816. On the medical treatment of suicide during this period, see Giraud 2000.

[17] Pinel 1791.

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> those that are independent of it, and which concern a particular state of illness, for these are the only cases that concern medicine and that can require methodical treatment.[18]

The ability to distinguish between these two types of suicide depended on acute observation and a close rapport with the patient. Upon identifying psychopathological suicide, the alienist then had to work closely with the nurse (*surveillant*) to prevent self-harm and to guarantee constant watching of the insane and suicidal patient.

The close collaboration between Pinel and the *surveillant* Jean-Baptiste Pussin in the Bicêtre and Salpêtrière asylums, in Paris, inaugurated a new approach to treating mental illness, but also a new relationship between physicians and non-medical personnel.[19] Despite the juridical connotations of the title *surveillant*, or guard, Pussin played an important role in redefining the possibility of a moral therapeutic approach to treating mental illness. Opposing violent mistreatment of the insane, Pinel and Pussin experimented with new, more humane therapeutic methods.[20] As a non-professional figure, and often lacking formal education during this early period of psychiatry, the nurse or the *surveillant* was fundamental in this new relationship between the insane patient and the healthcare professional.[21] Moral treatment consisted here not only of attentiveness, kindness, consolation, and thus of a dialogue with the insane, but also of a theatrical relationship. Indeed, theatricality between the nurse or the physician and the patient was one of the frequent therapeutic strategies employed by Pinel and Pussin, by which the nurse engaged with the patient's delusion in order to counteract it with reason. In his *Traité médico-philosophique* (1800), Pinel emphasized the fundamental role played by Pussin in the moral treatment of his patients:

> A young man, shaken by the upheaval of Catholic practice in France and dominated by religious prejudice, becomes maniacal, and following typical treatment at the Hôtel-Dieu, he is transferred to Bicêtre. Nothing comes close to his sombre misanthropy; he speaks only of the torments of the next life, and he thinks that in order to avoid it, he must imitate the abstinence and macerations of ancient anchorites; since then, he refuses all food and around the fourth day of this unshakable decision, his state of languor makes one scared for his life; friendly criticism, insistent invitations, all in vain [...]. Could the course of his sinister ideas be destroyed or counterbalanced other than by the impression of strong and profound fear? It is with this in mind that, in the evening, citizen Pussin comes to the door of his cell with a device capable of instilling fear, with fire in his eyes, a threatening tone of voice, a group of hospital personnel surrounding him closely and armed with heavy chains that they shake loudly; some soup is given to the insane patient and a strict order is given to him to eat it during the night, if he does not want to face the cruellest of treatments; everyone disperses and he is left in the most painful state of indecision, between the idea of punishment that he has been threatened with and the terrifying possibility of torment in the next life. After several

[18] Pinel [1791] 1981, p. 205.
[19] Jaeger 2016 a.
[20] Swain 1976; Postel 1979; Postel 1981, pp. 33–71; Juchet/Postel 1996.
[21] Swain 1994.

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> hours of internal combat, the first idea prevails, and he decides to eat his food. He is then placed on a regimen capable of healing him; he gradually recovers his sleep and his force, as well as the use of his reason, thus avoiding certain death.[22]

The use of chains to control the insane was replaced here by the simple threat of punishment. Despite the myth of Pinel – and Pussin – freeing the insane from their chains,[23] coercive measures continued to be used in asylums and were defended for their therapeutic value. While the case quoted above does not deal specifically with the treatment of suicidal patients, it nonetheless sheds light on the coercive strategy of moral treatment, which was also applied in cases of suicidal behaviour. Indeed, other methods of punishment were in regular use, to the point of blurring the line between treatment and punishment. As an example, we can consider the French alienist François Leuret's (1797–1851) defence of threats of punishment as a "strategy" or a form of moral psychiatric treatment, namely through the use of showers and baths in the treatment of insanity, including suicidal behaviour.[24] As he himself noted in a text on this method, treatment and punishment were sometimes considered as synonyms in dealing with the insane.[25]

In the context of treating suicidal patients, however, constant watching was the task most frequently named by alienists. This kind of surveillance involved not only passively watching for signs of self-harm to prevent suicidal behaviour, but also active close observation and consequently the ability to morally discipline suicidal and other insane patients.[26] If the threat of suicide called for close watching and observation, the methods by which such watching was conducted – primarily by nurses – became a question of interest for physicians.

3 Defining a Model Nurse

Within this setting, nurses – referred to in French as *gardiens*, *garde-malades*, *surveillants* or *infirmiers*[27] – played a crucial role in the moral and physical treatment of insane and suicidal patients. Moral treatment, as it was theorized by Pinel and further developed by later generations of alienists, placed emphasis on the relationship between healthcare professionals (physicians and nurses) and patients. This therapeutic turn also marked a shift in the nursing role played by the clergy, and by nuns in particular.[28] Indeed, the secularization of society following the French Revolution created a professional conflict in the hospital, and particularly in insane asylums, whereby the centuries-long religious authority in the treatment of insanity gave way to a new group of medical personnel, the alienists, who considered their religious counterparts as rivals lacking competence and knowledge of mental medicine.[29] Despite their profoundly religious and moral implications, consolation, moral education and authority had to be guaranteed by secular medical professionals, with nurses playing a particularly im-

22 Pinel 1798, pp. 224–225.
23 On the construction of this myth of liberation, see Swain 1976; Postel 1979; Postel 1981; Juchet/Postel 1996.
24 Leuret 1839.
25 Leuret 1839, p. 275.
26 Indeed, Michel Foucault's Surveiller et punir (1975) is translated into English as Discipline and punish.
27 Jaeger 2017, pp. 105–108.
28 Dinet-Lecomte 2005; Guillemain 2006; Guillemain 2012.
29 Goldstein 1987.

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portant role. However, at the end of the 18th century and the beginning of the 19th century, alienists and physicians in general were not only suspicious of religious medical personnel, but also of the *garde-malades*. While recognizing the importance of their functions in the treatment of patients, as Isabelle Coquillard shows, many physicians resisted the adoption and generalization of their formal training.[30] Despite this reticence on the part of physicians at the turn of the 18th century, manuals focusing specifically on the *garde-malades* encountered significant success in the medical sphere, with numerous translations and new editions.[31]

One of the earliest 19th-century nursing manuals was published by the French physician, alienist and forensic scientist François-Emmanuel Fodéré, entitled *Manuel du garde-malade*.[32] The objective of this manual was to detail the tasks a nurse was expected to undertake, namely care and observation. It also described the profile and the behaviour of a nurse, such as ways of protecting oneself against contagious diseases. As the prefect of the Bas-Rhin Department Lezay-Marnésia stated in his letter commissioning the publication of this manual, a good nurse

> can be considered as the physician's lieutenant; he is the physician's eye in his absence [...], the reputation of the physician and the life of the patient are no less in the hands of the nurse [garde-malade] as they are in those of the physician himself.[33]

Fodéré's manual begins by stating that the first guards, or nurses, of the sick, were not professional nurses but family members, who had three specific obligations in caring for their relative: choosing the best physician or surgeon, providing spiritual care and dealing with matters concerning the patient's testament. He then described the qualities that are expected of a good nurse.[34] These qualities include personal hygiene and health, good moral behaviour, respect for the physician's authority, and the ability to obtain patients' respect. A good nurse had to be sober, vigilant, compassionate, discrete, economical, intelligent, but also capable of attentive observation. A nurse also had to be capable of gaining the patient's trust and always had to use kindness and persuasion. Finally, while men are physically stronger, Fodéré considered women to be more appropriate for this profession, namely for their gentleness, patience, vibrancy, and skills in taking care of the sick.

Even though Fodéré published numerous treatises on the treatment of insanity, with a particular interest in suicide,[35] he deliberately avoided the subject of psychiatric nurses in this man-

30 Coquillard 2019. Some of the earlier attempts to impose formal training for the garde-malades were led by French physicians Edme-Claude Bourru during the late 1770s and Joseph-Barthélémy Carrère in the 1780s.

31 This is the case with Joseph-François-Barthélémy Carrère's manual, entitled Manuel pour le service des maladies ou précis des connaissances nécessaires aux personnes chargées du soins des malades, femmes en couche, enfants nouveau-nés (1786), and François-Emmanuel Fodéré's Manuel du garde-malade (1815), to name only a few.

32 Fodéré 1815.

33 Fodéré 1815, p. 10.

34 Fodéré 1815, p. 25–28.

35 Fodéré was one of the first alienists to establish a direct and consistent link between suicide and insanity, which he explored in four of his major treatises, published between 1798 and 1832: Fodéré 1798, 1813, 1817, 1832. On Fodéré's works on suicide, see Yampolsky 2018.

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ual, a profession that, as he stated in a footnote, required particular talent and qualities.[36] He reserved this subject for his *Traité du délire* (1817).[37] According to him, a psychiatric nurse needed to have a strong and well-proportioned body, a voice that could have a threatening tone if necessary; in addition, he or she needed to have integrity, pure morals, be capable of being firm as well as kind and persuasive, but also to be used to living with the sick, and finally to have absolute docility with regard to the physician's orders.[38] A psychiatric nurse also needed to be able to discern bizarre aspects of insane patients' ideas, to speak with them when they were sombre, to listen to their complaints and to encourage them to eat. In sum, for Fodéré, the role of a psychiatric nurse encompassed all aspects of a patient's everyday life, physical, psychological and moral. We find similar all-encompassing model profiles of nurses in subsequent nursing manuals throughout the 19th century.

Fodéré rejected all measures of repression, which in his view only aggravated the patient's mental state, echoing Pinel's moral treatment and foreshadowing Conolly's non-restraint method. While recognizing the difficulty of finding good nurses for an ordinary hospital, Fodéré insisted that psychiatric nurses were all the more difficult to recruit, namely due to the specificity of this type of specialization. Apart from the general criteria that constituted a good nurse, the treatment of the insane required these nurses to also have a "certain level of wisdom".[39] Despite these ambitious criteria, several studies in the history of nursing have shown that psychiatric nurses were often recruited from among past patients; others lacked formal education, and most faced harsh living and working conditions.[40] Indeed, at least throughout the first half of the 19th century, the status of the psychiatric nurse overlapped with that of a guard or a keeper, situated thus between care and discipline. The *Dictionnaire des sciences médicales*, published by Panckoucke, made an attempt to elaborate distinct definitions of "*garde-malade*" (1816)[41] and "*infirmier*" (1818)[42], nonetheless the two overlap in many ways and refer to one another. A more precise distinction between *surveillant*, *infirmier* (nurse) and *gardien* (keeper) was elaborated in 1839, by a royal ordinance, whereby a psychiatric nurse's duties were to take care of the insane, while those of the keeper concerned not only their care, but also their observation and protection.[43]

4 The Limits of Suicide Prevention in Asylums

The treatment and prevention of suicide concern only a brief and final part of these publications, with the majority of each text focusing more on its definition, causes and symptoms. The relatively minor attention paid to the therapeutic and preventive strategies is all the more surprising when one considers that, from the 1820s until at least the 1840s, suicide was de-

36 Fodéré 1815, p. 110.
37 Fodéré 1817.
38 Fodéré 1817, p. 237.
39 Fodéré 1817, p. 243.
40 Jaeger 2017; Cialdella 2022.
41 Marc 1816.
42 Percy/Laurent 1818. While longer in length than the article on "garde-malade", this definition of an "infirmier" focuses almost exclusively on the military context and the role of soldier-nurses. Neither article, however, is followed by a bibliography of scientific studies on these two subjects, in contrast to the lengthy bibliographies in most other entries of this 58-volume medical dictionary.
43 Bouchet 1844. See Jaeger 2016 b.

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fined by alienists as almost always being a symptom of mental illness. Among these alienists taking an absolute stance on the psychopathology of suicide were Esquirol, according to whom suicide was "almost always a symptom of insanity", and Jean-Pierre Falret (1794–1870), who published the first full-length psychiatric treatise on this subject.[44] If suicide was not a disease *sui generis* but a symptom, as Esquirol affirmed,[45] treatment then had to focus on the disease itself. In this case, suicide prevention in the asylum was limited to observation, protection and feeding, in the event of a patient refusing to eat, whereas psychiatric diseases, of which suicide was a symptom, required a more global approach to treatment.

The most common "treatments" of suicidal behaviour included hydrotherapy, plant-based medications and emetics, all of which had to be accompanied by moral treatment. In fact, therapeutic methods such as hydrotherapy and various types of evacuation were considered by alienists not simply as somatic and purifying treatments, as was the case in previous centuries, but also and more importantly as being part of moral treatment. They provided a shock to the body and consequently to the mind,[46] or what Leuret, and Esquirol before him, called "disruptive medicine" (*la médecine perturbatrice*)[47]. Despite these various therapeutic approaches, according to Esquirol, no single cure existed for this symptom.[48] Alienists focused more of their theoretical reflection on suicide prevention beyond the hospital setting, approaching it from a public health perspective. Within the asylum specifically, nurses played an important role in preventing suicide attempts, especially among patients suffering from mental illnesses most prone to suicide, such as melancholy, lypemania and monomania. As Geertje Boschma shows, suicides in asylums were not always easy to prevent and the legal responsibility often fell on nurses, whose duty it was to watch such patients closely and to prevent access to dangerous objects.[49]

While these earlier studies allowed alienists to place suicidal behaviour firmly within the parameters of their expertise, new considerations on suicide emerged during the 1840s, with alienists such as Pierre-Égiste Lisle (1816–1881), Gustave Étoc-Demazy (1806–1893) and Alexandre Brierre de Boismont (1797–1881). These alienists engaged in lively debates in the *Annales Médico-Psychologiques* and the question of suicide was proposed as a theme for a medical prize, resulting in twenty-one studies submitted in 1846 and 1848 for the Civrieux Prize, awarded by the Medical Academy in Paris. This new generation of alienists questioned the exclusive stance of their predecessors on the psychopathology of suicide, founding this new position on moral statistics and the consideration of the social, moral and environmental factors of suicide.[50] Indeed, these alienists accepted the existence of non-pathological suicide, which in their view required preventive public health measures concerning morality, education, religious practices and social welfare. While these measures did not concern the hospital context directly, this new understanding of suicide placed further emphasis on the moral treatment of suicidal and insane patients, through the relative isolation of patients from their

44 Esquirol 1838 c, p. 576; see also Falret 1822.

45 "C'est pour avoir fait du suicide une maladie sui generis, qu'on a établi des propositions généralement démenties par l'expérience", Esquirol 1838 c, p. 528.

46 Guislain 1826, p. 7; Rech 1846. On the excesses and abuse of baths and showers, see Fauvel 2007.

47 Esquirol 1838 a, pp. 132–133; Leuret 1840, p. 96.

48 Esquirol 1838 c, p. 658.

49 Boschma 2003, pp. 133–135.

50 Brancaccio/Lederer 2018.

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normal social environment, work and other activities, or what would later be considered as "occupational therapy",[51] with nurses playing a fundamental role.

5 The Non-Restraint Method

At the same time that alienists were questioning the pathology of suicide, another debate was taking place among French alienists, relating to *non-restraint* in the treatment of the insane, which gave rise to an increasingly important role of nurses. Strongly defended and popularized by the English alienist John Conolly during his direction of the Hanwell Asylum, from 1839 to 1852, the asylum policy of non-restraint rejected all forms of physical and mechanical repressive measures, favouring instead a form of moral treatment that focused on distractions, leisurely activities, and moral education.[52] In other words, this approach not only eliminated restrictive and coercive measures, continuing the therapeutic project initiated by Philippe Pinel several decades earlier, but also aimed to improve the living conditions of patients. More focus was placed on the asylum itself as a therapeutic setting and on the relational aspects of care by nurses in their day-to-day contact with insane and suicidal patients,[53] and thus on the social and environmental influences on mental health.[54] As Marcel Jaeger shows, the suppression of mechanical restraints called for a reconsideration of nursing as a profession, requiring a larger number of nurses and new interpersonal techniques in caring for mentally ill patients.[55]

Non-restraint became an object of debate among French alienists, starting with Brierre de Boismont's article, published in 1844 in the *Annales Médico-Psychologiques,*[56] and continuing to the end of the century. This debate came in two stages. The first questioned the efficacy of using no mechanical restraints, including the straitjacket, and the second one, during the latter half of the century, placed more emphasis on the improvement of the therapeutic conditions of the asylum to such an extent as to make mechanical restraints irrelevant and unnecessary. While recognizing the benefits of moral treatment, Brierre de Boismont was critical of Conolly's approach of non-restraint, specifically of its ability to prevent violent and self-destructive behaviour. Indeed, suicidal behaviour became the measure of the effectiveness of non-restraint, often cited by alienists as the exception whereby restraints could be warranted. If surveillance and persuasion were to be the main duties in caring for the insane, according to Brierre de Boismont, even the most rigorous surveillance "[could not] always prevent suicide attempts".[57] Some critics pointed to a certain hypocrisy of the non-restraint policy, by which mechanical restraints were replaced by nurses themselves, who had to use physical force to restrain agitated and violent patients.[58] This criticism was addressed in the second stage of the French psychiatric debate on non-restraint, which focused less on mechanical restraints, and more on the therapeutic conditions of the asylum. The stakes of this second

[51] Thifault/Desmeules 2012.
[52] Dubois 2017.
[53] Jaeger 2017.
[54] Scull 1989, esp. chapter 7 ("John Conolly: A Victorian Psychiatric Career").
[55] Jaeger 2017.
[56] Brierre de Boismont 1844, pp. 111–115.
[57] Brierre de Boismont 1844, p. 114.
[58] Renaudin 1853, pp. 497–498.

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phase of the debate had much more important repercussions, not only on the management of the asylum, but also on the qualifications and role of psychiatric nurses.

One of the strongest defenders of non-restraint was the French alienist Bénédict-Augustin Morel (1809–1873), who published an influential report, in 1860, in favour of this method.[59] Following his observations of several English asylums, Morel presented this principle in detail and attempted to dispel some of the misunderstandings and criticisms expressed by his French colleagues. In fact, during his 22-day trip to England in 1858, he visited not only asylums, but also prisons and other institutions for individuals suffering from physical or cognitive ailments, in order to acquire a better understanding of the "moralizing system of the English".[60] For Morel, this English model of "moralizing the human species" represented a grand anthropological project that was in line with his own theories on heredity and degeneration.[61] Following a description of English asylums, Morel paid close attention not only to the intellectual and moral superiority of nurses in England, in contrast to the French context, but also to their working conditions, namely their significantly higher wages.[62]

Drawing on his own observations of the non-restraint model at the Earlswood Asylum, French physician Eugène Billod (1818–1886) came to a similar conclusion, according to which the respectable and professional status of English nurses had beneficial effects on insane patients.[63] Asylum conditions and the qualifications of personnel, namely of nurses, were therefore at the heart of the non-restraint method. Referring directly to Conolly, Morel underscored the importance of first improving asylum conditions before applying such a method. In this sense, non-restraint was less a question of not using straitjackets and other coercive measures, than of improving the architectural, therapeutic, and interpersonal conditions of asylums. This was the main conclusion put forward by Billod, as well as by Louis-Jean-François Delasiauve (1804–1893) in his review of Morel's report:

> In my opinion, the success [of non-restraint] depends not on the more or less absolute abandonment of certain coercive measures, which in some cases can be useful, but on all the influences affecting the physical and moral aspects of the insane. In reality, non-restraint is nothing other than the increasingly rational improvement of the environment in which these unfortunate individuals reside.[64]

Billod came to the same conclusion: non-restraint consisted first and foremost in organizing asylums in such a way that the recourse to coercive measures became unnecessary.[65] Once the asylum and surveillance were perfected, the straitjacket would become secondary. John Conolly himself underscored the importance of selecting qualified nurses, or attendants, in order for the non-restraint system to succeed:

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59 Morel 1860.
60 Morel 1860, p. 12. On the use of mechanical restraints for suicide prevention in 19th-century prisons and their counterproductive effects, see Guignard 2014 and Guignard 2018.
61 Morel 1857. On Morel and his theory of degeneration, see Dowbiggin 1985 and 1991; Coffin 1994.
62 Morel 1860, p. 28.
63 Billod 1861, p. 420.
64 Delasiauve 1861, p. 111.
65 Billod 1861, p. 409.

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> The physician who justly understands the non-restraint system well knows that the attendants are his most essential instruments; that all his plans, all his care, all his personal labour, must be counteracted, if he has not attendants who will observe his rules, when he is not in the wards, as conscientiously as when he is present.[66]

While considering attendants as being *essential* in the asylum, Conolly nonetheless viewed them as *instruments* of the physician, subordinate to his rules and authority. It was not enough for attendants, or "helpers", to accomplish duties; they needed to serve as a model of moral character for the patients:

> Many of the insane take their character from the attendant under whom they are placed; so that under one they become morose, sullen, and dangerous; under another tranquil and docile. The physician requires the agency of cheerful helpers, healthy and contented, of natural good disposition, and possessed of good sense. His government of them should be such as to preserve their cheerfulness, and health, and contentment. They are his instruments, and he should keep them finely tempered. They may often be considered, indeed, his best medicines; and they should be well chosen and well preserved.[67]

We witness here an objectification of attendants, or nurses, by Conolly, as instruments, or machines, that could be "finely tempered" or tuned to the needs of the physician. They were his moral and behavioural "medicines" that he administered to the patients, and who had to be recruited, or "chosen", and treated, or "preserved", in accordance with his needs. This was clearly far from the agency that nurses themselves would defend several decades later. In contrast to the close collaboration and friendship between Pinel and Pussin, the hospital staff were described here as parts of the "healing machine". In the case of suicidal patients, vigilance and constant watching by nurses were supplanted by this projection of character, by which the nurse counteracted their melancholy and suicidal thoughts with joyfulness and comfort. In this sense, the expected moral character of nurses for the success of the non-restraint model set the stage for the development of the relational aspects of care, as they would be developed later in the century.

While certain French alienists remained suspicious of the effectiveness of Conolly's method, seeing it as a simple suppression of the straitjacket, they recognized nonetheless its heritage in the reforms enacted by Pinel several decades earlier. The controversy seems to lie partly in national competition between France and England, but also in the recognized difficulty of treating several types of psychopathology with this method. Suicide was one of the mentioned pathologies, for which vigilance and persuasion as the main tenets of the non-restraint method were deemed insufficient. This was the opinion expressed by Auguste-Stanislas Bécoulet in a long article published in 1882,[68] which cited several cases in which recourse to the straitjacket was the only means possible to prevent a patient's suicide attempt. In these cases, however, English alienists such as Hack Tuke (1827–1895) and Conolly, as well as Morel and Valentin Magnan (1835–1916) in France, perceived the isolation of suicidal and other violent

66 Conolly 1856.
67 Conolly 1856, p. 99.
68 Bécoulet 1882.

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patients in padded cells as a better temporary alternative, especially for patients for whom moral treatment by qualified nurses did not suffice.[69]

Despite these therapeutic developments and debates on the best way to treat suicidal and mentally ill patients, suicide prevention in the asylum posed a challenge for alienists and nurses. Morel himself, a strong defender of the Conolly method, questioned whether suicide constituted an exception in the rejection of mechanical restraints, concluding nonetheless that such coercive measures only aggravated the mental state of suicidal patients and were thus counterproductive in *healing* suicidal behaviour.[70]

6 Conclusion

The reforms in the treatment of mentally ill and suicidal patients, namely the shift to moral treatment and the non-restraint method, had significant effects on the professional role of nurses in the care for insane and suicidal patients. Firstly, they placed more focus than ever on the relational qualifications of psychiatric nurses for this moral treatment to be effective. Nurses were recognized as central figures in the day-to-day care of patients, who had to fulfil specific criteria, not only relating to their technical skills but also to their character and behaviour. Several alienists noted the importance of improving nurses' working conditions, their salary, and their recognition among the hospital personnel. Secondly, the non-restraint method set the stage for a new and more specialized role of nurses. Seen not only as guardians but also and more importantly as caretakers, nurses were expected to develop a therapeutic relationship with patients, through consolation, listening, empathy and persuasion.

The rejection of restraints in the care for and treatment of mentally ill patients demanded a rethink of the professional profile and function of nurses. These considerations took place within the vibrant movement of the professionalization of nurses and the establishment of systematic nursing education which had been taking place since the 1880s. In 1911, the French psychiatrist Théodore Simon dedicated an entire chapter of his manual, entitled *L'Aliéné, l'Asile, l'Infirmier*, to a critique of mechanical restraints in asylums. Restraints could be abandoned if the psychiatric nurse developed effective means of taking care of the patients, such as presence and listening, active engagement in watching and caring for patients.[71]

At the end of the 19th and the beginning of the 20th century, the nurse-patient relationship became a strategy for care, observation and treatment. As Désiré-Magloire Bourneville (1840–1909) remarked in his famous *Manuel pratique de la garde-malade et de l'infirmière* (1888–1889):

> An experienced nurse[72] must find ways to discover accessible aspects of each of her patients, their points of weakness, taking advantage of these aspects in order to appease them and to prevent them from disturbing order in the rooms.[73]

69 Semelaigne 1890, p. 491.
70 Morel 1860, pp. 41–42.
71 Simon 1911. See Klein 2018, p. 95.
72 The nurse here is referred to in the feminine form.
73 Bourneville 1889, vol. 3, p. 299.

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Nurses supervised patients' entertainment and work activities, but also prevented violent actions, such as suicide attempts.[74] In addition, they were responsible for the safety of suicidal patients, and therefore had to remain vigilant of the patients' ruses. This required nurses to develop a close relationship and a regular exchange with patients, a relationship of trust and empathy that would lead the patient to confide in them. The establishment of trust in turn facilitated the observation and treatment of these patients. From being regarded as an instrument, according to Conolly's conception, nurses had their agency and subjectivity reconsidered during these first decades of professionalization. As Georges Carrière explained in his nursing manual entitled *La Garde-malade et l'infirmière* (1903),[75] the nurse-patient relationship based on devotion and charity, piety and pity, was replaced progressively by the "principle of *solidarity*".[76] It was also the nurse who entered into a dialogue with the mentally ill patients, who could counteract their moral or mental symptoms and suffering. Like other physicians before him, Carrière painted what he considered to be an ideal portrait of a nurse, as a model of moral and physical attributes:

> A model nurse [la garde-malade] must be at the same time: healthy and robust, honest and courageous, educated and well-mannered, clean, skilful, simple, docile, discrete, patient and disinterested. She must love her patients and make them love her, take care of them not only with interest but also out of preference and vocation, be content of a modest salary for work that is harsh and at times difficult and unpleasant. Beyond monetary remuneration, she must learn to savour the internal reward, the intimate satisfaction gained from the feeling of the nobly accomplished duty.[77]

From the perspective of alienists throughout the 19th century, the constant contact with mentally ill patients required a model nurse not only to master technical skills, but also to embody moral and behavioural attributes. These attributes were seen by physicians as parts of the "healing machine", creating the necessary therapeutic environment, and as a mirror through which patients' thoughts, beliefs and behaviours could be modified. While restraints continued to be considered as useful and even necessary tools in preventing suicide in the hospital setting, these reflections and debates on the relational aspects of care contributed to improving the treatment of suicidal patients.

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[74] Bourneville, 1889, vol. 4, pp. 55–56.
[75] Carrière 1903, p. 7.
[76] Carrière 1903, pp. 7–8.
[77] Carrière 1903, pp. 28–29.

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The Tightrope Walked by Psychiatric Nursing Staff Caring for People with Suicidal Thoughts Between 1920 and 1970

Sabine Braunschweig

Abstract

Nurses working in psychiatric care in the 20th century faced an ethical dilemma between monitoring and caring for suicidal patients. On the one hand, they had to comply with strict instructions to prevent suicides, but on the other hand, they were not supposed to restrict patients unnecessarily and should still allow them a certain amount of freedom. It was a tightrope walk between control and trust. Combating and preventing suicides was therefore considered to be a very challenging task within psychiatric nursing. An analysis of historical sources, such as textbooks, annual hospital reports, medical records, minutes of the supervisory committee, and interviews with former nurses, gives a broad insight into how the issue was dealt with in the 20th century. Suicide attempts and suicides could be interpreted as actions by patients to free themselves from a life situation that they no longer found bearable. Psychiatric doctrine assumed that suicides could not be prevented altogether. They did not happen very often. Nurses were rarely sanctioned for suicides, but nevertheless felt bad and had feelings of guilt even decades after such serious incidents. The risk of suicide can be minimised if nurses are well qualified and have sufficient resources available for everyday care duties.

Keywords: psychiatric nursing, suicide, twentieth century, Switzerland

1 Introduction

The ethical dilemma of psychiatry is inherent in the dual nature of its mission.[1] On the one hand, it has a function as a therapeutic institution and, on the other, is a force for social order. Psychiatric nursing is also characterised by contradictory demands and expectations. Nurses are integrated into the hierarchy of a psychiatric institution, where they are responsible for the care of inmates around the clock and, at the same time, responsible for the observance of house rules and regulations. They observe and monitor the sick, but are themselves subject to rigorous control and discipline. This is exacerbated by the harsh working conditions, especially if they are living on site, as was mandatory in many places in the first half of the 20th century. So they had to follow numerous regulations not only during duty hours, but also in their free time. This dual mission of psychiatry, and therefore of psychiatric nursing, shaped everyday psychiatric care.

Suicidal intentions or suicidal behaviour on the part of patients posed a particular challenge.[2] Even though suicides were rare, nurses were confronted with the implicit danger of sick people taking their own lives in the hospital. How did they deal with it when patients escaped from the institution and/or tried to end their lives? How did they endure the

[1] The article is based on my PhD thesis: Braunschweig 2013.

[2] On the history of suicide: Hintermayr 2021; Hoffmann 2009; Bowman 2009; Baumann 2001. Suicide means “intentional suicide”. For a discussion of the German terms “Selbstmord” and “Freitod” cf. Sauter et al. 2004, p. 940.

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dichotomy between the duty of control and caring for the sick? What did it mean for them if they could not prevent a suicide attempt or suicide? Did the nurses who were responsible for supervision on the ward have to fear sanctions? How are ethical conflicts at the crossroads between coercion and self-determination of the sick discussed and judged in psychiatric care today? Has the assessment changed over the course of the last few decades? I examine these and other questions on the basis of various sources from the Friedmatt psychiatric hospital in Basel, which opened in 1886.

Because suicides were a special but rare occurrence in the institution's everyday life, they were a recurring topic of discussion. In the early decades of the institution's existence, they were explained in detail in the annual reports. I show what function and role was assigned to the nursing staff. With the unionisation of the staff and the establishment of the trade union journal in the 1920s, the topic of suicides and suicide attempts was also discussed in articles. Escapes were feared because of the threat of suicide, as shown in a survey, which I supplement with case studies from the Friedmatt hospital. A tragic suicide at the Friedmatt resulted in a court case that produced a large number of files. This shows the considerations that led to the widow being denied compensation for loss of the breadwinner's income. In another section, I show how comprehensively the author of the Swiss textbook on psychiatric nursing, which first appeared in 1930, dealt with the subject of suicide and suicide prevention. Retired nurses who had worked at Psychiatric University Hospital Friedmatt between 1930 and 1960 told me in interviews in the 1990s how they had been affected by suicides, and how the subject still bothered them years later. Nurses had some leeway in their day-to-day care decisions. But finding the balance between duty of control and duty of care was a major challenge, as I discuss in section 8. Finally, I take a look at the textbook in use today and the current research on the care of suicidal patients in psychiatry. As a conclusion, it can be said that senior staff in psychiatric hospitals never assumed that suicides could be avoided altogether. But containing the risk was, and is, a fundamental task.

As a university hospital with 250 to 300 beds, the Friedmatt was one of the largest psychiatric institutions in Switzerland. It was built according to the pavilion system: the patients were accommodated in separate pavilions for “quiet, semi-quiet and restless patients”, according to their behavioural problems. The service buildings along the longitudinal axis separated the men's and women's sides of the hospital. In the early days, the nursing staff were also divided according to gender. It was not until the 1910s that female nurses were assigned to “quiet men's wards” because they were easier to recruit, were paid lower wages and exerted a positive influence on sick men.

Since the opening of the Friedmatt, the annual reports have been available in printed form. In the medical reports, the clinic director recorded changes in personnel and described special incidents in the everyday life of the institution. A statistical section provided information about diagnoses, admissions and discharges, and also deaths. Suicides were listed under the heading “violent deaths”. A review of the annual reports shows that suicides only occurred every few years. Because they were not common, they were specifically highlighted in the annual reports.

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2 Disruptions in Everyday Life in the Psychiatric Institution

Until the beginning of the 20th century, nurses in Swiss psychiatric hospitals learned their work through experience, learning by doing. They received some knowledge from colleagues and superiors. Only occasionally were there lectures on psychiatric topics. With the introduction of somatic cures (fever, sleeping, insulin and electric shock therapies) in the 1920s, psychiatrists became increasingly dependent on competent support from nursing staff. Experiential knowledge was no longer sufficient. In order to recruit suitable staff, systematic training for psychiatric nursing staff became indispensable. From 1925 onwards, courses started to be organised in some clinics. In 1930, the first textbook became available in Switzerland. It went through seven editions and was in use until the 1960s.[3]

Due to the different and unpredictable ways that mental illness expresses itself, everyday life was marked by incidents that disturbed the order of the institution. The severe incidents included outbreaks of violence, phenomena with a sexual element, escapes, suicide attempts and suicides. They can be interpreted as actions by which patients attempted to free themselves from a life situation that they no longer found bearable. For the nursing staff, on the other hand, they were a disruptive factor in the routine of everyday life.

According to Carlo Ginzburg and Carlo Poni, these incidents could be described as the "exceptionally normal" (l'exceptionnel normal, das außergewöhnlich Normale).[4] The "normal", the everyday, which is not narrated or commented on, is revealed indirectly in connection with extraordinary events and thus allows conclusions to be drawn about everyday life and daily routine. These incidents were a challenge for the nurses, who had to learn to deal with them.

Suicides were unavoidable if one did not want to secure the area like a prison and lock up patients who were a risk to themselves. This was a basic conviction in psychiatry. In the annual report of 1891, the director of the Friedmatt hospital, Ludwig Wille (1834–1912), stated that the clinic was "principally and systematically designed for the task of granting the sick the greatest possible degree of free movement". He was referring to escapes which, according to his experience, would very rarely lead to suicide. It would be irresponsible to make the other patients "suffer unnecessary restrictions" because of a few patients. Wille was an advocate of the no-restraint system. The aim of the no-restraint system was to use as few restraining measures as possible against agitated patients.[5] It was partly down to Wille that the professional association of Swiss psychiatrists, the Swiss Society of Psychiatry, agreed on the introduction of the no-restraint system at its annual meeting in 1868. This reform meant not only eliminating means of coercion, such as straitjackets, but treating the sick differently, examining them carefully and individually. The idea was that nurses would continuously observe and supervise the patients in order to recognise incipient moods and agitation in good time and intervene to defuse them. But without training, without professional expertise and without knowledge about the psychiatric illnesses of the sick, it was difficult for nurses to meet the medical requirements and demands. Psychiatrists were reluctant to provide information because they considered the nurses – most of whom came

3 Morgenthaler 1930–1962.
4 Ginzburg/Poni 1985, p. 51.
5 Cf. on the no-restraint system Sammet 2004; Aan de Stegge 2005.

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from the lower classes – to have little formal education and did not want to forfeit their own authority. Instead, they complained about the unsuitable nurses and the high staff turnover.

The directors of psychiatric clinics were aware that more liberal institutional treatment also had a downside and could lead to serious incidents. The cases listed in the Friedmatt annual reports prove that it was almost impossible to avoid suicides. A "melancholic patient" ran away from a nurse on a walk and threw himself under a passing express train. 1889 Wille wrote in the annual report:

> Anyone who can judge such situations objectively and according to experience will not blame such a nurse too much, if he has otherwise proven himself to be dutiful and reliable, even if, after the event and taking all circumstances into account, one might think that it could most probably have been prevented [...].[6]

He made a similar judgement about the following case: an elderly patient diagnosed with "severe hypochondriacal melancholia with manifold obsessions" was given round-the-clock care because of his anxiety. However, he chose to hang himself at the precise moment when the nurse went out to get him a cup of coffee. Since the patient had been sleeping well and talking to him, the nurse assumed he could leave him alone for a few minutes.[7] In 1890, a 58-year-old patient with "depressive paranoia" was able to hang himself from his bed frame by means of his handkerchief in the immediate vicinity of the nurse in the dormitory, without the nurse or any of the other patients noticing anything. Because the patient's previous behaviour had never indicated such an intention, the suicide had come as a surprise to everyone.[8]

In the annual reports, the director made an effort to exonerate the nursing staff, because these accountability reports were intended for authorities and donors. Assigning blame would have reflected badly on him. He could have been criticised for employing unsuitable staff.

But in one case he criticised the "negligence" of the nursing staff in the annual report, when a patient managed to escape from the clinic during the daytime in 1901. The nurses searched for him in vain. Hopes that he had returned to his family were dashed when he was found dead in a river eight days later. "With correct conduct" the death could have been prevented, Wille said.[9] But without training, nursing staff at that time were not sufficiently aware of what "correct conduct" meant. It was difficult for everyone in psychiatry to correctly assess such unpredictable actions. Although suicides could not be avoided, they caused dismay among the medical and nursing staff.

3 Escapes With Consequences

In connection with their demand for nursing training, psychiatric nurses began to organise themselves in a trade union at the beginning of the 20th century and to promote professionalisation. The nursing journal *Kranken- und Irrenpflege* was a joint project of the trade union

6 Wille 1889, p. 4.
7 Wille 1892, p. 5.
8 Wille 1890, p. 5.
9 Wille 1901, p. 3.

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and the psychiatric association and published articles by both psychiatry and nursing professionals from 1922 onwards.

In 1924, a large survey was conducted among psychiatric nursing staff in Swiss institutions, the results of which were published in the journal. The focus was on escapes, which were a big worry, especially where suicidal patients were concerned.[10] In addition to developing a typology of the patients who were likely to escape, the survey looked at the reasons for escape, the types of escape and the instruments used, and addressed questions concerning the prevention of escapes.

As long as patients were admitted against their will, the question of escape was part of everyday life in the institution. It was always possible to escape from the institution, for example to run away on walks, not to return from the city or to make off while working in the fields. Even on closed wards, it was not impossible to break out with cunning, luck, good preparation or outside help. A few incidents from the nurses and patient files of the Friedmatt hospital illustrate this.

A young male nurse had only been employed on a permanent contract for a few weeks, following a one-year probationary period. He was on supervision duty in the garden on a Sunday in August 1922 when a patient managed to escape from the area. When the nurse noticed he was missing, he immediately went in search of him. The incident ended well, the patient was apprehended and brought back in a cab. The nurse was ordered to pay the transport costs or have them deducted from his wages. The union appealed against this order, arguing that the lack of a clear view over the whole garden had prevented him from tracking down the patient in time; this had also been confirmed by colleagues. The punishment was said to be too harsh because the nurse had never previously been admonished or fined.[11] The supervisory committee looked at the garden, but rejected the appeal. It wrote that the nurse would have had sufficient visibility from his position to observe the patient, and warned that special attention must be paid to the few "patients at risk of absconding".[12] According to the penal regulations, the director could even have fined him up to five days' wages for neglecting his duties or violating the house rules.[13]

A few years later, when patient escapes became more frequent, the principle of fining the nurses responsible for them was discussed by the supervisory committee. The key factor was a specific case in which a nurse had failed to prevent the escape of a patient who had already attempted suicide. After a lengthy discussion, he was fined thirty francs as well as the cost of transporting him back.[14]

According to her medical records, a 66-year-old female patient, who had stayed at the Friedmatt five times since 1912 for shorter and longer periods, managed to escape spectacularly

[10] N.N.: Ueber Entweichungen 1924.

[11] Letter from the trade union to the supervisory committee dated 21 August 1922. In: Staatsarchiv Basel-Stadt (StABS): Staff file, SD-Reg 2a 991.

[12] Minutes of the supervisory committee meeting of 30 August 1922, and letter from the supervisory committee meeting of 31 August 1922. In: StABS: Staff file, SD-Reg 2a 991.

[13] Dienstordnung für das Wartpersonal der Irrenanstalt of 1886, § 13, 2. fines up to 5 francs [equivalent to about 5 days' wages]. In: StABS: San-Akten T 2a.

[14] Minutes of the supervisory committee meeting of 11 June 1925. In: StABS: San-Akten T 2a.

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in 1947. Because she "pestered" doctors and nurses about her discharge, she was locked in the toilet one morning. She was to be transferred to another ward later. But in the toilet she climbed over the wall and left through a watch room window at an unguarded moment and fled over the wooden fence. That was how she had discharged herself, as her medical records laconically put it.[15]

In another case, a 36-year-old patient diagnosed with "defective hebephrenia", a severe mental illness with an unfavourable prognosis, failed in his first attempt to escape in 1935, but shortly afterwards managed to escape over the garden fence. Two weeks later, relatives from Nancy, France, called to say that they had seen him and given him money, but could not convince him to stay with them. A nurse was assigned to bring the patient back, which was apparently possible without any problems. According to his medical records, the patient did not resist being returned to the Friedmatt.[16]

In his guide to practical psychiatric care, the head nurse at the Friedmatt, Franz Küpfer (1904–1967), distinguished between "harmless escapees", such as "senile, arteriosclerotic or even certain imbeciles", and "dangerous patients". The former would run away without a plan if they found the opportunity. One had to look for them immediately, because they could have an accident or freeze to death in winter. Among the "dangerously ill" he included "schizophrenics who are under the influence of commanding voices or delusions, patients who commit impulsive acts, epileptics in a twilight state, those suffering manic episodes", as well as "criminal psychopaths" and "remand prisoners entrusted for evaluation". In these cases, senior staff would have to be informed before the search. If the search was unsuccessful, the relatives were to be contacted so that they could notify the hospital when the sick person appeared. Finally, the police should be informed, with the exact details of the missing person. In the case of patients who were a danger to themselves or others, a police dog should be called in to pick up the trail.[17] Although such escapes usually took place without serious consequences, the nursing staff never knew exactly what would happen because of the unpredictable nature of the medical condition.

4 Suicide With Legal Repercussions

When Ernst Rüdin (1874–1952), director of the Friedmatt from 1925 to 1928, took office, he asked for some structural changes that he thought were necessary to reduce the risk of suicide, although in his opinion suicides could not be completely prevented even in the best-equipped psychiatric hospital.[18] A suicide occurred under his leadership that had legal consequences. Albert E. had been admitted with a diagnosis of depression at the beginning of May 1928, accompanied by his wife and father, after he had increasingly expressed suicidal ideas and had possibly already attempted suicide. After eight weeks in the watch room, the director prescribed occupational therapy. The nurse took him with three other patients to work in the fields. When they passed a building with a ladder for renovation work, E. broke away and climbed up the ladder. Although the orderly followed him immediately and caught him by

[15] Entry dated 7 September 1947. In: StABS: Universitäre Psychiatrische Kliniken (UPK): KG archives, KG 53 (1), Medical record 6215.
[16] Entries dated 28 March and 10 April 1935. In: StABS: UPK: KG 53 (1), Medical record 2912.
[17] Küpfer 1944.
[18] Minutes of the supervisory committee meeting of 23 October 1925. In: StABS: San-Akten T 2a.

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the foot, E. pushed him away and threw himself headfirst from the roof. He was killed instantly.

His wife was convinced that the hospital management was responsible for her husband's death. She therefore demanded compensation, as she lived in poor conditions with her two small sons and without an income from her husband, who worked as a painter. The doctor in charge wrote to her lawyer that the institution was not to blame "because the supervision had been carried out professionally". Only an unfortunate chain of circumstances could have caused the "accident". Even "with reliable and close supervision", suicides and self-inflicted injuries could "occasionally" occur. "Given the rapid, impulsive action of the patient and the proximity of the supervising nurse, no one can be blamed," he added.[19]

While the supervisory committee would have granted the widow compensation to avoid a court case, the Health Department was against any compensation payment because it did not want to set a precedent. For reasons of principle, it therefore had the case settled by the courts. The civil court ruled in favour of the hospital management and dismissed the claim for compensation. The patient had been adequately supervised on the way to occupational therapy. Whether he should have stayed longer in the watch room was a matter of discretion, for which there were several possible approaches in medicine. According to the doctor's colleagues, the director, who in the meantime no longer worked at the Friedmatt, had "perhaps been somewhat careless in the treatment of such cases, perhaps even consciously." It had been one of his therapeutic views.[20] At no time was the nurse held responsible for the suicide. It was emphasised that he immediately followed E., who, as a painter, was probably more experienced in climbing ladders, and even put himself in danger.

Not only because of the different doctrines on how to deal with suicidal patients, but also for reasons of power politics, the widow, a woman from the lower classes, had no chance of getting her claim accepted by the authorities, despite having the support of a lawyer. If she had succeeded, the Friedmatt would have had to clarify the question of compensation for every suicide in the future. The institution and the government did not want to take this financial risk under any circumstances.

5 Care of Suicidal Patients in Theory and Practice

Before 1930, when the first Swiss textbook on psychiatric nursing appeared, which would be authoritative for the following three decades, the doctors of the first training courses in German-speaking Switzerland used the textbook *Geisteskrankenpflege* by Valentin Faltlhauser and the manual *Der seelisch kranke Mensch und seine Pflege* by Karin Neuman-Rahn as teaching materials.[21] Both textbooks attributed self-endangerment above all to patients diagnosed with "melancholia" and "depression" respectively. The danger of suicide is particularly high at the beginning and when the illness subsides. Care requires extremely

[19] Letter from the doctor to the lawyer dated 7 December 1928. In: StABS: UPK, KG-Archiv, KG 53 (1), Medical record 10628.

[20] Letter from the supervisory committee to the Health Departement dated 19 June 1929. In: StABS: UPK, KG-Archiv, KG 53 (1), Medical record 10628.

[21] Faltlhauser 1923, p. 168; Neuman-Rahn 1925, p. 99.

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careful supervision because any unguarded moment is enough for the patient to take his or her own life. A nurse should never believe that the patient is healthy, even if he appears to be calm on the outside and is waiting to be discharged.

The Bernese psychiatrist Walter Morgenthaler (1882–1965), author of the first Swiss textbook *Die Pflege der Gemüts- und Geisteskranken* (The Care of the Mentally Ill), also wrote that "combating and preventing suicides and caring correctly and properly for suicidal patients is one of the most important, but also one of the most difficult tasks of the institution and the nursing staff".[22] Morgenthaler devoted a chapter to "behaviour in depressed and suicidal individuals" and explained the risk of suicide for the various diagnoses, the stage of the patient's stay at the institution that was particularly delicate, the suicide methods used and the demands to be placed on nursing care.[23] Until the sixth edition of the textbook in 1954, he maintained that "extremely close supervision", which "should not let up for a second", was central. He meticulously pointed out the dangers for suicidal patients in every possible situation. In his opinion, they belonged in bed. He wrote, for example, that the bed should not be too close to the window, that it should be easily visible to the nurse, quickly accessible and sufficiently well lit at night. The sick person must "not crawl under the covers", must at most hold his hands above the covers, and must be accompanied to the toilet. In the bathtub, he must be bathed in the shallowest depth of water possible, potentially lying on a sheet. On walks, the accompanying nurse must exercise utmost caution near water, railways and cars, as well as when crossing bridges and in unclear terrain.

Morgenthaler explained in detail the possible dangers when handing out medication and food. Patients who were a danger to themselves or others were only given spoons to eat with. In the Friedmatt, knives had to be counted after the meal to be sure that none had been stolen. When twelve knives went missing from a men's ward after breakfast one day in July 1946, it caused a great commotion.[24] The night before, the orderly had only reported to the night watch that knives were missing. He had assumed that they had been mistakenly stored in another drawer. He defended his omission by saying that if only one knife had been missing, there would have been a risk that it had been taken "with dangerous intent", but not with this large number. And he added that, in any case, the "kitchen attendant" was responsible for checking. Later, the head nurse found the knives in a patient's room "under a folded piece of fabric on the floor". During a conversation, the male nurse confessed to having allowed patients to leave the dining room and go into the garden before the knives had been counted. This was often done in order not to keep the patients at the table until the cutlery had been washed and counted. He received a written reprimand for this mistake and for not reporting it to his superiors.[25]

This incident shows that in the everyday life of an institution, nursing staff had to weigh up whether they followed all the rules to the letter or whether they confidently gave the

[22] Morgenthaler 1930, p. 180.
[23] Morgenthaler 1930, pp. 179–186, the same wording until the 6th edition, 1954.
[24] Report on missing knives on ME 1 on 21/22 July 1946, dated 22 July 1946. In: StABS: Personaldossier: SD-REG 2b 2-2-3 (1) 47.
[25] Interlocution of 26 July 1946 and reference of 30 July 1946. In: StABS: Personaldossier: SD-REG 2b 2-2-3 (1) 47.

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patients a certain amount of freedom, in this case not making them wait at the table after eating.

Even trained and qualified nursing staff were not always able to prevent a suicide or a suicide attempt. In the case of the patient Berta Z., there seemed to be nothing to indicate that she was suicidal, as the nurse reported after finding her hanging in the summerhouse one afternoon in 1943.[26] She had been unobserved for ten to twenty minutes. Immediate attempts to resuscitate her with an emergency respirator, initiated by the nurse, were unsuccessful. Although the patient was described in the medical record as depressed and distressed about her child, who was in a home, neither the nurses nor the attending physicians had recognised the danger. Like any extraordinary incident, this unexpected suicide required a detailed explanation. All the nurses involved in the patient's care had to write a report. A patient who had got on well with the deceased was also questioned. It turned out that the night supervisor had told a nurse a few weeks ago that Ms. Z. had said that "she would like to die". Evidently, the nurses had not taken this remark seriously enough to report it, since an entry in the report book would have triggered strict supervision.

In the report to the highest authority, the Health Department, which had to be notified of such incidents, the doctor stated that it was only known that the patient had attempted suicide five years earlier in connection with marital conflicts, but that there had been no further attempts since then. There had been no reason to consider the patient as explicitly suicidal or to monitor her particularly; they had believed that they could justify "somewhat freer treatment", namely unaccompanied walks in the garden. It was "one of those abrupt and unpredictable actions of schizophrenics that can occur most often at the beginning of the illness, but more rarely later on," the doctor explained, describing the dilemma:

> If one wanted to take precautions against every such incident through much stricter supervision, the personalised treatment, psychotherapeutic consideration of the character and special wishes of a sick person would be called into question and many chances of improvement would become impossible.[27]

He hoped to make the authority understand that not every risk could be covered.

Nurses had to weigh up whether they wanted to follow all the rules precisely or whether they wanted to allow the patients a certain amount of freedom, i.e. not restrict them unnecessarily. Morgenthaler also addressed this balancing act in the textbook when he called for "scrupulously strict" supervision to prevent suicide, but said it should never "degenerate into thoughtless torture of the sick person". Nevertheless, he gave priority to strict supervision. It was not until the seventh edition of the textbook in 1962 that he revised his position and wrote that "too strict supervision is torture for the sick person". And he went even further, saying that tight control not only worried patients but could directly stimulate them to make further [suicide] attempts.[28] A "new liberal and relaxed treatment" had shown that the frequency of suicides did not increase, but actually decreased significantly. The

[26] Report by L. K. dated 11 August 1943. In: StABS: UPK, KG 53 (1), Medical record 8626.
[27] Friedmatt report to the health departement with copies to the members of the supervisory committee, 12 August 1943. In: StABS: UPK, KG 53 (1), Medical record 8626.
[28] Morgenthaler 1962, p. 228.

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beginning of the 1960s heralded a new era in psychiatry, which slowly moved away from the hierarchical and authoritarian system.

6 Controversy Between Psychiatry and Nursing Concerning Information About Sick Patients

To what extent should nurses receive background information about the patients entrusted to them? Although head nurse Küpfer expressed the opinion in the above-mentioned guideline that staff should be made aware of "dangerous sick people", this was not the case in many institutions.

For years before 1950, there was a controversial discussion among psychiatrists and nurses about how much information nurses should receive about patients and whether they should be allowed to inspect medical records. The question was: who was "in charge of the record system"? Some psychiatrists denied the right of nurses to see medical records. A psychiatrist argued that the psychiatric medical history, which contains the "history, findings and course of the illness", reflects the doctor's opinion and is subject to medical professional secrecy. For this reason, nurses were only allowed to inspect it in exceptional cases. There are fashions in "medical jargon", scientific opinion changes, new questions arise, and as a result the doctor's personal opinion and interpretation can lose its value. He wanted to prevent nurses from learning about medical misjudgements and errors. The doctor could only do "responsible, conscientious psychiatric work" if he recorded observations and progress in a case history only "for himself and later generations".[29]

This opinion was contradicted by a psychiatrist colleague: "Misunderstandings between doctor and nurse" could be avoided if the nurse knew "the history of the individual case".[30] Informed staff could care for the sick in a more personalised and adequate manner.

A nurse who dealt with nursing responsibility also criticised the distrust of hospital administrators who did not tell the nurses anything about the background of sick individuals.[31] For forensic patients in particular, the nurses' duty of supervision is essential. They must therefore be informed about "patients with criminal tendencies" who are interned for assessment of their sanity, in order to be able to act appropriately; after all, they are "nurses" and not "jailers". "Silence and mistrust of the staff" only lead to "trouble and damage for both parties". It was a mistake of many hospital administrators to withhold medical histories from the nursing staff, treating it as "top secret". A good nurse is aware of the duty of confidentiality.

The conflict over access to medical records showed once again that there was a widespread fear among psychiatrists of losing authority over nursing staff, their auxiliary staff. This line of conflict was already evident when training was introduced in the 1920s. Precisely because psychiatric expertise was not yet well established in the first decades of the 20th century, psychiatrists feared that trained and informed nursing staff would challenge their supremacy and that they would lose their power in the day-to-day running of the

[29] Pflugfelder 1958, pp. 225–229.
[30] Straus 1937, p. 3.
[31] E. E. 1928, pp. 149–152, and E. E. 1931, pp. 215–217.

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institution.[32] In the Friedmatt too, the nursing staff did not have access to patients' medical records, nor could they write in them themselves.

7 Suicides Remembered by Former Nurses

Suicide attempts and suicides affected all staff members. They searched for their own failures and mistakes. Even years and decades later, a suicide could still bother them, and they remembered every detail. I discovered this in interviews with long-time psychiatric nurses. None of my interviewees mentioned suicides or suicide attempts without emotion.

As late as the 1920s, patients in the Friedmatt were fastened to the bed with leather straps on one leg, said Rosa S., a retired psychiatric nurse, who had a key to loosen the restraints. "There were patients who would have done themselves harm," she explained.[33]

Retired psychiatric nurse Ida D. told me about a stressful memory. One patient had succeeded in taking his own life. She had accompanied him on a walk authorised by the doctor, but was restricted because of a hand injury: "This was an elderly gentleman, of course he already wanted to die, that was inside him, but he hadn't had the chance [before]."[34] The previous day, in fact, he had been outside with a nurse who had been able to restrain him. When he jumped into a stream outside the area, Ida D. could not pull him out because of her bandaged hand.

The nurse Fritz D. was once able to remove a patient who had "hanged himself" just in time: "He was still wriggling, so he got away,"[35] he said casually, trying to hide the fact that the incident had affected him, and that he was glad to have saved the patient. In the course of the interview, he returned to the subject: "I was lucky that nothing ever happened to me, outside, that nobody committed suicide when I was on duty, supervising in the watch room; nothing, one was glad."

Other interviewees expressed equal relief that they had not been personally affected by a suicide. Retired psychiatric nurse Helena F., for example, told of a young man who had obtained arsenic at home and died of it shortly before she started her shift, after having taken it at the institution.[36] From his medical record, it was possible to trace the incident in detail.[37] Max U., only 19 years old, was a patient at the Friedmatt in 1946. He had been diagnosed with "hebephrenia" and was considering questions of murder and suicide from the moment he arrived. His statements were written down, yet his death could not be prevented. Following his request for female care, he had been transferred to the private ward on the women's side. There, a fellow patient complained to the ward nurse that Max U. had spoken of his "homicidal desires" and of his intention over the following weekend, whereupon she herself became frightened and wanted to spend the night in another pavilion. A few days later, another patient reported to the head nurse that Max U. had made "strange remarks", that he wanted to see "what it was like on the other side". The fellow patient feared that he

32 Radkau 1997, p. 86.
33 Interview with Rosa S., 29 April 1989.
34 Interview with Ida D., 30 May 1989.
35 Interview with Fritz D., 25 May 1989.
36 Interview with Helena F., 11 May 1989.
37 Entries dated 28 July and 3 August 1946. In: StABS: UPK, KG 53 (1), Medical record 1858.

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"was planning to do something to himself". The doctor on duty on Sunday was then instructed to talk to him after his return to the clinic. According to the progress sheet, the patient returned accompanied by his father in a good mood and was asked about his "homicidal and suicidal thoughts". He claimed that he was confident about the future, that "everything had survived and was no longer relevant". However, a few hours later, the nurse telephoned the doctor that a patient had reported U.'s suicidal thoughts and a vial of poison. Although the ward nurse had not noticed anything about his behaviour – he was smoking a cigar in the lounge – the doctor instructed her to discreetly search his bedside table and the room and keep an eye on the patient. Barely half an hour later, she called back to say that he had probably felt sick from the cigar, that he was very pale and had vomited. A short time later, she phoned again to say that he was very poorly and had just confessed to having drunk a vial of cyanide three minutes ago. The patient was immediately transferred to the treatment room and treated with the available medical options such as mouth rinsing and stomach pumping, injections of the heart drug coramine and administration of oxygen for respiratory distress. However, early in the morning, the patient died as a result of the poisoning. According to the letter written by child and adolescent psychiatrist Carl Haffter (1909–1996) to the Health Department about the tragic incident, the suicide could only have been prevented if the young man, whose "prognosis was extremely unfavourable", "had been kept permanently on a completely closed ward and not allowed to go out."[38]

8 Scope of Action of the Nursing Staff

The ethical dilemma of whether to constantly monitor suicidal patients, possibly against their will, or to grant them some privacy, which entailed some risk, was inherent in psychiatric and nursing treatment.

Medical and nursing staff had to deal with this question and decide in each individual case. Morgenthaler described this individual discretion of the nursing staff in various articles. He demanded that although the doctor's orders had to be "scrupulously understood and kept in mind", they should "absolutely not be rigidly and slavishly carried out" on the sick.[39] Psychiatric nursing staff needed a great deal of "adaptability and versatility in the execution of the task and in the choice of means" – in other words, they needed a great deal of flexibility and creativity in individual care. In everyday psychiatric nursing, situations could arise at any time in which the doctor's "original orders could no longer be carried out pedantically". Therefore, the psychiatric nurse has to "change the orders, refrain from implementing them, or make completely new ones, while adapting as fully as possible to the changing situation as well as to the intentions and original orders of the doctor".[40] This gives the nursing staff "a much greater freedom of action". This requirement to weigh up at every moment whether to react in one way or another, i.e. to sound out the possibilities for action, to use their discretion, was virtually a condition of psychiatric nursing.

Morgenthaler did not discuss the dangers that existed for staff in everyday nursing as a result of this large scope for interpretation, for example if they decided and acted "wrongly"

[38] Letter from Carl Haffter to the Health Department dated 6 August 1946. In: StABS: UPK, KG 53 (1), Medical record 1858.
[39] Morgenthaler 1925, p. 433; Morgenthaler 1926.
[40] Morgenthaler 1925, p. 433.

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in the eyes of their superiors. He concealed the relationship of dependence between doctor and nurse and conveyed the impression that both acted as equal subjects. Due to the hierarchy of the institution and the doctor's powers, however, this did not correspond to reality. In her subordinate position, a nurse could never know and never be sure whether she had decided and acted in line with her superior's intentions.[41] The fear of having made a mistake and of being summoned before the director and punished was something the former psychiatric nurses brought up several times in the interviews.

Morgenthaler said that with careful selection, sound theoretical training and, finally, with professional experience, the high expectations placed on the staff could be met – here was a call for autonomy in the professional field of psychiatric nursing that was only addressed by the staff themselves in a much later debate about professionalisation.[42]

9 Conclusion

Suicide attempts and suicides in psychiatry cannot be avoided, as documents from every era in the history of psychiatry have shown, wrote Asmus Finzen, deputy medical director of the Basel Psychiatric University Clinic in 1990.[43] The sources from the Basel Psychiatric Clinic and the case studies show not only that it had been impossible to prevent suicides since the clinic opened, but also that the clinic directors refused to run the clinic like a prison in order to avoid any risk. They were aware of this ethical dilemma between granting freedom and confinement. As a rule, they did not hold the nursing staff responsible if a patient took his or her own life. Only in a few cases did they criticise a nurse for having acted negligently or carelessly.

Since the introduction of recognised training for psychiatric nurses, the topic of suicide has been part of the curriculum. It is a subject that trainee psychiatric nurses have had to deal with. The textbook, first published in 1930, contained some concrete advice on how to deal with suicidal patients.

The current textbook of psychiatric nursing (*Lehrbuch Psychiatrische Pflege*) also deals with the topic in detail in the chapter "Suicidality" and states:

> Suicides are one of the biggest global health problems and a frequent cause of death among the mentally ill. Assessing suicide risk, caring for suicidal patients and coping with suicides are among the most difficult interpersonal and professional challenges in psychiatric work.[44]

Behind this lies the basic ethical conflict of self-determination and heteronomy, which psychiatrist Tilman Steinert deals with in his research on psychiatric treatment and care.[45] Ethical problems are characterised by the fact that it is not possible to identify either scientifically (medical/psychiatric) or legally unambiguous solutions to problems or

41 Cf. on this "double-bind situation" Braunschweig 2008.
42 Raven 1995, pp. 347–355.
43 Finzen 1990, pp. 24–25. Finzen was deputy medical director of the Psychiatric University Clinic from 1987 to 2003.
44 Sauter et al. 2004 (4th ed. 2019), p. 940.
45 For the following cf. Steinert 2001, pp. 32–36.

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guidelines for action. The conflicts centre around the issue of personal freedom, for example when restricting or granting freedom in the case of suicidal tendencies, danger to others or questionable helplessness, and when administering treatment against the will of the person concerned. The basic question relevant to care is: "Do we have to respect the patient's personal freedom and his or her stated wishes, or do we have to override these wishes for his or her own good, in accordance with his or her presumed 'real' will?"[46]

Steinert places the answer between the two poles of liberalism and paternalism. A liberal therapeutic attitude is associated with a certain willingness to take risks and allows the patient a certain degree of self-determination and personal responsibility, while the basic paternalistic therapeutic attitude focuses on security. Which of these attitudes a nurse is more closely aligned to has an impact on decisions in the daily organisation of a psychiatric ward. The different attitudes also affect the care of suicidal patients. Ward teams are constantly challenged to be clear about their attitudes and values and to negotiate appropriate measures. However, one basic rule must be observed at all costs, writes Steinert: "We can avoid ethical conflicts in the area of tension between self-determination and coercion if we succeed in convincing the patient!"[47]

But sometimes, despite nursing commitment, the success of persuasion is limited, in which case nurses and treatment teams have to reflect on the extent of coercion and heteronomy that can be ethically justified. A central prerequisite if teams are to be able to function in such dilemmas is a high level of collegial solidarity and clear support from superiors. This is particularly important when problems arise in difficult situations or when a suicide has occurred.

Findings from scientific studies that either confirm or call into question the usual measures and behaviour of the nursing team up to that point are also helpful. In many psychiatric hospitals, for example, high-risk patients are placed on locked wards. Only if they are prevented from attempting suicide and escaping, so the reasoning goes, can they be adequately protected and receive appropriate therapy. But until now there had been no proof that closed wards prevent self-harming behaviour. Now, a large study by Basel University and the University Psychiatric Clinics Basel, which evaluated nearly 350,000 cases in 21 German clinics over 15 years, has shown that the risk of patients committing suicide or escaping from treatment is no higher in exclusively open psychiatric clinics than in clinics with closed wards.[48] "The effect of locked clinic doors is overestimated," said first author Christian Huber.

> Being locked in does not improve patient safety in our study and is sometimes even counterproductive to the prevention of suicide and escape. An atmosphere of control, restricted personal freedoms and coercive measures is more of a risk factor for successful therapy.[49]

According to this study result, an "open door policy" does not increase the risk of suicide. In other words, a liberal ethical stance does not exacerbate the risk of suicide.

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46 Steinert, p. 34.
47 Steinert, p. 26.
48 Huber et al. 2016, pp. 842–849.
49 Huber et al. 2016, p. 848.

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Psychiatrists had already recognised at the end of the 19th century that suicides cannot be prevented altogether. But the risk can be minimised if nurses are well qualified and have sufficient resources at their disposal while carrying out their care duties. Nevertheless, psychiatric nursing remains a tightrope walk between supervision and care.

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Suicide Through the Eyes of Fellow Patients (1920–2020)

Catharina Th. Bakker

Abstract

This article shows how suicides in psychiatric hospitals were described by fellow patients in the past and how these descriptions relate to developments in the context of nursing and care. This is a hitherto unexplored area of research. From the sources – six autobiographical novels about life in psychiatric hospitals – it can be tentatively concluded that, whether the story is set in 1920, 1970 or 2010, three factors are almost always represented: suicide is a ubiquitous phenomenon in the psychiatric hospital, it has a great impact on fellow patients, and patients can be very concerned about the fate of their fellow patients. However, some differences can also be pointed out that have to do with the time in which the story is set. More research is needed to support and deepen the preliminary conclusions.

Keywords: suicide, psychiatric nursing, patient perspective, twentieth century, autobiographical novels, narrative history

1 Introduction

> Trudy hasn't moved for a long time, Sister. I am scared, because once they found her in the toilet. There she tried to hang herself [...] Sister, I am afraid for Trudy, go and look again, please stop reading, otherwise it will be too late. [1]

These words were written in 1927 by the Dutch writer Fré Dommisse (1900–1971). [2] From the age of 17, Dommisse was admitted to a psychiatric institution for several years and she wrote a novel about it entitled Krankzinnigen („Madmen"). The book became popular and was reprinted several times. While reading, it struck me that there were similarities with a contemporary autobiographical novel: *Up* by Myrthe van der Meer (2015). Both novels are accounts of the author's experience from the first day of their admission to when they are discharged. One of the subjects in both novels is suicide – or rather, the risk of suicide – among fellow patients. The possibility of suicide hangs like a dark cloud over the institution; the well-being of fellow patients is at stake.

Yet suicide is described differently in the two novels. There is a gap of about 90 years between Krankzinnigen and Up. This made me wonder how suicide was described in other autobiographical accounts set in psychiatric institutions over time. Are there any particular developments to be observed, and if so, how do they relate to the way care was organised in the institution during the period in question? In other words, how were suicides in hospitals described by fellow patients in the past, and how did these descriptions compare to developments in the context of nursing and care?

1 Dommisse 1929, p. 30.

2 Dommisse is the subject of the biography I am working on. She writes in Dutch, just like the other novelists in this article. All translations are done by me (CThB).

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2 A Hitherto Unexplored Research Field

A brief search of Dutch literature generated no reports of historical research on this subject, and even contemporary academic (international) literature on the impact of suicide on fellow hospitalised patients is rare.[3] Contemporary research on suicide in institutions mainly focuses on professionals and on next of kin (family, friends), who have a high risk of being confronted with suicide.[4] It also looks at numbers, and the background, experiences and treatment of suicidal patients themselves from a risk management perspective, in order to provide precautionary interventions and deter copycat behaviour.[5] This is one of the few subjects in which the experiences of fellow patients are indeed studied – that is, only a specific group of patients, namely potentially suicidal patients. Fellow patients in general are not considered in this research either.

Historical research on suicide from the perspective of fellow patients seems to be non-existent, at least as far as Dutch research is concerned. In fact, Dutch historiography of psychiatry pays little attention to the patients at all; it largely focuses on institutions and therapies, although Porter's groundbreaking research in the eighties did lead to a few very interesting studies 'from below'.[6] Psychiatric nursing is also still the poor relation of psychiatric historiography. This is, in fact, not only true for Dutch historiography, with Smith writing as recently as 2020, 'Where Are the Nurses in the History of Psychiatry?'.[7]

3 Boschma and Aan de Stegge

The two main representatives of the Dutch historiography of psychiatric nursing are Boschma and Aan de Stegge. They both look at suicide in the psychiatric institution in their PhD theses on psychiatric nursing. Both emphatically point out that the pervasiveness of suicide in mental hospitals played an important role in the history of psychiatric nursing.

Boschma explains that the nurses had a key role in preventing suicide. Suicide was a threat to the institution's reputation and nurses were held responsible when a suicide occurred. She writes that, in the period she examined, the annual statistics on suicide were always very low. Nevertheless, there was always a threat of suicide, especially among melancholic patients. Because it could cost them their jobs if a patient committed suicide under their supervision, the nurses were very concerned about it.[8]

Aan de Stegge describes in detail how nurses had to deal with suicide and how this changed throughout the twentieth century. Dealing with suicide is one of the factors that sheds light on the professionalisation of nursing.[9] Since this study covers much of the twentieth century

3 Seeman 2015. Thanks to Bart Debyser and Remco de Winter, who were able to confirm this for present-day research.
4 Hendin et al. 2000; Pilkinton/Etkin 2003; Bijlsma 2012; Maple et al. 2014; Malik/Gunn/Robertson 2021.
5 Bowers/Nijman/Banda 2008; Arensman/De Leo/Pirkis 2020; Vandewalle 2020; De Beurs/Maes/Beekman 2021.
6 Porter 1987; Dutch exceptions are Vijselaar 1988; Louter 2005; Vijselaar 2010; Hovius 2015. To find out more about international perspectives, see e.g. Porter/Wright 2003.
7 Smith 2020, p. 1.
8 Boschma 2003, pp. 134–137.
9 Aan de Stegge 2012, passim.

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and focuses on numbers of suicides and on the practices of nurses in dealing with suicide, I used Aan de Stegge's thesis in my research for this article, to provide more background information on the subject.

Fig. 1: Bookcover Dissertation Aan de Stegge 2012

Boschma and Aan de Stegge not only pay considerable attention to the pervasiveness of suicide in the psychiatric institution, but also describe suicide attempts. However, because their focus is on nursing, like most other authors, they do not address the experiences of *fellow* patients.

4 Listening to Patients' Voices through Narrative History

In order to find answers to the questions posed in the introduction to this article, I studied patient experience stories. Over time, psychiatrically ill people have recorded their experiences. Following an initial reluctance, the number of psychiatric autobiographical stories has increased dramatically since the 1960s and especially after the turn of the century.[10] In 2003, Fleur Parabirsing made a short survey of published psychiatric ego documents in the Netherlands from the 1970s to the 1990s. She divides the publications into two types: stories that go 'from dark to light' and stories that serve as a support and an example to others.[11]

Written accounts of experiences are an excellent way of gaining in-depth insight into the perspectives of patients.[12] Whether it is an autobiographical novel or an autobiography per se, a patient experience narrative is never an exact reproduction of the human experience in question; it is an interpretation of it, a construction – within a socio-cultural context.[13] A patient

[10] www.patiëntervaringsverhalen.nl.
[11] Parabirsing 2003, p. 12. More about patient experiences in the Netherlands: Vijselaar 1988; Louter 2005; Hovius 2015. International: Porter 1987; Reaume 2009 (based on an asylum in Toronto).
[12] Van de Bovenkamp/Platenkamp/Bal 2019.
[13] Fitzpatrick 2011.

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experience narrative is more than just an individual account. The form of the story helps the narrator to give meaning to a complex, ambivalent experience (such as suicide). Narratives also help to trace changes over time and to gain knowledge about what patients considered important at the time. In other words, they involve more than just the experience of the narrator. For this reason, patient experience narratives can also be used for research into the history of nursing and care.

5 Autobiographical Novels

To find answers to the main questions in this article, I examined a series of six Dutch autobiographical, published accounts by former patients, from around 1920 to 2015.[14] Suicide plays a role in all of them. Most of the stories can be found on the website www.patiëntervaringsverhalen.nl of Erasmus University Rotterdam. Since this study is an initial exploration of a topic that has not yet been studied in detail, the selection is somewhat arbitrary and in no way claims to be exhaustive. The sources are divided equally into three periods:

First period (± 1920–1960)

A. *Krankzinnigen* ("Madmen") by Fré Dommisse.

B. *Zorg dat je een gekkenbriefje krijgt* ("Make Sure To Get a Madman's Note") by Ger Verrips.

Second period (± 1960–1985)

C. *De inrichting. Dagboek voor mijn dochtertje* ("The Institution. A Diary for My Young Daughter") by Jan van Lemmer.

D. *Heden geen medisch bezwaar* ("At Present No Medical Objections") by August Geldof.

Third period (± 1985–2020)

E. *Kerstbomen in de hel. Achter de schermen van de psychiatrie* ("Christmas Trees in Hell. Behind the Scenes of Psychiatry") by Amber Gardeniers.

F. *Up. Psychiatrische roman* ("Up. A Psychiatric Novel") by Myrthe van der Meer.

This division coincides more or less with important changes in the history of psychiatry in the Netherlands.[15]

The leading questions in this article – how were suicides in the hospital described by fellow patients in the past, and how did these descriptions compare to developments in the context of nursing and care? – will be approached with methodological tools derived from narrative historiography and contemporary studies of patients' accounts of their experiences.[16] This includes questions like who is the narrator? When and why is the story told? How did the narra-

[14] Dommisse 1929; Verrips 1973; Van Lemmer 1975; Geldhof 1977; Gardeniers 1995; Van der Meer 2015.
[15] Oosterhuis/Gijswijt-Hofstra 2008, passim; Aan de Stegge 2012, passim.
[16] Sools et al. 2014, p. 11; Burke 1969; Charon 2006.

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tor experience suicide? What is said about the nursing staff? And what does this say about the care context in which the suicide event took place?

These are, of course, also the standard critical questions asked in historical source research. At the risk of appearing somewhat anachronistic, in order to dig deeper, the texts will also be compared to one of the few contemporary studies I found concerning suicide seen through the eyes of fellow patients: a Canadian study from 2015 by Mary Seeman.[17] Seeman's study focusses on a community mental health service, but also describes other cases (including in-hospital situations) in Canada. Making such past-present comparisons is not uncommon, especially in the field of public administration and political decision-making.[18]

In addition, at first glance, it seems that several results of this research could also apply to the two historical sources mentioned at the beginning of this study: the suicide threat is omnipresent in both of them and it seems to have had a profound impact on both of the narrators. Seeman's analysis too may ultimately be useful for further research into the history of suicide seen through the eyes of fellow patients, which in turn may provide pointers for nursing and care today. So the last question to be asked will be: what are the differences and similarities between the historical texts and Mary Seeman's research? But first let me elaborate on the findings presented in her study.

6 A Useful Framework

"A suicide of a patient in a service for the seriously mentally ill can exert a profound effect on peer survivors," Seeman states.[19] In a psychiatric setting, suicide risk is higher than in society as a whole; the threat of suicide is ubiquitous. Outside the institution, patients also face a higher risk of suicide, whether it concerns a family member (because of possible heredity of the disorder), a fellow outpatient and/or a friend. In the latter case, as a result of their condition, people with psychiatric disorders often have few social contacts. The few friendships they *do* have are usually very close – and these are often fellow patients.

Because of their condition, patients are vulnerable, so the impact of suicide by a loved one has a profound effect on their well-being – not only because they identify with the deceased. They can also be affected by the suicide of a stranger (news of a suicide spreads quickly). The better one has known the deceased, the deeper the impact. The event leads to an overwhelming sense of vulnerability, and the stress can result in depression, anxiety and increased psychotic symptoms. Drug abuse may also increase. In addition, there is an obsessive need to understand why the suicide occurred, to find a rational explanation or meaning in what happened. For many co-patients, it triggers feelings of guilt and self-blame, for example because they did not inform the staff about the suicidal plans of the deceased, or did so too late.

Copycat behaviour comes in many forms and various factors may be involved. Susceptibility to commit suicide can be triggered by concern for or identification with the deceased. Some-

[17] Seeman 2015.
[18] Boele/Dixhoorn/Van Houwelingen 2015.
[19] Seeman 2015. The rest of this paragraph is based entirely on Seeman's article. Unfortunately, the article does not contain page numbering.

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times the act is glorified by co-patients. Furthermore, circulating detailed information about the suicide method may give ideas to fellow patients.

Surprisingly, suicide in an institution can also have long-term positive consequences for the victim's fellow patients. Patients who normally lead rather isolated lives may be forced by a suicide to reflect on their relationships with others. This can lead to more self-respect and to connection with others, because together they have been able to overcome this adversity.

In short, the following factors play a role to a greater or lesser extent when a fellow patient in a psychiatric institution commits suicide:[20]

1. pervasiveness of suicide;
2. huge impact (shock, distress, disbelief etc.) especially when a friendship is at stake;
3. compassion for suicidal co-patients;
4. vulnerability, often leading to increased symptoms, anxiety, depression and drug abuse;
5. obsessive search for a reason;
6. feelings of responsibility (warning the nursing staff), guilt and self-blame;
7. copycat behaviour;
8. long-term positive consequences (sometimes).

As you can see below, these factors served as an additional analytical tool in the examination of the sources.

7 The First Period (± 1920–1960)

Broadly speaking, until the early 1960s, institutional psychiatry took place in large institutions, where men and women were accommodated in separate buildings. Quiet and restless patients were placed in different units, but the differentiation of patient groups did not go much further. From 1929, a system of 'open wards' (i.e. wards for voluntary admission) was funded by the municipalities.[21] Previously, the community paid only for patients admitted to an institution with a legal warrant. Now, many more patients were admitted to a mental institution on a voluntary basis. These patients enjoyed more freedom (hence 'open') – with all the risks that entailed. Privacy was non-existent.

Now and then, new forms of treatment were introduced, including bed and bath nursing, occupational therapy, electroshock and – from the 1950s onwards – psychopharmaceuticals. The patients, however, rarely saw a doctor; they were cared for, nursed and – sometimes – treated by (psychiatric) nurses and apprentices. In Catholic institutions, these tasks were mainly performed by nuns.

Vijselaar, who studied 160 patient records over the first half of the twentieth century, notes that suicide played a major role in institutions. Many patients had thoughts of death. They feared death, felt condemned to death or longed for it; suicidal thoughts were omnipresent.[22] In 1920, there were 579 successful cases of suicide reported by the Dutch government, 7.3 per

[20] I distilled this summary myself from Seeman's paper.
[21] Oosterhuis/Gijswijt-Hofstra 2008, pp. 269–174; Bakker 2009, p. 190.
[22] Vijselaar 2010, pp. 25, 57.

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100,000 inhabitants. Of these, it is estimated that half took place in an institution.[23] Nursing patients with suicidal thoughts and behaviour was very demanding and required a lot of attention. 'Successful' attempts were followed by a judicial investigation. The nurses were interrogated to find out whether they had followed the rules for dealing with suicidal patients (such as checking for sharp objects). If the answer was negative, dismissal could follow. Thus, suicide could pose a double threat to the nursing staff: fear of the act itself and fear of dismissal. Textbooks referred to the 'danger of infection' (copycat behaviour). This was one of the reasons why nursing staff were not allowed to talk to the patients about suicide.[24] So what did the patients themselves say about suicide during this period?

A. *Krankzinnigen* ("Madmen")

The first novel I examined, *Krankzinnigen*, is written by Fré Dommisse (1900–1971), who stayed in several institutions from around 1917–1922. She wrote the book about her experiences a few years after her discharge, with the intention of creating understanding for mentally ill people.

In this book, the word 'suicide' appears only twice.[25] But the narrator does experience its constant threat. The word 'death' appears as many as 54 times in the book. These include the death (whether desired or feared) of others, the desire to die, and death as salvation (either for oneself or for fellow patients). The narrator feels great pressure linked to the thought of suicide among fellow patients: "not a rest, it was a pressure, a tension".[26]

Fig. 2: Fré Dommisse (1900–1971), author of *Krankzinnigen.* Photographer unknown (private collection)

In addition, she feels uneasy, worried, almost afraid of her fellow patients' fate, for whom she feels great compassion. One of them is Trudy (Trui in Dutch), the young woman who is mentioned in the quotation at the start of this article. "When she lay still for a long time, the nurse on duty always went to have a look, and even during the day she was not allowed to have a

[23] Aan de Stegge 2012, p. 296.
[24] Aan de Stegge 2012, pp. 296–300.
[25] Dommisse 1929, pp. 45, 96.
[26] Dommisse 1929, p. 27.

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handkerchief with her, she had to ask for it."[27] The narrator also wants to warn the nurse (whether this actually happens is not clear):

> Trudy hasn't moved for a long time, Sister. I'm afraid, because one time they found her in the bathroom. There she tried to hang herself, and then she would be damned to God. Sister, I am afraid for Trudy, go and look again, please stop reading, otherwise it will be too late. Yes, that's right, she gets up already, takes the blanket off Trudy's head, everything is fine. Trudy should never lie under a blanket.[28]

The nurses have taken several precautionary measures. In a list on the cabinet door, the names of suicidal patients are underlined and medicines are carefully stored in a locked cabinet.[29] Nevertheless, the narrator manages to make a suicide attempt herself by using stolen medicine, but the nurse who had been negligent at first (she had left her keys on the table) then reacts quickly and adequately.[30]

Several factors in Seeman's research are reflected in Dommisse's novel: the suicide threat is omnipresent and has a profound impact on the narrator; she feels its pressure and is anxious. Her thoughts are constantly with her fellow patients; she is very concerned for them. She also wants to warn the nurse. Although the narrator herself attempts to commit suicide too, this might not be a copycat case.

B. *Zorg dat je een gekkenbriefje krijgt* ("Make Sure to Get a Madman's Note")

The second novel I examined is written by Ger Verrips (1928–2015). As a young conscript, he tried to avoid being sent to Korea (to fight in the Korean War 1950–1953) and for that reason he simulated a psychiatric disorder and was sent to a military hospital. This autobiographical novel with a sociocritical approach dates from the early 1950s.

The narrator describes two suicide attempts.[31] The first attempt concerns a boy who has been saving sleeping pills. The narrator's description is rather flat, but his fellow patients and the staff are shocked and upset: "A lot of boys got crazy. The hospital staff panicked."[32] However, the night nurse reacts resolutely. After the attempt, the staff (unsuccessfully) intervene to prevent copycat behaviour, talking to the fellow patients and checking all cupboards and duffel bags. In the narrator's hut, three patients were found to have pills in their possession too. Despite the precautionary measures, a second attempt takes place: a boy tries to hang himself in a bathroom, but is found in time.

The nursing staff's reaction is not described in detail, merely that some of them panic and others (in both cases a night nurse) react quickly and appropriately. The narrator feels the urge to warn the staff about the strange behaviour of another (befriended) fellow patient. "He

27 Dommisse 1929, p. 27.
28 Dommisse 1929, p. 30.
29 Dommisse 1929, p. 29.
30 Dommisse 1929, pp. 152–153.
31 Verrips 1973, pp. 127–134.
32 Verrips 1973, p. 128.

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too…? flashed through my mind. […] Suicides often give some kind of signal, I had heard. Should I warn the doctor about him?"[33] In the end, the suicide attempts give the narrator the idea to pretend to be suicidal in order to convince the staff of his serious psychiatric complaints.

In this novel too, several factors described by Seeman appear: fellow patients and staff in shock, an increase of psychiatric symptoms ('crazy'), concern for a (befriended) fellow patient and the urge to warn the staff. Copycat behaviour is also present, firstly through the precautionary measures after the first attempt and, secondly, in the following suicide attempt. There is, however, one aspect in this story that Seeman's research does not take into account when it comes to copycat behaviour: the narrator comes up with the idea of pretending to be suicidal. This has to do with the reason for his admittance: he was not actually mentally ill, but simulated his illness in order to avoid military service. Thus, in this story, suicide is presented as a plot twist. We will encounter this phenomenon (suicide as a plot twist) again later in this analysis.

In short: compassion for fellow patients

In both novels, several aspects of Seeman's study are visible, the most obvious being shock, compassion for fellow patients and the urge to warn the (nursing) staff. As mentioned above, in this period, patients had almost no privacy. As the wards were overcrowded, other patients were constantly watching them – and they did (in the selected novels, that is). Add to this the fact that after a suicide attempt, the nurses took immediate action – usually to prevent copycat behaviour. It is remarkable that, under these circumstances, suicidal patients *did* succeed in taking their own lives. How this was possible – for example, whether it was due to a lack of (qualified) nurses – requires further investigation.

8 The Second Period (± 1960–1985)

This period is a turbulent one in the history of mental health care in the Netherlands. As part of wider counter-cultural and social activism and an emerging patient rights movement, public interest in the fate of people suffering from psychiatric disorders increased. Hospital psychiatry was criticised, especially the strict regime and the medical model. This manifested itself in a spate of autobiographical writings criticising the lack of respect for patients and their experiences, the fact that patients were not being listened to, and authoritarian and coercive behaviour by therapists.

It led to new ways of dealing with psychiatric disorders: improved care, smaller (even single) rooms, more privacy. This was also due to growing general prosperity levels. Patients were given a greater say in their treatment – in interaction with the rise of the client movement. New groups of professionals entered the institutions, including body-oriented psychotherapists and sociotherapists, and the 'therapeutic community' made its appearance. In therapeutic sessions, patients started talking to each other about their experiences. In autobiographies,

[33] Verrips 1973, p. 130.

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authors demonstrate high expectations of psychiatry, which often fail to be met, resulting in both psychiatry and society being castigated in these books.[34]

According to the Dutch Central Bureau of Statistics (CBS), 30,000 people took their own life between 1950 and 1980, a considerable number of whom had psychiatric disorders. Suicide was more than twice as common in 1980 as in 1950.[35] However, for nurses, the probability of having to deal with suicide was much higher than these numbers might suggest. Not only did they have to cope with the 'successful' cases counted by the CBS, they also had to deal with patients who had suicidal thoughts or were suicidal (who planned to commit suicide). These phenomena increased dramatically between 1970 and 1980, although the cause is still unclear.[36] Still, the pressure that suicide risk put on psychiatric care remained as high as ever and, as in the previous period, police investigations took place after suicides.[37] So how did fellow patients describe their experiences of suicide during this period?

C. *De inrichting. Dagboek voor mijn dochtertje* ("The Institution. A Diary for My Young Daughter")

After driving while heavily intoxicated with drugs and alcohol and nearly causing an accident, writer and journalist Jan van Lemmer (pseudonym for Jan de Boer, 1930–2003) was admitted to a mental hospital in 1968. In the institution he kept a diary, which he published a few years later. The book was intended as an indictment of consumer society and of distressing and often silent suffering, especially in psychiatric institutions.[38]

Two cases of suicide attempts come up in this novel. The first one concerns an attempt that can hardly be called serious: in a flash of insanity, a patient grabs a knife and threatens to kill himself. Fellow patients immediately intervene in order to avert the danger. "[L]ike shit mosquitoes we immediately got on top of him [...] [and] managed to calm him down."[39] The narrator adds that the nurses "were fortunately not needed", as if normally, when something like this happened, the staff were immediately warned.[40]

The second description pertains to a suicide attempt which ends with the death of a patient. During unsupervised leave, this patient took his own life by jumping in front of a train. The narrator is deeply shocked. "Unbelievable, such a quiet, handsome, sympathetic guy, and now cut to pieces."[41] The suicide seems to have an effect on the fellow patients, the atmosphere is "sombre and stuffy". In the narrator's words, "We are all suffering from it."[42]

The narrator tries hard to understand why his fellow patient committed suicide.

34 Parabirsing 2003, p. 14.
35 Aan de Stegge 2012, p. 827.
36 Aan de Stegge 2012, pp. 827–836 and 841–842.
37 This is evidenced in part by a study by psychologist A. Kerkhof, cited at several points in Aan de Stegge 2012, pp. 827–842.
38 Van Lemmer 1975, cover text.
39 Van Lemmer 1975, p. 51.
40 Van Lemmer 1975, p. 51.
41 Van Lemmer 1975, p. 56.
42 Van Lemmer 1975, p. 57.

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> Just last night he asked me, 'Do you think I am normal?' [...] Of course I said yes, I am neither God nor doctor, but what is normal? I don't know anyone without a strange trait or a certain frustration or peculiarity. But there must have been a lot going on with him, otherwise you don't just throw yourself in front of a train [...] What happened last night, what happened this morning?[43]

In these examples, several aspects noted in Seeman's study seem to apply: although there appears to be no pervasive fear of suicide, when it does happen (one attempt and one successful suicide), it does have an impact on the other patients. In the first case, the others react so quickly that informing the nurses – which would have been a usual action – was not even necessary. In the second case, the fellow patients seem to be depressed: "We are all suffering from it." However, the most important aspect seems to be the narrator searching for a rational explanation of what happened to the patient who took his own life: the 'why?' The narrator does not find the answer.

D. Heden geen medisch bezwaar ("At Present No Medical Objections")

The Flemish writer August Geldhof (1922–1981) wrote in 1977 a sociocritical novel about the time he spent in an institution. In this novel, the author wanted to show that mentally ill people are no different from healthy people.[44]

Suicide occurs twice. At first the narrator shows anxiety when a befriended fellow patient unfolds his suicide plans. He is shocked and shows grief. "Oh Jules, if only you knew how sad those words made me feel. You have pierced my heart [...]. You must have been plotting from the day your voices informed you about that date."[45]

In the second fragment, another fellow patient has committed suicide by hanging. The narrator is deeply shocked by this: "'Jesus Mary', I groan and make the sign of the cross."[46] He drowns his sorrows in whisky, which he presumably smuggled in. Then he writes, "Edwin, my heart's blood! These last words today for you!"[47] The narrator also shows a certain feeling of guilt; suddenly he remembers that the deceased had given him a large sum of money that morning. "Now I understand why [...]."[48]

Although the nursing staff hardly appear in the fragment about suicide, some criticism can be heard; however, this criticism does not concern the nurses themselves, but society as a whole. A fellow patient (George) reacts rather bluntly, saying "If a madman has something like that in mind, he carries out his plan. Whether he is on leave or in an institution."[49] The narrator responds, as if stung by a wasp: "Is that your opinion?" George's reaction doesn't make it any better: "Do you have another opinion? What do we have, what do the doctors have, what do

[43] Van Lemmer 1975, p. 56.
[44] Bruinsma 1977.
[45] Geldhof 1977, pp. 8–9.
[46] Geldhof 1977, p. 186.
[47] Geldhof 1977, p. 188.
[48] Geldhof 1977, p. 189.
[49] Geldhof 1977, p. 189.

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the staff have to do with this desperate act?" The narrator's answer makes it clear that he is trying to make sense of the suicide, to put what has happened in a social context. "We all have to do with it, Georges. When someone hangs himself in an institution, everyone, the family, the doctor, the nurse, the carer, the whole society has something to do with it' [...]."[50]

Here again we see many aspects identified by Seeman: concern about the fellow patients involved in suicide, shock and distress. It is not clear whether there is any copycat behaviour; the two events seem to be unrelated. The second event also leads to an increase in substance abuse (drinking). Self-reproach occurs indirectly, in the sentence "Now I understand [...]" – as if he means to say: "I should have seen it coming and (perhaps) warned the staff". Most important however is the need the narrator feels to find meaning in what has happened. "When someone hangs himself in an institution, everyone, the family, the doctor, the nurse, the carer, the whole society has something to do with it' [...]." In the context of the story, this even seems to be a key phrase. Not only suicide, but all forms of psychiatric suffering concern the whole of society.

In short: looking for an explanation

In the novels in this section, too, various aspects of the results of Seeman's research can be recognised: the great impact of what happened, the shock, the distress, which in the second case even leads to alcohol abuse. In the latter case, the feeling of self-reproach will also have played a role. However, the most striking aspect may be the attention given by both narrators to the search for a reasonable explanation of what happened. This aspect was not addressed in the previous two novels, *Krankzinnigen* and *Zorg dat je een gekkenbriefje krijgt*, probably because the suicide attempts in these two books were unsuccessful. But there may also be other explanations. As mentioned, it was a turbulent time in psychiatry. One of the major differences from the previous period is that in therapeutic sessions patients started to talk in detail about their own experiences. Perhaps this made the narrators more aware of the possible motives that their fellow patients may have had to commit suicide. Here too, further research is needed.

9 The Third Period (± 1985–2015)

From the mid-1980s onwards, psychiatry went through a major transformation, which is still taking place today: scaling up, de-institutionalisation and commercialisation. Massive institutions became out of date and were closed down. Mergers took place and space was created for (commercially attractive) milder forms of psychiatric care (more oriented towards outpatient counselling or guidance etc.). Groups of patients could now be accommodated in smaller units 'in the city' (sheltered housing). Some patients ended up on the streets, especially after 1993, as a new law on psychiatric hospital admission was passed, which made involuntary admission more difficult. However, voluntary admissions continued to exist, but their duration decreased. Psychiatry was criticised less than in the previous period, as one can also see in autobiographical writings. The writers of these documents seemed to accept the prejudices

[50] Geldhof 1977, p. 189.

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against patients with a psychiatric illness more easily and dared to write about their psychiatric 'coming out'. Their texts are more individualistic and focused on personal growth.[51]

The number of suicides in the Netherlands decreased.[52] In the years around the turn of the century, the number was stable for a while. However in 2008 it increased again – in connection with the economic crisis. Since 2013, the figure has fluctuated around 10 per 100,000 inhabitants. Mental disorders still play an important role in suicide. Of the people who commit suicide, 2/5 on average are being treated by a mental health institution. This means that suicide is still an important factor in mental health care. So how did patients write about suicide in this period?

E. *Kerstbomen in de hel. Achter de schermen van de psychiatrie* ("Christmas Trees in Hell. Behind the Scenes of Psychiatry")

Narrator Amber Gardeniers (pseudonym for Ietje Hoving, 1952–2002) was admitted to a mental hospital in 1992, where she was treated for pain-related depression. The autobiographical story *Kerstbomen* was meant to be a therapeutic instrument, a way of 'writing off' her fear, anger and rebellion about her illness, including towards God. She wanted to encourage others and herself. (Later in life, she commits suicide after all.)[53]

Suicide plays a major role in this story. In several chapters, the narrator introduces fellow patients with whom she gets along (very) well, but who eventually commit suicide. Among them is Henri Latour, who had been in rehabilitation from drug use, but who started using again in the institution. He manages to escape from the ward and commits suicide by jumping in front of a train.[54] Another patient is Bella, with whom the narrator becomes close friends. She writes a farewell letter to the narrator and jumps off an apartment building.[55]

In both cases, the narrator is in shock. For example: "I could not sleep for two nights. And although I cried continuously in my heart, my eyes remained dry."[56] Her shocked reaction is understandable: she had formed a bond with the victims and is very concerned about them. With Henri, she almost sees it coming: "In the weeks that followed, I began to realise that there was something terribly wrong with Henri."[57]

The nursing staff play a modest role in the suicide fragments. In the first case, the narrator introduces a doctor who declares in a serious tone that Henri has committed suicide. He adds, "'Anyone who feels the need to talk to one of us should let us know [the 'us' being himself and the nurses]. For the next three days, no one is allowed to leave the ward without an escort.'"[58]

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51 Parabirsing 2003, p. 16.
52 https://opendata.cbs.nl/statline/#/CBS/nl/dataset/7022gza/table?ts=1689675946484 (CBS=Central Statistics Bureau).
53 Van Hintum 2018.
54 Gardeniers 1995, pp. 87–89.
55 Gardeniers 1995, pp. 114–115.
56 Gardeniers 1995, p. 89.
57 Gardeniers 1995, p. 87.
58 Gardeniers 1995, p. 88.

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Of course this leave restriction is a precautionary measure to prevent copycat behaviour. In the second case, keeping her face blank, a nurse tells the narrator that Bella has been found.[59]

The narrator identifies with the victims and shows an increase of psychiatric symptoms. The death of her fellow patients causes her to play with suicidal thoughts herself. This can also be seen as copycat behaviour, fuelled by identification with the victims and by knowledge of the modus operandi chosen by the victims:

> Thus, I was trapped between my wavering faith and the bare, bitter facts. And as the pain grew worse, so did my longing for salvation. And I trusted that God would forgive me the sin of suicide. I had heard that two ways were the most guaranteed: throwing yourself in front of a train or jumping off a high building. And I knew it: Henri and Bella, after all… Although this knowledge evoked images that sometimes choked me to death, I tried to look beyond: I would wake up in a new perfect life and I would be greeted with joy. And gradually, the prospect of my salvation began to overpower my fear. And thus a plan developed in my mind, a plan that began to take shape […].[60]

In the end, she abandons her plans, supported by her faith in God. The fact that she does commit suicide a few years later is beyond the scope of this story.

Almost all aspects of Seeman's research appear in these fragments: the suicide threat is ubiquitous in the institution. The narrator describes several (successful) attempts by befriended co-patients, which have a profound impact on her well-being, leading to shock, grief, increasing vulnerability and psychiatric symptoms (depression). The urge to warn the staff leads to a small sense of self-reproach, for being too late. In the end even copycat behaviour occurs, with the narrator contemplating the possibilities of suicide herself, obviously infected by the knowledge of the previous cases involving her fellow patients.

F. *Up. Psychiatrische roman* ("Up. A Psychiatric Novel")

Author Myrthe van der Meer (1983) was previously admitted to a psychiatric unit in a general hospital. *Up* is the second novel about her psychiatric experiences. The novel is more or less autobiographical, being based on experiences in various mental institutions, both as an outpatient and as an inpatient. The novel was written after her last discharge.

The novel contains several fragments about the threat of suicide: suicide is omnipresent. This is partly because the narrator herself regularly thinks about suicide. She also describes several cases of (nearly successful) suicide. For example, there is a fellow patient who tells about a suicide he witnessed – someone the narrator also knew from a previous admission.[61] Another fellow patient (Beatrice) is about to attempt suicide herself, with pills that were left unattended. The narrator 'catches' her just in time and intervenes by talking her out of it.[62] There are other examples, but this one contains all the ingredients that apply to this study:

[59] Gardeniers 1995, p. 115.
[60] Gardeniers 1995, pp. 119–120.
[61] Van der Meer 2015, pp. 62–63.
[62] Van der Meer 2015, pp. 261–263.

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Beatrice is sitting on the bed with the bag of drugs clutched in her hands, when the narrator enters her room. She shows her concern, saying, "I thought everyone was asleep by now [...] That's why I thought it was so strange that your door was open. I thought... Is something the matter?" Beatrice does not react, instead she gazes at the white paper bag clasped stiffly between her fingers. Then the narrator understands what is going on. "Where did you find those pills?"[63] The thought that Beatrice wants to commit suicide seizes the narrator: "I feel my stomach cramping." Beatrice explains her motives: "This emptiness... I can't do it anymore. I finally don't want to feel it anymore. I can't anymore. I don't want to anymore."[64] In the end, the narrator is able to persuade Beatrice to hand in the pills herself.

> We'll take this back to the nurses, you tell them you found them, so you can talk to them about how you feel now. The alternative is that you sit here in the dark like this for a few more hours until the night shift comes, then they take the pills away from you and put you back in lock-up.

The thought of being locked up in the closed ward persuades Beatrice.[65]

Later in the story, the narrator again talks to Beatrice about suicide. Beatrice tries to understand her own reasons for wanting to take her own life.

> When I was on the other side, I heard the nurses talking about suicide, how many people a year... And that's not me. I'm not someone who... And yet I'm sitting here now, waiting until Christmas, until I can end it myself. I just don't get it. I never thought I would ever be one of them, one of the numbers.

Once again, the narrator shows her feelings: "Painfully stricken, I look away."[66]

The nurses are only mentioned indirectly: the sloppiness of one of them (who left the pills unattended), the office where the pills must be returned (in exchange for a good conversation) and also the threat: if Beatrice does not return the pills and she is 'caught' (by the nursing staff), she will have to go back to the closed ward.

As in the previous story, almost all aspects concerning suicide in fellow patients that Seeman found in her study occur in this novel: the threat of suicide is omnipresent. The subject is often mentioned in the book and the narrator often thinks about it. The great impact that the threat has on the narrator is especially evident in the quoted fragments about Beatrice. Empathy and concern are obvious. The search for meaning is also present: Beatrice wants to understand why she wants to leave this life. The narrator hesitates whether to warn the staff, but eventually solves the problem herself. Copycat behaviour is also indirectly discussed at the end of the book. There is even a positive effect of the suicide attempts: the narrator understands that suicide is not the answer. Then she is discharged. In this way, the threat of suicide in this novel can also be seen as a plot twist.

63 Van der Meer 2015, p. 261.
64 Van der Meer 2015, p. 262.
65 Van der Meer 2015, p. 263.
66 Van der Meer 2015, p. 295.

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In short: the narrator's own feelings

Suicide is omnipresent in the institution, but also in the stories themselves. The narrators often write about it, they often have suicidal thoughts and even make plans to take their own lives. There are several cases of suicide in both books, with copycat behaviour playing a role to a greater or lesser extent. The narrators show exactly the thoughts and feelings that Seeman also describes. The events make a big impression on them, they identify more or less with the victims, their symptoms worsen (this only applies to Gardeniers' text) and an explanation is sought – in the first case by the narrator herself, in the second by the patient with suicide plans. In both cases, there is a strong urge to warn the staff in time.

What is particularly striking in both texts is the personal way in which the authors deal with suicide. In all the previous texts (with the possible exception of the first one), we see that suicide is described in a rather distant way, as something that concerns 'others'. In the last two texts, however, there is much more of a connection with the narrator's individual experience: they start to think about suicide themselves. This fits in well with the trend in autobiographical psychiatric writing in general – a more individualistic approach to the writers' experiences. Here too, suicide is used as a plot twist. We will come back to this.

10 Conclusions

In this article, six autobiographical writings have been studied using methodological tools from narrative historiography. The analysis uses a recent study of patient experiences to answer the question of how in-hospital suicides were presented by fellow patients in the past, compared to developments in the context of nursing and care.

In general, we can observe that, in almost all cases, the narrators are people who have been admitted as adolescents. They wrote down their stories relatively soon after their discharge. The writers wanted to create understanding through their stories. For example, Dommisse writes: "The purpose of this book has been to help bridge that gap (between normal and abnormal people) by creating understanding."[67] Others used writing as social criticism, like Geldof, who wanted to make clear that 'normal' people are not that different from mentally ill people and who wrote: "'When someone hangs himself in an institution, everyone, the family, the doctor, the nurse, the carer, the whole society has something to do with it' [...]"[68] And some used their books as a form of therapy. Amber Gardeniers is the best example of this. She wrote her novel to 'write off' her fear, anger and rebellion about her illness, including towards God. She wanted to encourage others and herself.[69]

Suicide is of course the main focus of all the selected quotes; the threat of suicide is constantly present in most of the stories, especially in those written in the first and the last period. The suicide attempts (whether successful or not) occur in various forms: drugs and hanging are the most frequently mentioned, but there are also instances of jumping in front of a train or from a flat. Over time, there seem to be only slight changes in the way the suicide takes place. Suicide by drug overdose appears to be relevant in all time periods, as does hanging, but sui-

67 Dommisse 1929, p. VIII.
68 Geldhof 1977, p. 189.
69 Van Hintum 2018.

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cide by train, by jumping or by drowning could of course only occur when patients were able to leave the institution unattended (whether or not for a short time). What this meant for the nursing staff – for example in terms of increasing fear of incidents – needs further investigation.

Although suicide has played a major role in the work of nurses throughout history, in most of the fragments no judgement is made about the nursing staff. However, as the literature shows, patients had generally become more assertive by the mid-1960s. One might expect that their expectations of care providers would have changed as far as dealing with the threat of suicide was concerned. Yet this is not explicit in the chosen books. More research is needed to find out if this is indeed true – did patients' expectations increase after the 1960s with regard to nursing staff involvement in the event of suicide? And if so, might these high expectations have been frustrated more often?

Seeman's descriptions provide an adequate narrative that is also relevant to experiences of fellow patients who witnessed suicide over time. The aspects of her study often recur. Whether the story is set in 1920, 1970 or 2010, three factors are almost always represented: the ubiquity of suicide, the major impact of a suicide on co-patients and the concern for fellow patients. Frequently, the severity of the event manifests itself in an increase in psychiatric symptoms. Anxiety often leads to the desire to warn the nurses, who will do everything possible to prevent suicide – sometimes, unfortunately, without success, and this can lead to copycat behaviour. Feelings of guilt are seldom reported.

In a few cases there are also positive effects, but these are only found in autobiographical novels using the suicide (threat) as a plot twist (with Verrips and Van der Meer). Perhaps further research could determine to what extend psychiatric novels make use of the phenomenon in this way. It would be interesting to find out whether the use of narratives in this respect can have a therapeutic function.

Fig. 3: Patients waiting to see the doctor, with figures representing their fears. Oil painting by Rosemary Carson, 1997. Welcome Collection

It seems then as if the experiences of fellow patients with suicide in the institution have not changed much over the past century. So has everything really remained the same? No. What

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does seem to have changed is the amount of text devoted to suicide in psychiatric patient stories and the personal touch, the openness with which this is done. In the last period, suicide is given a lot of attention. It is not entirely clear why contemporary authors are eager to write about suicide. Perhaps it has to do with the reason why patients want to tell their story. In the 'critical' age between 1965 and 1985, the stories focused mainly on the more problematic sides of mental hospitals. In the period thereafter, the experiences of the narrators themselves were the main focus. In this context, it is perhaps more logical to expose the experience of suicide. The story of Amber Gardeniers illustrates this particularly well. Almost all the chapters she dedicates to a fellow patient end with (an attempted) suicide. Here too, further research is needed.

As mentioned above, this article deals with a hitherto unexplored but promising research field. From the sources it can be concluded that suicide is an ever-present phenomenon in the psychiatric hospital, it has a major impact on co-patients, and patients can be very concerned about their fellow patients' fate. These factors seem not to have changed over time. Further research can reveal whether these provisional conclusions are correct, whether they also apply to other areas of mental health care (e.g. outpatient care) and whether there are differences between patient groups over time – for example, between men and women, or between different diagnoses. The function of narratives (suicide as plot twist) as a therapeutic tool may also be further explored.

But above all, the role of the nursing staff also deserves further investigation, as they are the ones who deal with the patients the most. In such research, narrative historiography based on patient stories can be a good starting point.

As is shown in this article, in the absence of a historical framework for this type of research, the analysis of Seeman can provide a reference for hypotheses regarding this topic. Considering that historical research into health care and nursing contributes positively to future health care policy decisions, research on patient experiences of suicide by fellow patients is to be recommended. Research from the patient perspective is needed to further develop the historiography of (psychiatric) nursing and of psychiatric care today for people at risk of suicide.

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"An Optimal Relationship of Familiarity and Trust": Operating Room Nurses' Material Knowledge of Surgical Instruments (1900–1975)

Mieneke te Hennepe

Abstract

This article investigates the development of nurses' knowledge of surgical instruments in the twentieth century. Material knowledge has been an overlooked area of nursing history. Yet surgical nurses in particular gained a great amount of knowledge about the material qualities, handling, manoeuvring, and arranging of many different types and varieties of surgical instruments. By studying objects, film, handbooks, and the first Dutch journal for surgical nurses, this article focuses on three areas of material "literacy", using the Dutch context as a case study. First, it explores the way nurses had to understand and work with different materials before, during and after operations. Second, it discusses training in dealing with instruments. And third, it considers the explicit need for and discussions around uniformity and standards for surgical instruments, which show the professionalisation of surgical nursing during the 1960s and 1970s. By taking a fresh look at surgical instruments from the nurses' perspective, a new picture emerges, revealing the importance of surgical instruments for nursing history.

Keywords: History of Nursing, Material Culture, Surgical Instruments, Surgical Nursing, 20th Century

1 Introduction

Figure 1: Combination of two skull saws (left), Cornelis Solingen, 1650–1684, inv. no. V08028, collection of Rijksmuseum Boerhaave; and Combination of two probed incision knives (right), Cornelis Solingen, 1650–1684, inv. no. V08061, collection of Rijksmuseum Boerhaave.

How can two seventeenth-century surgical tools shed light on the instrument knowledge of operating room (OR) nurses in the twentieth century? In 1965, Ethicon OP Forum, the first Dutch journal for OR nurses, devoted several pages to a discussion of the history and specifics of surgical instruments made by the surgeon Cornelis Solingen (1641–1687) (see figure 1).[1]

[1] Chirurgie in de 17e eeuw 1965, pp. 3–6.

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This journal first appeared in 1963, and provided a much anticipated focus on OR nurses, who were, according to one nurse, in danger of becoming a "forgotten group".[2]

Ethicon OP Forum: een tijdschrift voor de operatiezuster ran under this title between 1963 and 1989 and its first article with a historical focus appeared in the very first issue.[3] It was published by Ethicon, a company producing surgical sutures and wound closures.[4] The free journal published articles written by surgeons, nurses and head nurses for the surgical nursing community. According to the unknown author of the historical article on the seventeenth-century instruments, the surgical tools had "stood the test of time outstandingly".[5] Details concerning the difficulty of disinfecting the instruments and their manufacture must have made the subject interesting to the target readership of OR nurses.

In this paper, I will argue that for the OR nurse in 1965, the discussion of these old instruments, their manufacture, purpose and usage in the seventeenth century appealed to their own material expertise. What (material) knowledge of surgical instruments did OR nurses gain during the formative period of the profession in the first three quarters of the twentieth century?

This paper investigates how (surgical) nurses developed a deep and increasingly professionalised knowledge of surgical instruments between 1900 and 1975. How did OR nurses in the twentieth century learn and internalise instrument knowledge? And what role do material qualities and the senses play? By looking at surgical instruments from a nursing perspective, this paper argues that material knowledge is a crucial and overlooked part of nursing history. What happens when we take a fresh look at material dimensions and objects?

Instrument knowledge today is part and parcel of nursing education and practices for every operation assistant or scrub nurse.[6] Yet when considering surgical collections in museums, and surgical instruments from a historical perspective, scholars have often primarily focused on surgeons as key figures in instrument development and usage.[7] However, historians of nursing have recently published new perspectives on the history of operation nursing. For the German context, a book on the history of the surgical assistant sheds new light on the history and importance of the figure of the surgical assistant,[8] and Bettina Schmitz provides a detailed description of how the duties and training of German surgical nurses changed in the twentieth

2 "We have been talking and asking around for a long time whether there was no magazine for OR staff. All the more so since this is or will become a 'forgotten group'." Original: "Reeds lang hebben wij gepraat en rondvraag gedaan of er niet een tijdschrift bestaat voor personeel van de OK. Temeer daar dit een 'vergeten groep' is of zou gaan worden." Reacties 1963, p. 2.

3 Wie vond de rubberhandschoen voor operaties uit? 1963.

4 Ethicon also published the bimonthly journal *Ethicon OP Forum* in German (*Ethicon Op-Forum; eine Zeitung fuïr die Op-Schwester* 1961–1995) and French (*Ethicon Op-Forum; journal pour l'infirmière de salle d'opération* [1961]–1969). The Dutch edition of the journal was edited by operating room nurse Zuster A.M. van der Laan from The Hague. She was most likely the author of many of the unsigned articles in the journal.

5 Chirurgie in de 17e eeuw 1965, p. 3: "[...] werktuigen [...] die voortreffelijk weerstand hebben weten te bieden aan de tand des tijds".

6 See for example Moutry 2018, and Criscitelli 2022, Chapter 11: Surgical Instrumentation. For the history of surgical instruments in museums see for example: Beretta 2014.

7 See for example the scholarly attention to invention and innovation of surgical instruments: El-Sedfy/Chamberlain 2014. See also Jones 2017.

8 Büttner/Pfütsch 2020.

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century.[9] Much revolves around instrument knowledge. Similarly, Thomas Schlich and Audrey Hasegawa's argument for the gender-specific prominence of cleanliness and ordering has a strong focus on surgical instruments in the US context between the 1870s and 1930s.[10] Yet the instruments themselves have hardly ever taken centre stage.

Despite recent attention to the history of operation nursing, the history of material knowledge for the OR nurse has not yet been studied in much detail. While operation nursing can hardly be defined by instrument knowledge alone, this paper will show why material knowledge is an underestimated yet important part of the practice of operation nursing. As Joan Lynaugh argued in New Directions in the History of Nursing (2005), nursing knowledge may form an important subject for studying the history of nursing.[11] A material focus on instrument knowledge in nursing can provide just that. Furthermore, Karen Nolte and Sabine Schlegelmilch have shown how an object-centred approach to the history of nursing can offer a valuable gateway for understanding nursing practices and the ways in which the uses of particular objects – theoretically conceptualised as "hybrid-objects" – demarcate nursing care from medicine as practised by doctors.[12]

Yet a focus on the practices around surgical instruments may highlight not only the responsibilities and boundaries of care, but also the value and extent of material knowledge. Taking a material culture approach, as recently discussed by Serena Dreyer, rather than using objects to understand their role in the demarcation of nursing practices, I discuss the role of "material literacy" for OR nurses in relation to surgical instruments.[13] While Dyer indicates that there is no unified agreed material culture methodology, I take material literacy here to mean the skills and competences for understanding the material world. The senses also come into play. As Dreyer states: "The sensory landscapes produced by and through objects, and the sensory strategies developed to navigate the material world, proffer rich veins for research."[14]

I will explore how nurses' material knowledge of surgical instruments was understood, disseminated and applied.[15] What skills did nurses acquire to deal with surgical instruments?

Nurses became involved in operations from the second half of the nineteenth century. With surgery and surgical specialisation gaining momentum towards 1900, more complex operations and new instrumentation entered the operating theatre.[16] Nurses in surgical wards took on more and more operation-specific duties, including the sterilisation of sponges, instruments and dressings.[17] By the first decade of the twentieth century, the term "operating room nurse" came into general use in the United States, and in the Netherlands the word "operatiezuster" (operation nurse) appears in new nursing handbooks and other publications.[18] World War II sparked a shortage in nurses and, while nursing at that time was not yet an official

9 Schmitz 2020.
10 Schlich/Hasegawa 2018.
11 Lynaugh 2005.
12 Nolte 2020; Schlegelmilch 2021.
13 Dyer 2021.
14 Dyer 2021, pp. 289–290.
15 Dyer/Wigston Smith 2020.
16 Büttner/Pfütsch 2020, p. 11.
17 Hamlin 2020.
18 Hamlin 2020, p. 21; Laan 1907.

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profession, the term in the Netherlands changed in 1966 from the female "verpleegster" to the gender-neutral term "verpleegkundige". Formal specialisation took place in 1974 in the Dutch context, when the operation assistant was formally recognized as a profession with specific training and a degree.[19]

Tacit and material instrument knowledge became crucial for the professionalisation of the surgical nurse, as this paper demonstrates, using the Netherlands as a case study. Whereas surgeons became more and more specialised in procedures after the 1930s, OR nurses consolidated their understanding and handling of instruments and were trained in their use. They thus formally established themselves as overall specialists in "instrumentation", in other words as experts in the material knowledge of surgical materials and equipment.

The central question this article will explore in the following sections is: What is the specific "material literacy" of an OR nurse and how is it acquired? Before discussing education and training and the practice of handling instruments, we first delve into nurses' understanding of and expertise in the material qualities of instruments and other surgical equipment.

2 The Materially Educated Nurse: Books, Photos, Films

For nurses who regularly assisted in operations, knowledge about the material qualities of instruments was indispensable. This included an understanding of the making, handling, manoeuvring, cleaning and stowing of the surgical materials and instruments. Take the example of catgut, a suture material made of animal intestines, mostly from sheep (see figure 2). Before the introduction of synthetic suture materials, catgut and silk were commonly used as surgical suture and ligature.[20] Surgical nurses had to be able to properly prepare and handle the catgut prior to and during a surgical procedure.

The disinfection of catgut in particular proved an important subject for surgeons, catgut producers and nurses. In his 1907 manual of surgical nursing, orthopaedic surgeon Hendrik Laan explained, for example, how to disinfect catgut.[21] While silk could be boiled in water, catgut could not be boiled as that would cause it to "spoil". Sterile catgut in glass bottles with a lid could be bought from the producer (figure 2). But Laan also explained how nurses should sterilise untreated catgut themselves. Unsterile catgut contained lots of fat and intestinal bacteria. The nurse was supposed to spread out the catgut threads and rub them with green soap to remove the fat. After 12–24 hours the threads could be placed in ether which should be refreshed until no more precipitation was visible. After several days, the catgut could be placed in a bottle with an alcohol solution. This detailed chemical description shows the degree of preparatory work and knowledge behind the sterilisation of only one type of surgical material.

Knowing about the constitution and origins of raw materials mattered for the crucial processes of sterilisation, one of the key responsibilities of the OR nurse. This cleanliness went beyond a common understanding of cleaning. It was a chemically informed, scientific and material understanding of sterilisation. In 1912, news of catgut infected with tetanus demon-

19 Bolks 2017.
20 See for example: Surgical Catgut 1929.
21 Laan 1907, pp. 131–132.

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strated how vital it was to have a proper understanding of suturing materials.[22] In Germany, ministerial orders for new production procedures for catgut were issued to prevent future infections. New labels were added to the products with information about the exact treatments and methods of sterilisation used in the factory, which nurses had to be able to interpret.

Figure 2: A ball of sterilised catgut suture material for surgical use in an alcohol solution. 1925–1950, inv. no. V25082, collection of Rijksmuseum Boerhaave.

As treatment and materials changed over time, nurses had to update their knowledge. In the second edition of Laan's manual for surgical nursing of 1927, changes in dealing with catgut for example were clearly present.[23] World War I had caused a shortage of catgut, and companies offering the material sterilised and ready for hospital use grew as a consequence, resulting in a large supply of sterilised catgut during the interwar period.[24] The Rotterdam company Eerste Nederlandse Snarenfabriek brought sterilised catgut to the Dutch market from 1917 onwards.[25] But even these ampules of catgut had to be treated before they could be used in operations.

Laan describes how nurses should have the sterilised ampules inspected by bacteriologists and also boil them.[26] By 1927, the advice was to treat the raw material extensively for several days with different solutions of iodine benzene, potassium iodide and alcohol.[27] By the 1930s, several brands of catgut were available on the Dutch market. In a 1939 manual for nursing gynaecological patients, nurses were supposed to learn about preparing catgut of different

22 Bereiding van catgut 1912. See also: Richardson 1909.
23 Laan/Klein 1927.
24 Mackenzie 1973.
25 Kupferschmidt 2019.
26 Laan/Klein 1927, pp. 124–125.
27 Laan/Klein 1927, p. 125.

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thicknesses on a surgical trolley prior to an operation.[28] Preparing the material, manoeuvring the trolley and handing over the right size of catgut were all part of the nurse's expertise. After World War II, questions about treating and sterilising catgut continued to be relevant for OR nurses.[29]

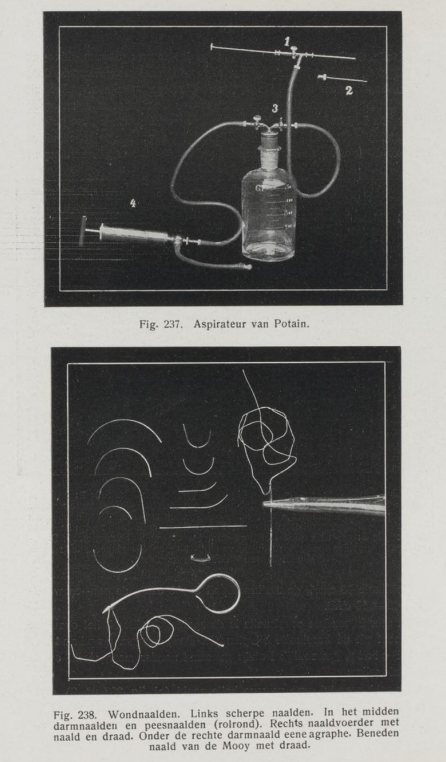

Figure 3: Depiction of instruments in Laan/Klein 1927, p. 238.

For the early twentieth century, sources relating to the actual practices of surgical nurses are scarce. However, handbooks containing instructions on materials and their uses can provide an insight into the proposed handling of surgical materials and instruments. Images and visual instruction matter here. While images in handbooks cannot convey the same knowledge about material aspects of instruments as could be acquired by handling or touching the physical surgical object, they did perform a particular function in providing knowledge about materials. Hence the authors of nursing manuals went to great lengths to make sure that the instruments, for example, were represented in the most detailed way.

For his manual on surgical nursing, Hendrik Laan had photographs of instruments and procedures taken by a professional photographer, Corine Ingelse (1859–1950). Ingelse was a female photographer who was also active in the Dutch Association for Women's Suffrage.[30] Ingelse's photographs in the manual form a particular visual language of surgical instruments. Mostly photographed against a black background or with a black edge around the photographs, the

28 Dongen 1939, p. 205.
29 Catgut 1963.
30 Wachlin 1994.

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scenes are highly staged and orchestrated; the photographs are probably extensively retouched (figure 3). Instruments, for example the wound needles in the lower part of the figure, are neatly arranged and ordered according to type: sharp needles, intestinal needles and tendon needles. The text refers to “straight, slightly and strongly curved” wound needles. Subsequent figures in the handbook show hands demonstrating the handling of needles.

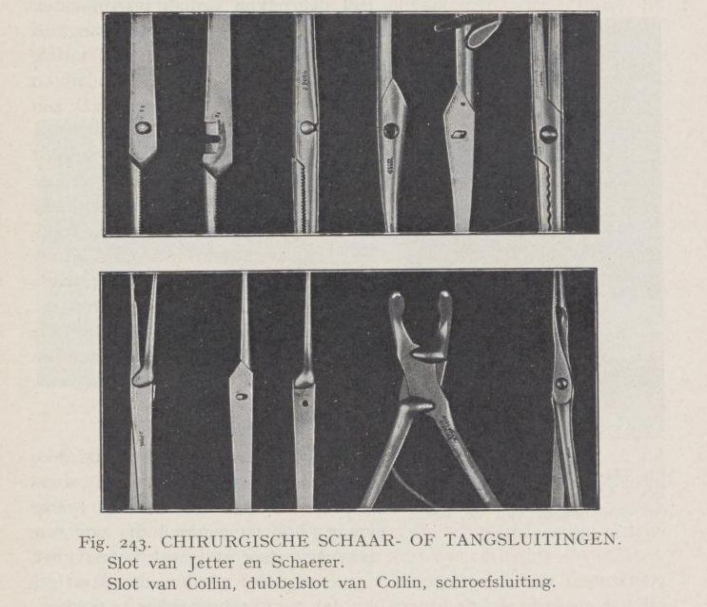
Fig. 243. CHIRURGISCHE SCHAAR- OF TANGSLUITINGEN.
Slot van Jetter en Schaerer.
Slot van Collin, dubbelslot van Collin, schroefsluiting.

Figure 4: Surgical scissor and clamp locks. In: Stumpff 1939, p. 359.

These photographs of arranged instruments and materials mimic the orderliness that the nurses needed to adopt in handling them. As such, the photographs in Laan’s manual can be seen as visual examples to live by. The photographs provide practical examples of handling and caring for surgical instruments, thereby enlarging the nurse's material instrument expertise in a visual manner. Similarly, one image in a 1939 manual shows the different detachable locks of surgical scissors and artery clamps (figure 4).[31]

Knowing about the most common constructions of interlocking parts of surgical instruments enabled nurses to anticipate handling and cleaning them. Nurses had to familiarise themselves with the different types of construction and structure of the instruments in order to dry them properly after cleaning them with soap and rubbing them with denatured alcohol. Photographs of instrument parts played an important role in expanding the material expertise of nurses, helping them to acquire practical knowledge about the structure of instrument parts and the sequence of different tasks.

Films offer another valuable insight into the prescribed practices and material knowledge of surgical nurses. For example, a 1938 British public information film about modern aseptic surgery, features (surgical) nurses handling and cleaning instruments before and during an operation.[32] At minute 3.10 we see a nurse taking a set of surgical scissors from the dust-free

[31] Stumpff 1939, p. 359.
[32] Modern aseptic operating technique 1938.

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cupboard where the instruments are kept, then bundling and counting them. She is shown sterilising the instruments by boiling them, as well as sterilising sharp instruments in Lysol, carbolic and formaldehyde solutions. The nurse takes out each instrument with different clamps to demonstrate it for the camera. Her handling is smooth and contained.

Focussing on the material skills in this film, we discover many more telling examples. At 5.50 we see a nurse preparing the instruments in the operating theatre. She handles sterile forceps to pick up a cloth from a sterilisation drum and spread it out on a table. She then takes sets of instruments (scissors, clamps, etc.) and places them, using forceps in each hand, on the cloth. This manoeuvre requires full control over the forceps. At another point (6.32–6.44) the camera zooms in on a special hook that the nurse uses to pick up multiple instruments at once. We again clearly see the dexterity involved in handling the forceps and hook to manipulate the instruments.

In the following section of the film, the preparation of the ligature table, the intertitles stress the fact that the theatre nurse uses forceps to move the table, because she has not "scrubbed-up" yet (7.31). In the remainder of the film, the nurse is seen handling many objects with either forceps or tweezers, for example a table, a lid from a metal container, swabs (that have to be counted and noted on a board) and bowls. It demonstrates a highly calculated and controlled way of handling and dealing with materials and instruments.

By the late 1960s, disposables proved an important game changer in practices around surgical materials. The increasing availability of disposables reformed the necessary material knowledge for sterilisation of instruments and other surgical equipment. The introduction of disposable gloves meant no more manual or mechanical checking for holes or careful powdering – not too much powder or it could accumulate and reduce the sense of touch for the surgeon, or act as a foreign body in the patient.[33] In the case of disposable needles, shaving knives and catheters, disposables could reduce or improve work processes, provide consistent stability and indefinite shelf life, and ultimately proved to be more cost effective, according to the author of an article in 1968.[34] Not only did nurses, and OR nurses in particular, maintain their knowledge and skills in dealing with a wide range of surgical instruments,[35] they also had to keep up with changes in materials. New materials could imply restructuring or changing workflows in the operating room, as was the case with the arrival of disposables. When disposable paper dresses became available for OR nurses in the 1960s, material knowledge changed as sterilisation was now entrusted to the factory.[36] But how would nurses learn about materials and instruments in the first place?

[33] De operatieafdeling 1968, p. 12.
[34] Het bevorderen van de steriliteit op een afdeling 1968, p. 13.
[35] For a reflection on instrument knowledge see Sandelowski 2000, pp. 35–38.
[36] Papieren zusters 1968, p. 16.

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3 The Skilled Nurse: Instruments

Education and training in the area of surgical instruments has a long history.[37] For nurses in the Netherlands, instrument education became part of the nursing curriculum from at least the early twentieth century.[38] Knowledge of instruments was part of the oral examination for nurses in 1911, organised by Nosokómos, one of the early Dutch associations for nurses.[39] Sterilisation, maintenance and cleaning of surgical instruments were seen as necessary requirements for a proper nursing education. In 1924, a law to safeguard nursing certification in the Netherlands came into effect, although it did not refer to requirements on the contents of the teaching.[40] Most nursing manuals contained a chapter or part of a chapter on instrument knowledge. A 1931 textbook included a separate chapter discussing instrument knowledge, mostly displaying the common instruments, their names and functions, how to keep them sterile, and how to handle them.[41]

Learning how to handle instruments meant practising manual dexterity. For example, early manuals included textual and visual instructions on ways to pass instruments to the surgeon during an operation (figure 5).[42] Handing over an instrument in a safe, timely and correct manner required trained skills and material knowledge on the part of the nurse. What piece is the most important part, how do I hand an instrument over in a ready-to-use state, where is it sharp, and how do I transfer it to the surgeon without compromising sterility? Each instrument could require a different approach, for example handing artery clamps over that are already opened and ready to use, or handing over a pair of scissors with the ring handles facing towards the surgeon.[43] Nurses were also taught to pay attention to the safety of both themselves and the surgeon during hasty transfers of sharp instruments, making sure they knew how to manoeuvre safely in a rushed situation.

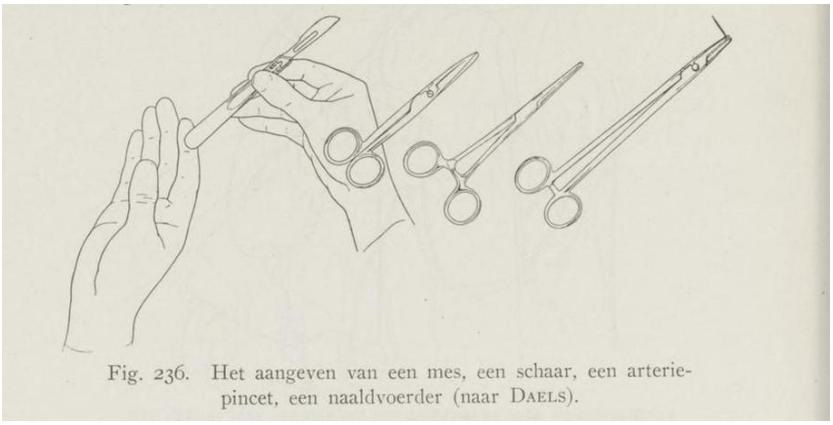
Fig. 236. Het aangeven van een mes, een schaar, een arteriepincet, een naaldvoerder (naar Daels).

Figure 5: Handing over Instruments. In: Van Dongen 1939, p. 234.

[37] Jones 2017.
[38] Dutch name is "instrumentenleer". See for example Centrale Gezondheidsraad 1911, p. 19.
[39] Centrale Gezondheidsraad 1911, p. 71.
[40] Aalberse/Ruijs de Beerenbrouck 1921.
[41] Gezelle Meerburg 1931.
[42] Dongen 1939, p. 230.
[43] Stumpff 1939, p. 360.

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Practice makes perfect, and that also applies to instrument education in nursing. We know at least that surgeons appreciated practically skilled nurses in the operating room. Leiden-based surgeon J.H. Zaaijer for example wrote in 1939 that his popular handbook on surgical nursing was not suitable as a textbook for OR nurses, because "the training to become an operating nurse must take place in the operating room".[44] Surgeons praised the practical experience of OR nurses they worked with. In a testimony on cataract surgery, a Leiden ophthalmologist explained how he nearly always performed a particular operation with the same OR nurse.[45] According to the ophthalmologist, the nurse had acquired a great deal of experience and skill as she was able to squeeze and release an eyelid-holder (figure 6) in such a skilful manner as to regulate pressure on the eye: "She is particularly skilled at squeezing and lifting the eyelid holder to immediately counteract any pressure exerted by the latter on the eyeball."[46]

Figure 6: Eyelid holder, 1925–1950, inv. no. V14279, collection of Rijksmuseum Boerhaave.

This OR nurse knew how to manipulate the instrument, which required a combination of manual dexterity and experience in using the instrument, and the ability to anticipate and react to events during the procedure. The nurse was expected to follow the operation very closely; she had to know in advance what instrument the surgeon was about to ask for, as noted later in the journal *Ethicon OP Forum* in 1964:

> Instrument handling can only be done properly if the nurse can follow the operation closely. She must therefore know what the surgeon is doing [...].

44 Hekman/Zaaijer 1939, Preface: "Men verwachte ook niet, dat dit boek geschikt zal zijn als leerboek voor operatiezusters. De opleiding tot operatiezuster moet in de operatiekamer geschieden; maar bij het verkrijgen van het zoo noodzakelijke begrip voor zich mogelijk voordoende toestanden kan dit boek wellicht helpen."

45 Flieringa 1941.

46 Flieringa 1941, p. 9: "In het bijzonder is zij er op ingesteld door samenknijpen en opheffen van den ooglidhouder een eventueelen druk van dezen op den oogbol onmiddellijk te ondervangen."

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> Actually, the nurse should know in advance which instrument the surgeon will ask for.[47]

A nurse's handling of surgical instruments is often very different from a surgeon's. Nurses hold the instrument at the opposite end to hand it over, and they may have to take instruments apart for sterilisation. Yet I would argue that surgical nurses obtained a wide range of skills in handling instruments, which are as valuable as, and mattered as much as the actual intended use of the instrument during operations. Furthermore, the wide variety of instruments and the material knowledge and experience in using them demanded different manual and intellectual skills than were required by the surgeons who used them. For example, nurses needed to know how to store, organise, clean and manipulate instruments for different surgical procedures. But instrument handling went further than this. Several ophthalmological manuals mention, for example, the importance for nurses of checking the sharpness of instruments prior to operations. They were advised to use a special test drum, which consisted of a very thin membrane of stretched chamois leather fixed inside a ring.[48] To prepare for ophthalmological surgery, the nurse was to test the sharpness of the fine cutting instruments, such as cataract knives and discission needles (see figure 7).[49] To handle the instruments in such a way, the nurse had to mimic the cutting pressure applied by the surgeon: "Fine, cutting instruments, such as cataract blades, lances, discission needles, must slide easily through the membrane without any force having to be applied and without the test drum grinding".[50]

Figure 7: Discission needle, 1925–1950, inv. no. V15909, collection of Rijksmuseum Boerhaave.

From the late 1960s, nurses and doctors started a discussion about the necessity of a legally recognized education for nurses and OR nurses.[51] In the Netherlands, nurses pleaded for a

[47] De operatiezuster als lid van het team 1964, p. 6: "Het instrumenteren kan alléén goed gebeuren als de zuster de operatie op de voet kan volgen. Zij moet dus weten wat de chirurg doet [...]. Eigenlijk moet de zuster van te voren weten om welk instrument de chirurg zal vragen."

[48] Heuven 1936, p. 93.

[49] Discission needles are long needles with two sharp sides. See also: Rompes 1940, p. 452.

[50] "Fijne, snijdende instrumenten, zooals staarmesjes, lansen, discisienaalden moeten, zonder dat er eenige kracht bij behoeft te worden uitgeoefend en zonder dat de probeertrommel daarbij knarst, gemakkelijk door het vliesje heenglijden." Heuven 1936, pp. 93–94.

[51] See also: Büttner/Pfütsch 2020 and Sandelowski 2000, pp. 115–120. For the Dutch context see Binnenkade 1973.

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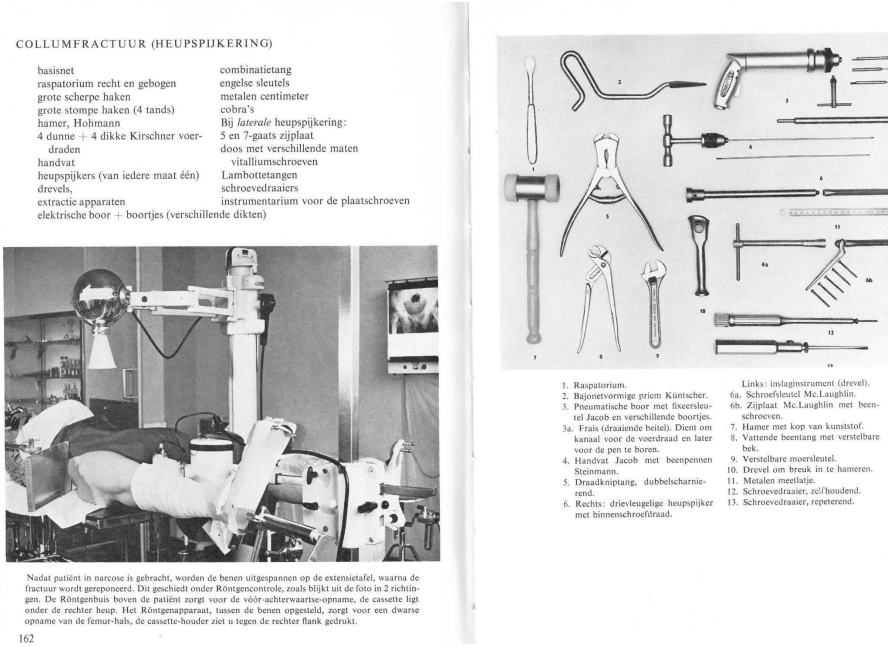
theoretical education in addition to practical training.[52] Instrumentation was still an important part of what had until then been primarily a practical education. But with increasing "mechanisation" and specialisation in surgery, "the days of the cleaning and soaking OR nurse are over".[53] Many OR nurses followed specialised training in orthopaedics, gynaecology or thoracic surgery for example.[54] And with the arrival of more medical staff, including the anaesthetist and the nurse anaesthetist, the division of labour also came under discussion. In a way, specialising in instrumentation for specific types of surgery made the operating nurse an even more integral part of the operating team.

In 1964, the first manual for OR nurses appeared in Dutch. The book, entitled "Instrumentenleer", provided easy orientation for OR nurses regarding surgical instruments, their names and uses.[55] Following sections on the specialisation and standardisation of surgical procedures, the book contains extensive photographic information on different types of instrument sets for any kind of operation common in 1964, including general surgical procedures such as appendectomy, herniotomy, stomach resection, and mastectomy. For urology, it contains specific instruments used for nephrectomy and prostatectomy among others. A similar approach is followed for procedures in orthopaedics and gynaecology. Instruments needed for each procedure are clearly named and displayed in photographs (figure 8). As such, the manual epitomises the continuing highly specialised instrument knowledge that OR nurses had to master.



COLLUMFRACTUUR (HEUPSPIJKERING)

basisnet
raspatorium recht en gebogen
grote scherpe haken
grote stompe haken (4 tands)
hamer, Hohmann
4 dunne + 4 dikke Kirschner voer-draden
handvat
heupspijkers (van iedere maat één)
drevels,
extractie apparaten
elektrische boor + boortjes (verschillende dikten)
combinatietang
engelse sleutels
metalen centimeter
cobra's
Bij *laterale* heupspijkering:
5 en 7-gaats zijplaat
doos met verschillende maten vitalliumschroeven
Lambottetangen
schroevedraaiers
instrumentarium voor de plaatschroeven

Nadat patiënt in narcose is gebracht, worden de benen uitgespannen op de extensietafel, waarna de fractuur wordt gereponeerd. Dit geschiedt onder Röntgencontrole, zoals blijkt uit de foto in 2 richtingen. De Röntgenbuis boven de patiënt zorgt voor de vóór-achterwaartse-opname, de cassette ligt onder de rechter heup. Het Röntgenapparaat, tussen de benen opgesteld, zorgt voor een dwarse opname van de femur-hals, de cassette-houder ziet u tegen de rechter flank gedrukt.

162

1. Raspatorium.
2. Bajonetvormige priem Küntscher.
3. Pneumatische boor met fixeersleutel Jacob en verschillende boortjes.
3a. Frais (draaiende beitel). Dient om kanaal voor de voerdraad en later voor de pen te boren.
4. Handvat Jacob met beenpennen Steinmann.
5. Draadknijptang, dubbelscharnierend.
6. Rechts: drievleugelige heupspijker met binnenschroefdraad.

Links: inslaginstrument (drevel).
6a. Schroefsleutel Mc.Laughlin.
6b. Zijplaat Mc.Laughlin met beenschroeven.
7. Hamer met kop van kunststof.
8. Vattende beentang met verstelbare bek.
9. Verstelbare moersleutel.
10. Drevel om breuk in te hameren.
11. Metalen meetlatje.
12. Schroevedraaier, zelfhoudend.
13. Schroevedraaier, repeterend.

Figure 8: Instruments used in column fracture surgery. In: Laan/Melse 1964, pp. 162–163.

52 Dam 1967.
53 Driel 1969 a, p. 2: "De tijd van de soppende o.k.zuster is voorbij".
54 Driel 1969 b.
55 Laan/Melse 1964.

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4 The Organised Nurse: Uniformity and Standardisation

The practice of working as a team in the operating room implied working together as a well-oiled machine. As one operating nurse put it in 1968: "The team spirit is very important at such a moment. You are working together, en bloc, so you all work together for that one person and everything falls away."[56] This quote comes from a Dutch television programme about an operating nurse. The programme portrays the nurse at work. She explains her motivation to work as a nurse in the operating room. We see images of her preparing for surgery, while she talks about her drive to care for patients, but also her specific interest in the surgical procedures and the variations in instrumentation for a range of different operations.

At one point in the programme, the camera takes the perspective of the patient being wheeled into the operating room. Here we see the nurse preparing the instrument table. She is portrayed in this reportage as the master of her domain; an eloquent, driven professional with lots of experience, who knows her own mind and is able to operate in a team. By the late 1960s, the operating nurse was a specialised team member with instrumentation as one of her main tasks.

Ever since nurses were required to lay out surgical instruments on a table or cloth, an unwritten standard emerged for arranging instruments. In Laan's 1927 manual on surgical nursing, we see an early example of surgical instruments spread out on a sterilised cloth (figure 9).[57] The order of the instruments on the cloth is not explained in the text.

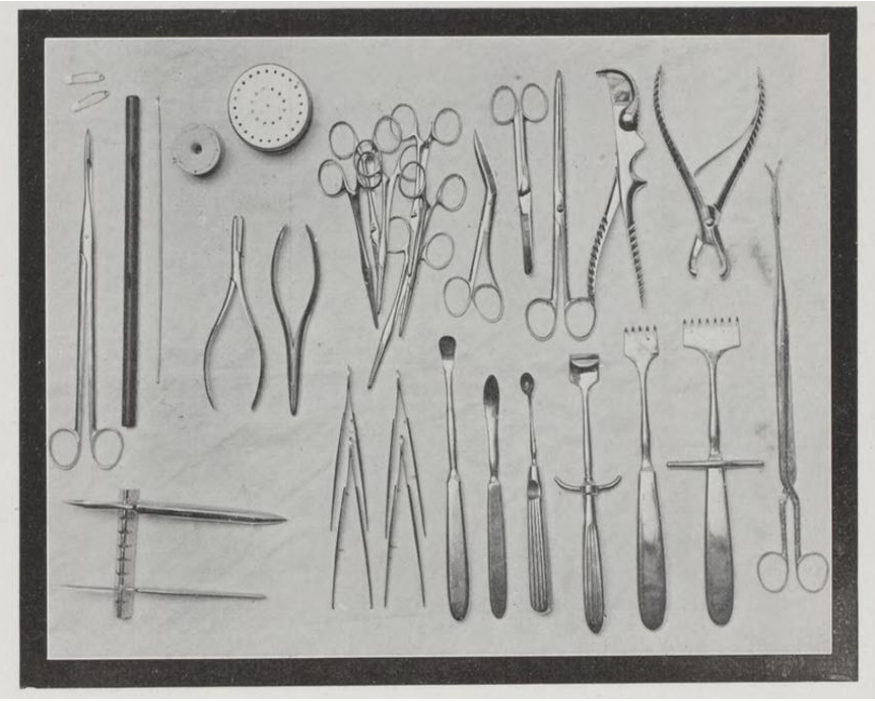

Figure 9: Instruments for rib resection arranged on a sterilised cloth in an early surgical nursing manual. In: Laan/Klein 1927, p. 118.

[56] Pasfoto 1968: "De teamgeest daar komt het op zo'n moment heel erg op aan. Je bent met z'n allen bezig, en bloc, en je werkt dus met z'n allen voor die ene persoon en alles valt alles weg".

[57] Laan/Klein 1927, p. 118.

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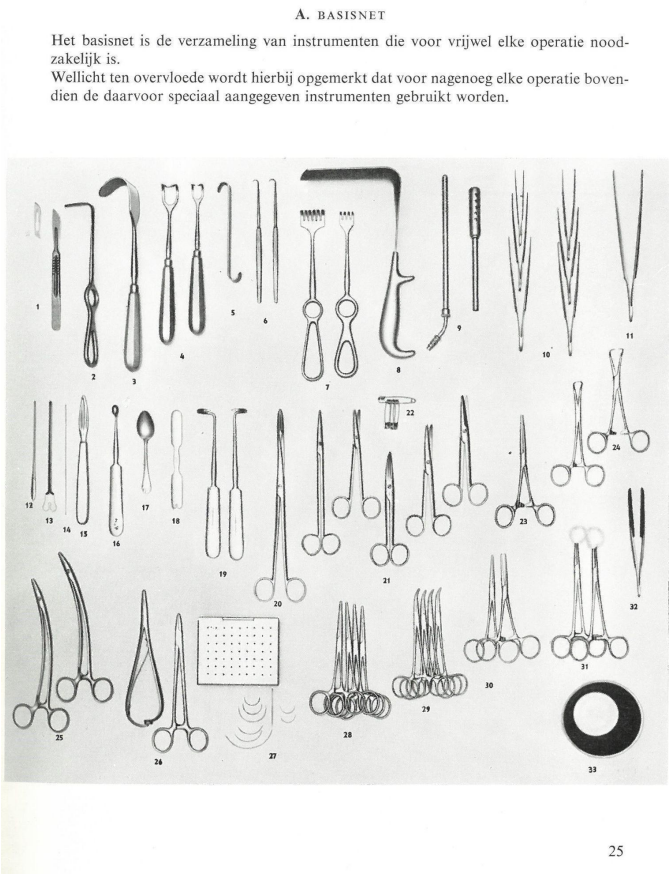
However, this way of arranging instruments was clearly functional as well as being aesthetically informed. Instruments are laid out according to their function, yet also in a somewhat symmetrical or visually pleasing order. The space is used as economically as possible. Although we cannot be sure if the depiction in this manual is representative of actual surgical practice, we do see similar arranged sets in other later manuals.[58] In the instrument manual from 1964 by Van der Laan and Melse, the term “basic set” emerges (figure 10).[59] The arrangement of such a set seemed to follow the order of the operation. Like other photographs of instruments, these arrangements may have fed back into surgical practice, with nurses aiming to achieve an arrangement as neat and well organised as in the manual.


A. BASISNET

Het basisnet is de verzameling van instrumenten die voor vrijwel elke operatie noodzakelijk is.
Wellicht ten overvloede wordt hierbij opgemerkt dat voor nagenoeg elke operatie bovendien de daarvoor speciaal aangegeven instrumenten gebruikt worden.

25

Figure 10: Arrangement of a basic set of surgical instruments. In: Laan/Melse 1964, p. 25.

There was no agreed uniform way of presenting and using standard sets of surgical instruments until the emergence of operation nursing as a profession. In the first issue of *Ethicon OP Forum* in the Netherlands, the demand for uniformity in operating practice was already clearly present in an article entitled “More uniformity”.[60] Due to high staff turnover, operating nurses experienced a lot of inconvenience, encountering different working methods in the hospitals and university clinics. By 1974, the call for uniformity had become even louder.

58 See for example Stumpff 1939, p. 99.
59 Laan/Melse 1964, p. 25.
60 Meer uniformiteit 1963.

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Nurses in the Netherlands pleaded for more uniformity after a series of roundtable meetings held throughout the country.[61] It is no coincidence that the same year, the profession of operation assistant was officially recognized in the Netherlands. The training had started in hospitals in 1970, preparing girls and boys from 17 years old to "assist the surgeon and anaesthetist in the operating theatre".[62] Yet, contrary to the American situation, this did not seem to lead to the disappearance of the OR nurse in the Netherlands.[63]

By 1974, a group of OR nurses and assistants were expressing their discontent about one particular aspect of their work. In *Ethicon OP Forum* they wrote that "Many an operating nurse, who can boast of experience, feels insecure when she (he) changes hospitals and, as a result, changes operating theatres."[64] Despite their years of experience, nurses would suddenly feel they were "all thumbs" when it came to dealing with the instruments in a different operating room.[65] Hence a series of photographs of instrument sets for common surgical procedures was published in *Ethicon OP Forum* including a "basic set", a "stomach set", and a "gallbladder set" (figure 11).

This demand for standardisation of instruments can be seen in the context of specialisation in surgery on the one hand, and the professionalisation and emancipation of surgical nurses on the other. OR nurses no longer considered themselves completely subservient to the surgeon. Discussing the issue of collaboration and division of labour on the operating ward in the training of operating nurses, nurse van Driel for example criticised the sometimes short-tempered and difficult behaviour of surgeons, who could behave like a "prima donna".[66] She subsequently refers to a quote about the sign of the times, referring to both the changing status of the specialist and the professionalisation of the nurse:

> This time knowingly tarnishes the professor, who turns out to be an ordinary person with a lot of knowledge about a very limited phenomenon; but also tarnishes the nurse, who turns out to be an ordinary woman with seemingly less of a calling, but with more awareness of collective employment agreements than ever; an ordinary modern worker.[67]

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61 It is difficult to define and research the nature and history of these roundtables. Based on the articles and letters in Ethicon OP Forum, we assume that these discussion meetings were organised by the editor of the journal and/or with Ethicon as a sponsor. During the meetings "specialists tell us something about their profession and we were given the opportunity to have pleasant discussions about all kinds of matters that we as operating nurses have to deal with". Wereldbond voor verplegend personeel 1968, p. 15.

62 Advertentie (Advertisement in *Trouw* newspaper) 1970.

63 Sandelowski 2020, pp. 115–120. National differences in the professional developments surrounding operating room nurses require more study, see also the conclusions section of this paper.

64 Uniformiteit in het gebruik van operatie-instrumentarium 1974, p. 5: "Menig operatie-verpleegkundige, die op ervaring mag bogen, voelt zich onzeker wanneer zij (hij) van ziekenhuis, en daarmee van operatiekamer verandert."

65 Uniformiteit in het gebruik van operatie-instrumentarium 1974, p. 5: "zich opeens voelt alsof zij (hij) beschikt over twee linkerhanden".

66 Driel 1969 b, p. 6: "Door de spanningen tijdens de chirurgische ingreep kan de operateur zich soms kortaangespannen en moeilijk gedragen, als een prima donna en dit schrikt ook de leerling-verpleegkundigen af, die er stage lopen."

67 Driel 1969 b, p. 6: "Deze tijd ontluistert willens en wetens de professor, die blijkt te zijn een gewoon mens met veel kennis van een heel beperkt verschijnsel; maar ontluistert ook de verpleegster, die blijkt te zijn

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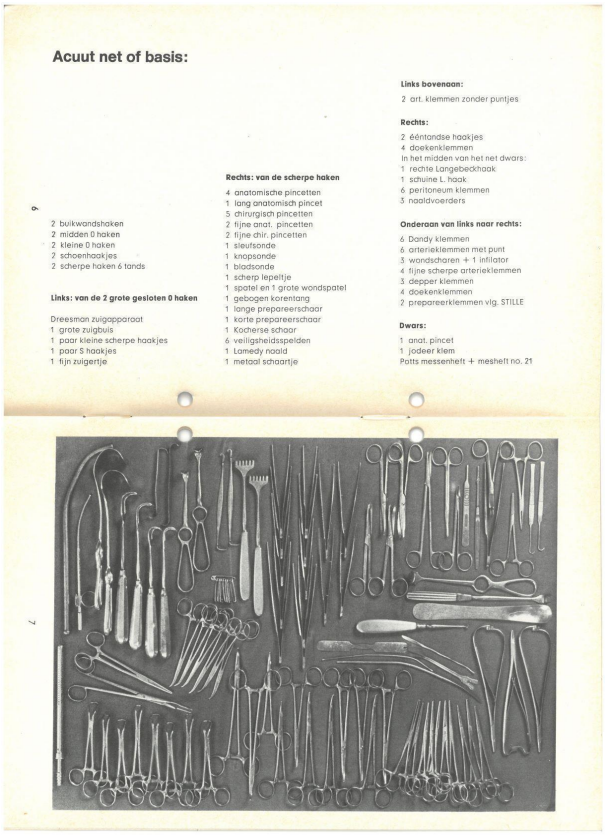

Figure 11: Acute or basic set. In: Uniformiteit in het gebruik van operatie-instrumentarium 1974, pp. 6–7.

In addition to uniform instrument usage, some OR nurses also called for a uniform nomenclature. One OR nurse complained, for example, about the excessive use of nicknames for instruments, such as the Dutch word for "goat's paw" used to refer to a desobstructor in vascular surgery.[68] According to this nurse, uniformity in the composition of the instrument sets should be accompanied by unified nomenclature. Manufacturers' instrument catalogues could serve as a reference for names. Knowing the right names and functions of instruments was a pivotal skill for OR nurses that was already recognized early on in the twentieth century. Handbooks contained pages with drawings and names of all the common instruments used in surgery, as well as explanations of their functions.[69] But the discussion in the 1960s and 1970s marked a new step towards the mastering and professionalisation of material knowledge. The demand for and discussion about uniformity in the nomenclature and composition of instrument sets ties in with the professionalisation of operation nursing in the context of nursing as a science.[70]

een gewone vrouw met schijnbaar minder roeping, maar met meer c.a.o.-bewustzijn dan ooit; een gewone moderne werkneemster."

68 Ook eenheid in naamgeving van operatie-instrumentarium gewenst 1974, p. 18.

69 Dijken 1916, p. 134.

70 Tobbell 2018.

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5 Conclusions

> There should be […] an optimal relationship of familiarity and trust between the OR nurse and the instrument.[71]

In 1974, another article on historical surgical instruments from the collection of Rijksmuseum Boerhaave appeared in *Ethicon OP Forum*.[72] This time, the (unknown) author discussed two decorated eighteenth-century amputation instruments: a saw and a knife. Based on the previous sections of this paper discussing the understanding, education and practices around material instrument knowledge, we may now see why OR nurses would potentially be interested in these old instruments. Notwithstanding the intention of the author, the article did reach a wide audience of OR nurses through the medium of the specialist journal. Remarks about the material qualities of the wooden handle shaped like a falcon's head and the handling of the instrument, and references to the design connected to the world of the OR nurse.

The making and practices resonated with the extensive and detailed material experience and knowledge of the readers themselves. For OR nurses in the 1970s, the relationship between instrument and user was a familiar one. During their training, and following intensive day-to-day handling of the instruments in the operating theatre, these nurses developed a relationship of familiarity and trust with their instruments. They knew with their heads, hands and eyes how to recognize, manipulate, clean, handle, hold and store the materials in an organised, orchestrated, and increasingly standardised manner.

This paper demonstrates how the relationship between nurses and surgical instruments evolved towards professional material knowledge between 1900 and 1975, becoming more and more specialised and part of surgery as teamwork. Unpacking the development leading up to this professional material literacy in the context of surgical instruments in nursing means placing the historical interest in surgical instruments within almost a century of material knowledge development in nursing – handling, cleaning, testing, arranging, recognizing and working with a large variety of instruments and materials. Contrary to Margarete Sandelowski's approach, this understanding, learning and handling material knowledge as suggested conceptually in the term "material literacy" moves beyond instruments as technology.[73]

In this paper I have discussed how instruments can be used in different (intended and unintended) ways by different people in different practices. The focus on these uses in nursing practice highlights other, more practice-based aspects than the role of objects in boundary work.[74] Furthermore, my analysis indicates the differences between the Anglo-American professionalisation developments in surgical nursing in the 1960s and 1970s versus the European, in particular Dutch, context.[75] Further research and study would be needed to unravel the professional history of operating nurses and discuss how these differences may play out.

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71 Ook eenheid in naamgeving van operatie-instrumentarium gewenst 1974, p. 17: "Er dient […] een optimale bekendheids- en vertrouwensrelatie te bestaan tussen o.k.-verpleegkundige en instrument".
72 Een 18e eeuws amputatiemes en -zaag 1974, pp. 12–16.
73 Sandelowski 2000, chapter 2.
74 Nolte 2020; Schlegelmilch 2021.
75 Sandelowski 2000, pp. 115–120: "Requiem for the Instrument Nurse".

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This paper focuses on the evolution of material knowledge of instruments and other surgical equipment. This focus has demonstrated two crucial aspects. Firstly, it demonstrates the very important and so far overlooked aspects of this material knowledge – insofar as they are different from the surgeon's knowledge and handling. And secondly, the paper demonstrates how this knowledge became more and more specialised, discussed and standardised during professionalisation of the operating nurse's role in the 1960s and 1970s. As Rosemary Wall and Christine Hallett discussed, the "significance of the history of nursing for the history of surgery is often underestimated".[76] Insight into material literacy, in particular, may prove a valuable contribution to the history of nursing and surgery alike. Future studies may then involve reconstructions or re-enactments to unpack the practices around instrument knowledge in nursing even further.[77]

Most importantly, this paper may start to provide a much needed historical perspective of instrument knowledge for today's surgical operation assistants. Knowing and learning about the relationship between form and function in surgical instruments, becoming familiar with the names and types, knowing how to manage, prepare and handle instruments, are still crucial tasks for the operation assistant.[78] And even instruments from the seventeenth century may help us understand and appreciate that.

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[76] Wall/Hallet 2017, p. 153.

[77] See the work by Palfreyman and Kneebone on re-enactment as a research method in the history of surgery: Palfreyman/Kneebone 2018.

[78] Weert 2006; Leids Universitair Medisch Centrum 2022.

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Call to Action: a History of Nurse Activism in the Netherlands

Iris van Versendaal and Hugo Schalkwijk

Abstract

Literature on nurse protests in the Netherlands is usually focused on the Witte Woede, a series of protests during the period 1989–1991. It is framed as a one-off, stand-alone event. Outside of these events, nurse protests and nursing activism are mostly invisible. This research calls for more diverse perspectives on nurse protests. Using objects and photographs from nursing history collections, we explore the under-researched history of nurse protests in the Netherlands. We analyse the media portrayal of earlier nurse protests to clarify why we do not remember them today. The objects analysed illustrate how nurses have at times positioned themselves as agents of change when their patients or profession needed it. We argue that such objects can be used to further debunk stereotypes of the apolitical, non-activist nurse.

Keywords: 20th Century, Activism, Image, Material Culture, Media, Nurse Protests

1 Introduction

At first glance, the simple, small, pink button is just one of many items of memorabilia that we hold in the museum collection of the Florence Nightingale Institute (FNI).[1] It is, in fact, a memento from a protest held decades ago. The Dutch slogan reads "I protest, for more.....!", obviously indicating a demand for an increase in salary. The abbreviation VVIO stands for *Nurses in Revolt*, the protest movement that organised the protest and made this button. The button further displays a bedpan held by a clenched fist: a nurse in protest. The bedpan displayed on the button symbolises the "dirty and simple" aspect of nursing work. This button in particular reflects a playful and humorous take on the image of nursing, while at the same time sending a clear message. By wearing buttons such as this, nurses and allies could identify themselves with the protest movements. The proceeds from the sale of the buttons helped fund further protests.[2]

Figure 1: Connecting old stereotypes with an activist image. Source: FNI Collection.

The protest, or rather series of protests, at which this button was worn took place between 1988 and 1991. They are referred to as *Witte Woede,* a term that originated during similar pro-

[1] The FNI is the Dutch museum for the history of nursing and boasts a unique collection of nursing objects and a nursing history archive. Since 2020, the museum has been part of the Dutch Nurse Association (V&VN).

[2] Van Vugt/Van Erp 2016, p. 25.

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tests in Belgium the year before. The name literally translates as "white anger", in reference to the colour of nurses' uniforms.[3] Nurse Gaby Breuer had set off the protests with a tiny advertisement in a national newspaper: "Police officers earn little, nurses earn even less. It is time for action!"[4] In often playful and sometimes fierce protests, nurses demanded better working conditions, improved salary and more professional autonomy.[5]

According to various media accounts of the history of Dutch nursing, these protests were unprecedented. Never before had Dutch nurses responded en masse to calls for protest.[6] Even though the protesting nurses had succeeded in mobilising support from politicians and the general public, the immediate outcomes were only moderately successful: a modest salary increase and rather vague promises of greater professional autonomy for nurses, without any concrete plans to carry them out.[7] Until today, these series of protests are seen as a major exception to the rule: nurses are generally viewed by the general public as apolitical and not as activists by nature. Thirty years later, the revolt is widely mythologised by nurses and within nursing histories as a stand-alone event. The Canon Verpleegkunde (Dutch Canon for Nursing) for example, even highlights it as the only significant protest event in nursing history.[8] Research on the tumultuous run-up to these massive revolts has, however, been missing until now.

In this article, we call for more attention to nurse activism. A search through the museum and archival collection of the FNI showed us that nurses protested many times, especially from the 1970s onward, when Dutch society was marked by activist and protest movements.[9] Still, these lesser-known protests in the run-up to the *Witte Woede* have gained hardly any attention from historians. It remains a blind spot in the historiography of nursing in the Netherlands. Through an analysis of six lesser-known objects and photographs from historical nursing collections, we show nurses' involvement in the political arena from the early 1900s up until the *Witte Woede*. We argue that such historical political work and activism in the service of the nursing profession and patient care should also be seen as aspects of nursing work and consequently included in future nursing education programmes.

2 Hidden Histories of Nurse Activism

We believe that one of the reasons why this part of Dutch nursing history remains underresearched lies in the dominant portrayals of nurses and nursing work, for example by the media. Historical research shows that nurses are all too often portrayed through gendered and subservient stereotypes, as doctors' handmaidens or sex objects, and their work is shown as being dirty and simple.[10] When examining international historiography more closely, however, a different image of nurses arises. D'Antonio et al. for example argued that nurses have

3 In this article we will refer to this series of protests as the Dutch nurse revolt.
4 Translation: "Agenten verdienen weinig, verpleegkundigen nog minder. De tijd is rijp voor actie". Breuer 1988.
5 Van Vugt/Van Erp 2016, p. 17.
6 See for example: www.canonverpleegkunde.nl or Van Vugt/Van Erp 2016.
7 Van Vugt/Van Erp 2016, pp. 185–186.
8 https://www.canonverpleegkunde.nl/canon/verpleegkundigen-in-opstand-1989/.
9 Duivesteijn-Ockeloen/Furnée 2016, pp. 16–19.
10 Hallam 2000, p. 15.

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historically been agents of change. Throughout their history, nurses have taken part (successfully) in political action. In most histories however, this side of nursing is usually rendered invisible.[11]

Other researchers, such as historians Kylie M. Smith and Karen Flynn, state the importance of challenging dominant narratives of nurses as powerless victims. Flynn highlighted nurses' advocacy in her case study on sickle cell activism and stated that such examples of political work should also be recognised as nursing work and included as such in the nursing curricula.[12] Smith stressed that, as well as recognising nurses' status as agents of change, we must not overlook nurses' roles in actively establishing and maintaining systems of inequality, stating that we must face history to build a better future for nursing.[13]

To better uncover these histories of activism, we highlight objects from the museum collection of the FNI. This collection is rich in photographs dating from the late 19th century to the early 2000s, most of which have been digitised and recorded. However, there were very few photographs of activism in the digitised section of the collection. In most cases, contextual information was missing. Our methods of investigating this material loosely mirrored the Panofsky method: we first described exactly what we saw, then we tried to uncover the geographical and historical context of the picture. Using contemporary sources, we then revealed the aims of the photographed protests as they were perceived by Dutch media. Finally, we connected our findings to historical literature on nursing and media histories to gain a deeper understanding of the results of our research.[14]

3 Nosokómos: Early Activist Protectors of the Profession?

Activist nurses had united in the professional organisation Nosokómos as far back as 1900.[15] The organisation's aim was the emancipation of the nursing profession. Its board boasted well-known Dutch feminists such as nurse Jeanne van Landschot-Hubrecht and the first Dutch female doctor, Aletta Jacobs.[16] Their small, silver-coloured insignia reads, from the inside to the outside, "*Nurses of Nosokómos Federation*". The insignia was awarded sometime between 1900 and 1921 and was gifted in 2018 to the Dutch Foundation for Nursing History (SHVB).[17] It was one of the many different insignias awarded after completing some form of nurse training, before these courses were regulated by law in 1921. The significance of this object does not lie in its lasting impact on nurse training – only a handful of nurses had completed the training by the time it was abolished. It does, however, symbolise an attempt at greater professional autonomy for nurses through education.

11 D'Antonio et al. 2010, pp. 207, 210–211.
12 Flynn 2017, p. 102.
13 Smith 2020, p. 1429.
14 Panofsky 1972.
15 Translated full name: Nosokómos, the Dutch Organization for the Advocacy of Nurses. Nosokómos is the Ancient Greek word for "nurse".
16 Wiegman 1993, pp. 111–112.
17 Full name: Stichting Historisch Verpleegkundig Bezit: verpleegkundigerfgoed.nl.

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Figure 2: Nosokómos insignia. Source: Dutch Foundation of Nursing History (SHVB).

Nosokómos saw the nurse training system as a major obstacle to an autonomous and powerful nursing profession. At the time, nurses were trained by the care institutions themselves. Standardised nurse training and examinations did not exist. Doctors and hospital directors held considerable influence over what nurses were and were not taught. Rather than being full-time students, nurse trainees often acted as full-time employees. They bore the brunt of the practical nursing work and got paid little in return. After completing their training, graduates were usually replaced with a new class of nurse trainees, as graduate nurses were deemed too expensive. The system limited the cost of nursing labour, so matrons and hospital directors were unwilling to change it.[18] Nosokómos accused the biggest nursing organisation, the Dutch Federation for Nurses,[19] of being run by doctors, directors and "lady nurses" and of failing to serve the needs of nurses at the bedside.[20]

In the course of its short existence, Nosokómos continuously strove to achieve a stricter, more uniform nursing education. It did so by advocating for state involvement in nursing education and by organising its own training courses and examinations. These were stricter and much more difficult than those of the Dutch Federation for Nurses. Because of the fierce competition with the much bigger and much more powerful federation, Nosokómos' training programme never gained much traction among nurses and employers.[21] In 1921, nursing examinations were standardised by the Dutch government. However, the government did not follow the radical reforms suggested by Nosokómos. Nursing education would still be greatly affected by the pragmatic needs of doctors and employers.[22] Non-official training courses, including those offered by Nosokómos, were discontinued. This insignia therefore symbolises an early, but failed, struggle by nurses for professional autonomy.

18 Wiegman 1993, pp. 309–311; Bakker-Van der Kooij 1983, pp. 470–473.
19 Nederlandsche Bond voor Ziekenverpleging.
20 Wiegman 1993, pp. 307–308.
21 Bakker-Van der Kooij 1982, pp. 205–207.
22 Van der Peet 2021, p. 25.

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4 The Return of the Protesting Nurse: 1970s and 1980s

The following photograph features people marching through the Dutch city of Rotterdam. They are wearing everyday clothes and holding signs with Dutch phrases asking the government to take action to improve healthcare. Several of the signs include a rhyming slogan such as "Funding guns, not medical resources."[23] Another sign poses the question "Who is the guarantor of our health?"[24] It is clear from these signs that the protesters are addressing the government. In total, six hundred district nurses, general practitioners and other healthcare workers protested for more funding for Rotterdam's "old suburbs", the pre-World War II suburbs in which healthcare was much less organised than the city's newer suburbs. While the latter were provided with local health centres, the former often had none.

The district nurses argued that they had trouble working together as they had no place to meet. Other necessities, such as pharmacies, were scarce in the old suburbs. Residents sometimes had to travel over five kilometres to reach one. According to the protesters, too much funding was directed towards hospital care. This resulted in a shortage of personnel among district nurses. In the Dutch newspaper *Het Vrije Volk*, Marijke Schreurs, a district nurse, said: "The healthcare system is ill; as of now we can only fight the symptoms. Providing proper help is impossible."[25] This photograph is a powerful example of how nurses stand up not only for themselves, but also for their patients.

Figure 3: Nurses, general practitioners, social workers and pharmacy employees demanding improved healthcare in the "old suburbs" of large cities in the Netherlands during a protest in Rotterdam, September 8th 1973. Source: FNI Collection. Photograph by Jan Stöpetie.

[23] Dutch: "Poen naar kanonnen, niet medische bronnen."
[24] Dutch: "Wie staat borg voor onze gezondheid?"
[25] Het Vrije Volk 1973, p. 7.

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5 Creativity in Nurse Protests: Black Books

The divide between the different groups of protesters in Rotterdam was considerable. They were unable to set aside their different views on improvements within healthcare. But one thing they did do was publish a black book, which was a common feature of nurse protests in the Netherlands in the 1970s and 1980s.[26]

The fourth object, or rather, series of objects, on nursing activism that we highlight is therefore the black book. This is a compiled collection of personal complaints and serves as a statement to both the public and the authorities. Many of these personal complaints revolve around distressing circumstances that have occurred due to the nurse being unable to give the patient the necessary care, often because of a lack of time and resources. A black book therefore provides a unique insight into nurses' views of healthcare at the time they were produced. Nurses and nurse advocacy groups often published these books around the time that nurse protests were taking place. Sometimes the public was able to buy them during the protests.[27] To educate other nurses about their cause, advocacy groups encouraged health institutions to buy the book for their nursing staff. The black book can therefore be seen as an object which was not only used as evidence of distressing circumstances in nursing care, but also as a vehicle for change.

Figure 4: Several black books from the 1970s and 1980s. Source: FNI Collection.

Much of the original contents are forgotten over time, but the tradition of black books has not ended; they are still produced today.[28] Another example of this lasting tradition is the work of a former nurse educator, who also produced one of the black books in the 1980s. Rather than publishing a new black book, he chose to highlight optimistic messages from people within the profession. His *white book* consists of personal contributions from 1,162 nurses, which together build a narrative for a more positive image of the nursing profession.[29]

[26] De Tijd 1973, p. 3.
[27] For example at the 1973 nurse protest in Rotterdam, see: De Tijd 1973, p. 3.
[28] For example in 2012 a black book was created by nurses at the Akkerwinde nursing home and given to the local authorities, see: https://www.nursing.nl/zwartboek-clienten-in-ontlasting-zieke-collegas-niet-vervangen-tvvnew102883w/.
[29] Eliëns 2022, p. 5.

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6 Nurse Protest Songs

Black books were not the only creative way in which nurses made their voices known. In the fashion of famous protest songs of the 1960s and 1970s, nurses and nurse advocacy groups also wrote their own protest songs, which they performed during protests. We found a number of these songs in the FNI's archival collection. Exact dates as to when these songs were created and where they were performed were, however, often unknown. But through research, we were able to reconstruct one of these nurse protest performances.

Figure 5: Nurses singing a protest song during a national protest in Utrecht, May 10th 1980. Source: FNI Collection, courtesy of NFP Utrecht.

Two days before International Nurses Day, on May 10th 1980, a union and a nurse protest group organised a protest in the city of Utrecht to demand increased staffing standards in care institutions. It was a national protest involving many Dutch nurse advocacy groups and representatives of the ministries of health and social affairs, and it revolved not only around the nurses themselves, but also around their patients. The aim was to increase funding by both the government and insurance providers, without increasing the insurance excess.[30] While fighting for a serious cause, the day was also filled with cultural activities, such as cabaret and music.[31]

A number of nurses had written a protest song (figure 5), based on the chorus and melody of the 1979 Dutch up-tempo pop hit "Opzij" by Herman van Veen. Van Veen's lyrics criticise the rush of daily life and are sung with much urgency. "We truly want to work hard, but we cannot go on like this for years" are just some of the lyrics that describe this urgency for change in the nurses' version of this song. It must be noted that we are not entirely certain whether this exact song was being performed in the photograph above (figure 5), but we do know that this song was performed at either this protest or a protest a year earlier, which was organised by the same nurse protest group. This makes it likely that they might have sung this song at the 1980 protest.

30 Hoekstra 1980, p. 5.
31 De Waarheid 1980, p. 7.

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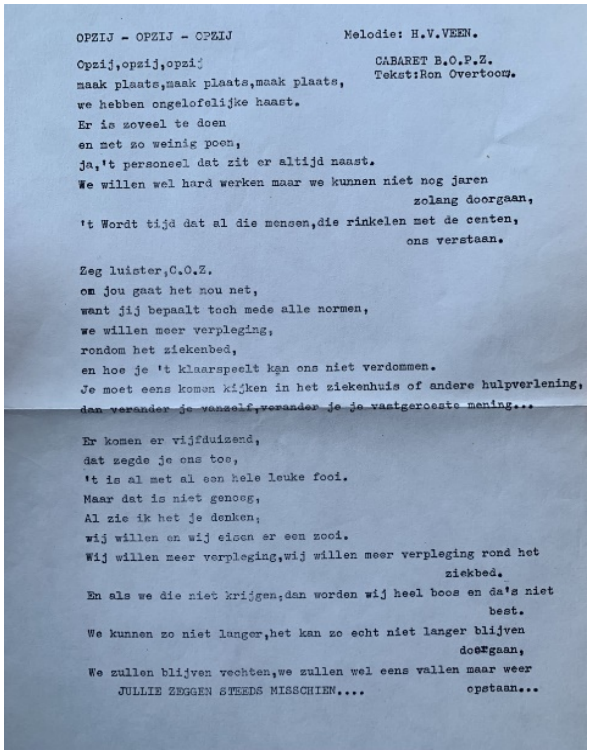
In figure 5, the banner in the background addresses the need for more personnel and argues that the government is responsible for creating more jobs. It fits perfectly with the lyrics sheet (figure 6), which also addresses the responsibility of the government. Ultimately, these objects are another example of the many creative ways nurses let their voices be heard.



OPZIJ - OPZIJ - OPZIJ Melodie: H.V.VEEN.

Opzij,opzij,opzij CABARET B.O.P.Z.
maak plaats,maak plaats,maak plaats, Tekst:Ron Overtoom.
we hebben ongelofelijke haast.
Er is zoveel te doen
en met zo weinig poen,
ja,'t personeel dat zit er altijd naast.
We willen wel hard werken maar we kunnen niet nog jaren
zolang doorgaan,
't Wordt tijd dat al die mensen,die rinkelen met de centen,
ons verstaan.

Zeg luister,C.O.Z.
om jou gaat het nou net,
want jij bepaalt toch mede alle normen,
we willen meer verpleging,
rondom het ziekenbed,
en hoe je 't klaarspeelt kan ons niet verdommen.
Je moet eens komen kijken in het ziekenhuis of andere hulpverlening,
dan verander je vanzelf,verander je je vastgeroeste mening...

Er komen er vijfduizend,
dat zegde je ons toe,
't is al met al een hele leuke fooi.
Maar dat is niet genoeg,
Al zie ik het je denken;
wij willen en wij eisen er een zooi.
Wij willen meer verpleging,wij willen meer verpleging rond het
ziekbed.
En als we die niet krijgen,dan worden wij heel boos en da's niet
best.
We kunnen zo niet langer,het kan zo echt niet langer blijven
doorgaan,
We zullen blijven vechten,we zullen wel eens vallen maar weer
JULLIE ZEGGEN STEEDS MISSCHIEN.... opstaan...

Figure 6: Lyric sheet of a nurse protest song performed during a national protest in either 1979 or 1980. Source: FNI Collection.

7 Researching the "Lost" Photographs

We found the photograph in figure 5 with no indication of subject, location or date. As most photographs featured nurses holding signs and protesting on streets, this is where we started our research. We closely examined each photograph, paying particular attention to what was written on the signs. Through this, we tried to determine which organisation was behind the protests. By carefully scrutinising any clues that might reveal the photographs' geographical location, such as store signs or, in one lucky case, a familiar hospital, we were also able to answer an even more basic question: which photographs belonged together?

After we had organised the groups of photographs, we used digital databases of city archives and Google Maps to determine the location of each photograph. Photographs on which geographical signs were absent, such as in figure 5, could be located by identifying familiar individuals found on other photographs in the same series. This proved to be an effective method, since we soon located protests in the cities of Rotterdam, Amsterdam and Utrecht. We could then browse newspaper and magazine databases such as *Delpher* to find articles describing the events that took place. This sometimes helped us pinpoint the location of the photographs taken and provided us with more context of the protests depicted.

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Although we found many short articles on the subject, nurse protests in the 1970s and 1980s never seem to have featured on the front pages of Dutch newspapers. What caused journalists to *not* write about these events? And what had motivated nurses to protest, besides their desire to improve the well-being of both themselves and their patients? The answers lie in societal and media developments, as explained in the next section.

8 Context: a Rebellious Society?

When it comes to societal developments, there are two important trends throughout the 1960s and 1970s. The first trend is that Dutch society in general was increasingly questioning traditional authority structures, such as the church and the state. This growing scepticism caused an increase in the number of protests during the 1970s.[32] Second-wave feminism had also emerged in the Netherlands. From the 1960s onwards, feminist movements demanded more freedom and greater equality in what work women could do.[33] In line with this movement, the nursing profession in the Netherlands achieved greater emancipation throughout the 1970s. An example of this was a new law that officially changed the name from "sick nurse" or *ziekenverpleegster* to "nurse" or *Verpleegkundige*. The new term was deemed more suited to the growing complexity of the profession, as *verpleegster* had a belittling and derogative undertone. The new term also included male nurses.[34] It seems plausible that these developments were examples of a more emancipated and vocal nursing profession.

The second trend is a shift towards post-material values. Social welfare, and prosperity in general, had improved enormously after World War II. This brought about a greater focus on quality of life and well-being. Because of the increased social welfare and growing scepticism, new social and political agendas were greeted with much enthusiasm.[35] These broader societal developments influenced the nurse protests of the 1970s and 1980s.

9 Media Developments

According to media historian Huub Wijfjes, Dutch journalists were not representative of Dutch society throughout the 1970s when it comes to political alignment. While society was mostly aligned to the political centre, with about a third voting for Christian democratic parties, most journalists leaned towards the left or even radical left.[36] During the 1960s, a critical culture had emerged among these journalists – a culture against authority. Criticism of and resistance to the established, the conventional and the self-evident was a central attitude among many Dutch newspapers throughout the 1970s. *Het Vrije Volk* and *De Volkskrant* were some of these critical newspapers used for our research. Whereas their journalists had previously worked *with* the authorities, they were now geared towards debunking them, striving to reveal an "ugly truth".[37] Combine this with the shift towards well-being as an important subject within society and it seems remarkable that there were no largescale reports of the nurse protests.

[32] Kennedy 2017, pp. 353–356.
[33] Kennedy 2017, p. 353.
[34] Van der Peet 2021, pp. 135–137.
[35] Kennedy 2017, p. 354.
[36] Wijfjes 2005, p. 363.
[37] Wijfjes 2005, pp. 340–341.

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Research shows that certain developments within the film industry had a major impact on nurses' public image. The Hays Code, a system of censorship that had been imposed on Hollywood studios for over three decades, was replaced in 1968. This caused a re-emergence of sexualisation of female characters, including nurses, in popular film.[38] Another study of films that feature nurses as a main role showed that, between the 1960s and 1980s, the portrayal of nurses as sex objects was a major trend.[39] This perhaps influenced the public image of the nurse as someone not to be taken seriously, or at least not as seriously as other, more radical protesters. Moreover, Dutch news media during this period were predominately staffed with male journalists. An example of the editor-in-chief of a major newspaper publicly stating that he did not want to add female journalists to his all-male staff, demonstrates the sometimes misogynistic attitude of the Dutch media at that time.[40] This offers one explanation as to why nurse protests do not feature prominently in Dutch newspapers.

10 Back to the *Witte Woede*

We started this article with a protest button worn during *Witte Woede*, a series of protests that lasted from 1988 to 1991, in which nurses demanded better working conditions, higher salaries and more professional autonomy. The nurses of VVIO felt frustrated that nurses had no say in healthcare policy making. According to them, the existing unions and professional organisations were doing little to change the situation. One of the reasons for this was the prevailing image of nursing work, which was seen as dirty but simple, or, as one organiser stated: not as something for which one needs "to work hard *and* know much."[41]

Through mass protests, VVIO wanted to break with the stubborn image of the sweet but subservient nurse. They wanted to show the general public and politicians a different side of nurses: that of an autonomous professional group that demanded to be treated as such.[42] The button described in the introduction to this article carries exactly this message. One of the leading nurses from VVIO would recall the actions as a radical attempt to change the stereotypical image of nursing work as simple and dirty and that of nurses as not willing to take action: "We did not just complain but we did something about it. We took action to change our situation ourselves."[43]

Through this message, VVIO was successful in mass-mobilising the media, politicians and nurses alike. Not only did these actions capture the attention of major national newspapers, but the Dutch Broadcasting Foundation (NOS) also covered the protests almost daily.[44] The widespread media attention in turn bolstered the ranks of the protesters, which grew in size significantly. In nursing's collective memory, this series of protests has until now marked the beginning and endpoint of nurse activism. At the time of Gaby Breuer's call, unionists and nurse advocacy groups still shared the common view that nurses were politically unmotivated

38 Hallam 2000, pp. 70–71.
39 Stanley 2008, pp. 89–91.
40 Wijfjes 2005, pp. 364–366.
41 Lammers/Goudriaan 1989, p. 381.
42 Lammers/Goudriaan 1989, pp. 379–381.
43 Jonkers 2011, p. 17.
44 De Graaf 1990, pp. 443–444.

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and unwilling to protest.[45] Rather than a stand-alone "bombshell", we argue that the *Witte Woede* was a strong example of a profession that was growing to be more politically aware after a 50-year period of relative silence.

11 Conclusion

Through the analysis of six objects, just a few of the examples of nurse activism present in the museum collection, we have shown that such objects can provide us with valuable knowledge concerning nurse activism. They illustrate how groups of nurses have at times positioned themselves as political agents of change when their patients or profession needed it. These objects are a valuable addition to the existing Dutch histories of nursing. Not only do they show a broader activist side to the profession than is usually remembered, but they can also help debunk other ingrained stereotypes of the apolitical nurse.

By contextualising the protests, for instance by connecting them to societal and media developments, we clarify why earlier protests have generally been forgotten. Even though the nursing profession became more emancipated and vocal from the 1970s onward, the image of the nurse was, at the same time, becoming more sexualised through popular film. Moreover, even though Dutch journalism had developed more of an anti-establishment attitude during this time, it still mainly consisted of male journalists who did not take women as seriously as men. We also suspect that the ingrained stereotype of the subservient nurse strengthened journalists' neglect of nurses' issues, as the image of nurses did not reflect their anti-establishment attitude. However, the *Witte Woede* protests of the late 1980s and early 1990s did gain significantly more media attention and mobilised more nurses than the previous protests. We suspect that this has led to these protests going down in history as a stand-alone event. Although it was the largest in size, we show that the *Witte Woede* is not the only example of Dutch nurse activism in history.

We suggest that more research is needed on this subject to broaden our understanding of nurse activism and political nursing work in the Netherlands. For example: what was the actual scope of all these nurse protests in the Netherlands before the *Witte Woede*? In what way did these protests change how nurses viewed themselves, or how nurses were viewed by society? What examples of nurse activism can be found in the period between Nosokómos and the 1970s and 1980s? Perhaps it is not possible to answer these big questions, but we believe that by starting small we might be able to answer them over time, for example by studying the contents of the black books and enriching them with oral history research.

The objects and photographs from this limited study show that nurses have a long history of standing up for their profession and their patients, despite their actions being at times invisible in nursing histories. For us, this research proved to be a great opportunity to test methods of dating and locating photographs from the FNI archive. By connecting them to other activist objects, these objects truly became "lost and found.

[45] Van Vugt/Van Erp 2016, p. 19.

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Personal Testimonies Relating to the Contemporary History of German Geriatric Nursing

Pierre Pfütsch

Abstract

In May 2022, nursing expert and critic Claus Fussek, who became known in Germany through his numerous media appearances, entrusted his enormous collection of files and documents to the Institute for the History of Medicine of the Robert Bosch Foundation for archival storage. This material includes approximately 50,000 letters from private individuals who reported severe shortcomings, acts of violence, and other issues in German nursing homes, covering the period from the 1990s to the year 2021. This extensive corpus of sources is unique due to its size and the type of selection, and it is hugely important for historical and social science research: it is a comprehensive reflection on the position and situation of nursing within German society. While reporting from different perspectives on the disastrous situations in German nursing homes, the writers – residents, family members, and nursing staff – provide many insights into the everyday practice of nursing.

Keywords: Geriatric Nursing, Germany, Nursing Homes, Every Day Practice

1 Introduction

On 1 February 2022, Claus Fussek officially retired from his life-long career as social worker and advocate of nursing care. He had made a name for himself as an expert and critic of nursing and gained a significant influence through the media. During his career, he collected thousands of personal testimonies reporting on the situation in German nursing homes. For instance, in 1997 a woman from Wolfsburg described the care her mother was receiving in a home as follows:

> We, as daughters, took care of our mother in her familiar environment until this was no longer possible, and she was admitted to a home because our mum now needed 24-hour care. Due to my physical disability, I was unable to perform extremely demanding care activities and my sister had to earn her living. In the following, I list some of the events that we regarded as inhumane and negligent. [...] At wintery temperatures and with the window slightly open, our mum was lying in her urine. The early shift arrived and heard whimpering from her room. She was freezing cold. In the presence of volunteers doing their community service, our mum was washed in her bed. The nurse was very rough while washing her intimate areas and our mother was in pain. [...] Our mother could not open her bowels without help. My sister asked the nurses for assistance. The stool was already halfway outside, but mum did not have the strength to push it out. The nurses' response was the following: "She should squeeze it back in. The bowels will be emptied only tomorrow." [...] For fear of being a nuisance to the nurses, our mum

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> had stopped drinking properly, because of course that makes you need the toilet. She was almost completely dehydrated.[1]

At first glance and to outsiders, this situation might seem degrading and scandalous, yet such instances might possibly have been part of normal practice in German nursing homes in very recent history. Fussek's documents contain numerous descriptions like the example above that are now being kept at the Institute for the History of Medicine of the Robert Bosch Foundation.

2 Who is Claus Fussek?

Claus Fussek was born in 1953 and studied social pedagogy. Fussek co-founded the Association for Promoting Integration (Vereinigung für Integrationsförderung, VIF) in the late 1970s in Munich and then worked in various functions as a social worker. In its first project, the association focussed on the (lack of) inclusion of individuals with disabilities in society. Over time, the scope of the association's tasks widened and Fussek increasingly concentrated on nursing and, in particular, geriatric nursing. He gained increasingly deep insights into this scene and found himself confronted with conditions that he would not have believed possible. In 1997, Fussek reported at a press conference on the catastrophic conditions in care homes in Munich, thereby making the "Munich nursing scandal"[2] public. Since then, he has been pointing out existing problems within the German nursing system in newspaper interviews and TV shows. Through his media appearances he has gained nationwide recognition. He has been a guest on all popular German talk shows, and even collaborated with the investigative journalist Günter Wallraff.

At that time, relatives and nursing staff began to contact him either in writing or by telephone. They regularly told him of their distress, described specific deficiencies, and asked for help because they could not get any from the authorities. Fussek always tried to step up. He gave advice to the relatives on an informal basis, but also contacted the financing bodies and authorities and, when nothing else worked, he turned to the media. He has received more than 50,000 letters, phone calls and emails over the past 40 years discussing the dismal conditions, enormous problems and acts of violence in nursing homes throughout Germany. He is continuing his work even after his retirement as he still receives daily requests for help from members of the public. In March 2022, the Bavarian Minister for Health and Nursing, Klaus Holetschek, presented Fussek with the Weißer Engel ("White Angel") award for his lifetime achievement. During the award ceremony, Holetschek highlighted Fussek's 40-year dedication to both nurses and people in need of care. He said:

> Claus Fussek has been justifiably called an "angel for the elderly". For about 40 years, he has tirelessly advocated for the dignity of the elderly and of disabled people and fought for better conditions in the field of nursing. He has truly earned

[1] The quotes used in this article were previously published by Claus Fussek himself. Hirsch/Fussek 2001, pp. 75–76.

[2] One social worker told Fussek that every Monday more old and dehydrated people would be admitted to the hospitals in Munich than usual. In response, Fussek began to investigate and learned that many residents would not get enough to eat and drink over the weekend and were fastened to their beds because on Saturdays and Sundays the number of staff was even lower than usual in many homes.

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the Weißer Engel award for exemplary achievements in the health and nursing sector.[3]

3 Transfer of the Collection

Fussek collected all these letters of complaint, emails and phone transcripts and kept them in the offices of the VIF. When he retired, however, a new home was needed for the collection of approximately 250 thick files. This collection, which the media had often called the "nursing wall", was at risk of being taken away or destroyed.

The Institute for the History of Medicine at the Robert Bosch Foundation in Stuttgart is not only home to the homeopathy archive, but also houses the archive of the Robert Bosch Foundation and its facilities. Aware of the situation, the institute contacted Claus Fussek to discuss the future of the files. At the end of May 2022, Claus Fussek presented his collection to the Institute for the History of Medicine in Stuttgart, where it will be kept for posterity. Fussek was grateful that his decades of work had not been in vain. In Stuttgart, the files are now being reviewed, catalogued and professionally packed for archival safe-keeping, meaning the documents will still be available for research purposes for many years to come. It is Fussek's express wish that Bundesinteressenvertretung der Altenheimbewohner (BIVA), the federal advocacy organisation for nursing home residents, be permitted to access and use the files at any time, in line with archival regulations and data protection laws, so that his documentation can be used to bring about urgent changes within the German nursing system.

Fussek's collection has found a good home at the Institute for the History of Medicine, not only from an archival perspective but also in terms of its content. The Robert Bosch Foundation has long advocated for the professionalisation of nursing and the improvement of working conditions in the health professions, and has sponsored various programmes since the beginning of the 1990s. For example, it prompted the creation of the highly regarded position paper "Pflege braucht Eliten" (Nursing Needs Elites),[4] in which leading experts advocated the academisation of nursing in Germany. The topic of aging is also an important issue for the Robert Bosch Foundation.[5] Every two years, the Otto und Edith Mühlschlegel Stiftung, a dependent foundation within the Robert Bosch Foundation, presents the Otto Mühlschlegel Prize for exemplary scientific work in all areas of old age and aging. Furthermore, the history of nursing has for years been a professional focus at the Institute for the History of Medicine. Seminal studies on everyday conditions in nursing have been based on research conducted here,[6] as have studies on the history of denominational nursing,[7] and on the development of geriatric nursing in the Federal Republic of Germany.[8]

3 Bavarian State Ministry for Health and Nursing (Bayerisches Staatsministerium für Gesundheit und Pflege) 2022.
4 Robert Bosch Stiftung 1992.
5 In 2002 the foundation began to support the research project "Life in Older Age – Aging and Demographic Structures".
6 Faber 2015 and also Hähner-Rombach 2009.
7 Kreutzer/Nolte 2016.
8 Grabe 2016.

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4 Research Corpus and Positioning

Geriatric nursing research is still in its infancy, both in terms of its own history and in terms of the history of nursing. Nina Grabe's pioneering study on the inpatient care of older people in Lower Saxony between 1945 and 1975 was a portrait of the establishment of geriatric care structures in Germany that also introduced the various agents, such as home providers, staff, and residents.[9] Kristina Matron's research on geriatric assistance in Frankfurt am Main addressed the question of what kind of nursing programmes were developed in the domestic setting.[10] Nicole Kramer's numerous articles provide insights into the development of a very complex job market within German geriatric care, and also disclose some of the reasons why the situation of geriatric nursing is so complicated in Germany.[11] Neglect, malpractice, and violence have often been addressed in the history of nursing, yet – with the exception of the participation in National Socialist medical crimes – have never been a separate subject of investigation. In recent years, these issues have appeared more often in connection with homes for children, adolescents, and disabled people.[12]

By default, the field of nursing ethics is often confronted with issues of malpractice and violence. Yet here, the focus is not on the analysis of specific cases, but rather on the ethical evaluation of actions by nurses in a particular context or the development of a distinct definition for geriatric nursing.[13]

5 Topics

Fussek's documents are in general very significant for historical and social science research because they reflect the position and situation of nursing in German society. Furthermore, they are unique in the field because of the size of the collection. The history of nursing often suffers from a lack of source materials, as often only normative materials such as laws or regulations are available because only these documents "matter" and are preserved. Personal testimonies such as the ones in Fussek's collection represent a valuable corrective voice to such administrative texts.[14] They are especially useful and informative for the history of patients.[15] While there are some investigations of everyday aspects in the history of nursing,[16] often the source material consists of testimonies by the nurses. In contrast, a large proportion of the testimonies in Fussek's collection came from the clients and their relatives, which allows a different perspective. The documents provide insights into the everyday life of the residents of the homes, show the working routines of staff and, more often than not, graphically illustrate the discrepancies between theory and practice in the institutions.

Yet, despite the large number of entries, one should not immediately succumb to the obvious temptation to interpret the contents described as "everyday life" without reservation and

9 Grabe 2016.
10 Matron 2017.
11 Kramer 2019; Kramer 2020; Kramer 2022 a; Kramer 2022 b.
12 The resources on this issue have since grown substantially. For instance: Wenger 2022; Schmuhl 2023; Winkler/Schmuhl 2011; Winkler 2021; Kaminsky/Klöcker 2020.
13 Schwerdt 1998.
14 On the role played by personal testimonies in historical research, cf. Schulze 1996.
15 On the history of patients cf. Porter 1985 and Jütte 1991.
16 Faber 2015; Hähner-Rombach 2009; Thiekötter et al. 2009.

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hence as the "normality" in nursing facilities. Ultimately, the collection is a compilation of complaints, descriptions of negative experiences and accusations. There are no descriptions of positive experiences in German nursing homes because a) it was not Fussek's task to keep such positive memories and b) when the writers of the letters sat down to put their experiences into words, they were pursuing particular goals and intentions: they hoped Fussek could bring about an improvement of the conditions. When everything was fine and the conditions were good, there was no need to write. This of course poses a problem of missing sources, which historians must not forget during their analysis if they want to be thorough and critical in their investigation of their source materials.

Fussek's collection can be roughly divided into four large areas:

Letters by Affected People

After initial inspection, there is only a small number of letters from those who were affected, which can most likely be explained by the fact that many of those individuals were not in a position to write the complaints themselves, let alone do the research necessary to find Fussek as the addressee. In those few instances where affected individuals wrote to him themselves, they mostly expressed their resignation and helplessness. They were particularly hurt by treatment from the nursing staff that they experienced as insensitive and degrading. One resident of a home in Bad Nauheim described her biggest problem in 1998 as being dependent on the nursing staff.

> It's the dependency on the young nurses (for me this is really bad!). We are so helpless and so at the mercy of their mood, their temper – but also dependent on the house rules and the work regulations of "our" home.[17]

Letters by Relatives

It is not surprising that the majority of Fussek's correspondence comes from relatives of home residents. Children, grandchildren, spouses and, in rarer cases, friends of the residents turned to Claus Fussek. The triggers for writing to Fussek vary, but in most cases it was a specific event or distinct incident that made them write the letter. Furthermore, most of the writers were looking for help.[18] Depending on the intensity, complexity and the specific requests of the relatives, Fussek's documentation of the different cases could vary in length. In some instances, there is just a single letter, but in other instances, we see correspondence that lasted for years. Sometimes a letter may have caused Fussek to dig deeper and take a closer look at the individual home, its structures and nursing practices on site. In such "cases", in addition to the letters from the relatives, there are accompanying photographs, medical reports, letters by authorities and funding bodies, or medical expert opinions.

Letters by Nursing Staff

Some of the cases that Fussek investigated were brought to his attention by the nursing staff. These letters reveal that the descriptions by the affected people and the relatives must contain a certain amount of truth. If we include these statements by the nursing staff in the analysis of the deficits we come closer to the multi-perspective approach required for analysis, be-

[17] Hirsch/Fussek 2001, p. 60.
[18] On reasons for writing to health institutions in Germany cf. Pfütsch 2017, pp. 128–129.

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cause it steers the question of guilt away from individual nurses and towards structural factors. For instance, one nurse from Ahenhausen described her experiences on a closed geropsychiatric ward in 1998:

> All the others would need help with washing and getting dressed, they would not do it on their own, meaning they are all at the back of the queue for physical hygiene, just like everyone else. The results were bad gum infections, since there was not even time for oral or denture hygiene. In the mornings and evenings, the residents underwent robotic processing, which would have led to massive protests by animal rights activists if this had happened in a cow barn. The bad thing is that you cannot "work" any differently because otherwise you would not have everyone out of bed before breakfast, and in the evening, you would not have them in bed before midnight. So you start to put people to bed by 3pm or at least put them in their nightgowns. Because it is fast, they are only fed pureed food because normal food would take far too much time. In terms of the amount they are drinking, it is extremely horrible. Sometimes they are hardly drinking anything for days on end, especially when they refuse, for example. And in such instances, you would need time![19]

Another nurse got to the heart of the matter as follows: "The system must be changed because only then will we be able to make geriatric nursing more humane again."[20]

Interviews, Manuscripts, Presentations

The extensive collection also contains numerous newspaper articles, interviews and manuscripts about and by Claus Fussek. They illustrate his work for the Association for Promoting Integration but also his increasing role as a nursing expert and critic. Furthermore, he also published some non-fiction books in which he tried to raise awareness of the disastrous situations.[21] These books are based on his experiences and are simultaneously an attempt to process what he had learned. With his public engagements, Claus Fussek also became a person who hugely influenced public discourse about the importance of nursing in the 1990s. This is another reason why it is so critical to secure and preserve these documents for the history of nursing.

When it comes to specific malpractices, experiences of violence and other problematic issues, Fussek's documents provide many insights, as discussed above. Many of the depictions provide insights into the everyday world of nursing institutions, describing the reasons for people being sent to homes, often combined with justifications from the relatives. Consequently, Fussek's documents are a remarkable illustration of the living situations, networks and self-assessments of older individuals in Germany.

Delving deeper into this material and researching it in more depth will probably be of interest in disciplines as varied as history, sociology, nursing ethics and even ethnology. Depending on the question and the approach, the documents may provide a wide range of answers. While the obvious topic might be research into horrific situations in the homes, the residents' rela-

19 Hirsch/Fussek 2001, p. 200.
20 Hirsch/Fussek 2001, p. 174.
21 Fussek/Schober 2008; Fussek/Schober 2013; Fussek/Loerzer 2005.

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tionships with their families might also become a research topic. Furthermore, the dealings between the managers and financing bodies of homes and the residents have not been analysed before. Finally, the documents may also provide insights into the practical implementation of nursing reforms over the past few decades.

6 Options for Use

As mentioned above, in a first step, the collection will be reviewed, partially indexed, and professionally packed for archival purposes. Due to the abundance and disparity of the individual pieces of writing, this work will take some time. Students, postgraduates and other interested scholars can contact the Institute for the History of Medicine to discuss potential research questions and approaches. Close collaboration with the institute will be obligatory because the initial searches will be conducted by institute employees. Due to certain data protection timelines and the sensitivity of the data, access to the data will be granted on a case-by-case basis after thorough evaluation. Once access has been granted, the material cannot be removed from the premises in Stuttgart and must be studied there. Users must also agree to anonymise sensitive data that could identify individuals or institutions.

After a first rough review of the documents, it seems apparent that one possible result of investigating Fussek's documents from a historical point of view could be the continuance of the disastrous conditions and issues in care homes. Letters by relatives from the 1990s sound nearly the same as letters from 2022, even down to the specific issues: going to the toilet, nutrition and feeding, and receiving empathy and attention. It seems that not much has changed, but more detailed analyses would be needed to confirm or contradict this impression.

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The History of Pediatric Nursing in Germany. Outlining a Research Desideratum

Christoph Schwamm

Abstract

The history of pediatric nursing is an underexplored field, particularly in the German-speaking world. While nursing history has seen significant research progress in recent years, there is still a gap regarding the specific evolution of pediatric nursing. This article outlines key research questions and areas of relevance for pediatric nursing history, addressing topics such as the professionals involved, the role of infant mortality reduction, infection control, changing childcare ideals, and the relationship between pediatric and general nursing. While the focus is on Germany, these perspectives are at least partly transferable to other European countries.

Keywords: Pediatric nursing, infant mortality, history of infectious diseases, semi-professionalization, ideals of education, child abuse

1 Introduction and Overview of Existing Research

Research into the history of nursing has produced visible successes over the past 20 years. Historians and nursing scholars interested in history have published papers on a wide variety of topics: Research exists on the history of general nursing, geriatric nursing, psychiatric nursing, professional organization, professional politics, wartime nursing, and on various nursing organizations and corporations. However, one research gap persists, at least in the German-speaking world: the history of pediatric nursing, which extends from circa 1890 to 1990. At the time of writing, there are only two relevant publications. One is an article by Bettina Blessing entitled "Baby and Infant Healthcare in Dresden, 1897–1930", the other is an article by Sylvelyn Hähner-Rombach about mothers on children's wards. An article in a nursing textbook is forthcoming at the time of writing (August 2023). A scarcity of literature therefore compels this article to draw on exemplary historical sources and otherwise to emphasize its exploratory nature.

Its aim is less about mapping initial research findings and more about seeking to derive suggestions for promising research on the history of pediatric nursing from the little that is available today. Thus, this article should not be regarded as an introduction to the field, nor as a blueprint for an encyclopedic future research program. Rather, it is intended to outline, in loosely linked fashion, possible areas within pediatric nursing that are of particular relevance to nursing history and its neighboring disciplines in Germany. These areas are based on the following questions:

First, what role did the fight against infant mortality play as a starting point for the development of the pediatric nursing profession?

Second, what was the significance of infectious diseases and infection control for pediatric nursing practice and professional policy, especially in relation to transitions in the history of epidemics?

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Third, how did historical changes in ideals of childcare and corresponding practices affect pediatric nursing?

Fourth, who exactly were the groups of actors who nursed children professionally? And how did pediatric nursing develop first into a highly specialized field and later into a modern salaried profession? And, in the case of Germany: How did pediatrics manage to maintain professional autonomy from general nursing?

This article is about the situation in Germany, where children's hospitals have been established in significant numbers since about 1890. The perspectives are likely to be transferable, to some extent, to Austria, where pediatric nursing has developed structures similar to those in Germany. With the exception of these peculiar aspects of professional policy, the points covered in this article might be partially relevant for other European countries (as well as those where nursing developed by adopting the Anglo-American system). It must be emphasized that a separate research project would be needed to reach definitive conclusions here.

2 The State of Research in the English-speaking Countries

The statement that the history of pediatric nursing is a largely unexplored field may be true for the German-speaking world, but the situation appears to be somewhat better in the English-speaking research landscape, especially in Great Britain: Here, after all, there are a number of summaries in textbooks and journal articles on the development of pediatric nursing, although the majority of these are brief introductions.[1] Taking this into account, it must be noted that research here is also still in its infancy. These works describe the emergence and development of pediatric nursing in the context of the rise of children's hospitals in the second half of the 19th century. Another topic is its relationship to general nursing, which does not seem to have been entirely free of tensions here either. The quantity of articles and their thematic scope already provide a much better overview than for the German-speaking world. Moreover, some of them are reflective in terms of method and theory, take into account dimensions of social and ethnic origin and gender, and thus also meet historiographical requirements.[2] Some specific topics have also been explored, such as the reorganization of visiting hours in children's hospitals since the 1950s in Great Britain[3] and Australia[4] public-health nurses in the context of the fight against child mortality in the USA,[5] school nursing in Great Britain[6] and the USA[7], the emergence of intensive care pediatric nursing, and nursing in pediatric oncology in the USA.[8] Finally, an oral history publication already exists for Great Britain, in which numerous contemporary witnesses, including (former) pediatric nurses and patients, were interviewed.[9]

1 Glasper/Clarke 2021; Clarke 2017; Glasper/Charles-Edwards 2002; Jolley 2011; Whiting 2005; Glasper/Mitchell 2010; Lomax 1998.
2 Hawkins 2012; Tanner/Hawkins 2016; Hawkins 2021.
3 Jolley/Shields 2009; Bradley 2001.
4 Bradley 2001; Wood 2008.
5 Thompson/Keeling 2012.
6 Kelsey 2002.
7 Houlahan 2018.
8 Foglia/Milonovich 2011; Wilson 2005.
9 Jolley 2003.

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3 How Important was Infant Care to the Emergence of the Pediatric Nursing Profession?

By the middle of the 20th century, pediatric nursing had succeeded in claiming a monopoly on the professional care of sick children, although it remains to be researched how thoroughly this claim was actually enforced.[10] This semi-professionalization started with the establishment of infant homes in the latter half of the 19th century. Here, nurses, in collaboration with pediatricians, developed practices to successfully reduce infant mortality. By 1890 there was a body of knowledge comprehensive enough to enable the creation of a new medical field with corresponding specialist care. First, neonatal care required highly specific skills and long experience. A second area was the provision of adequate baby food and the monitoring of its safety.[11] Reducing infant mortality was also a public health education project. Therefore, pediatric nurses became experts who advised mothers on nursing and nutrition.[12] Apparently, the field of infant care preceded the later expansion of the scope of the pediatric nurse's expertise to include toddlers, older children, and adolescents. In Germany until after World War I, a pediatric nurse was called a "Säuglingsschwester" (infant nurse). In 1923, the job title was changed to "Säuglings- und Kleinkinderkrankenschwester" (infant and toddler nurse). Only from 1957 onwards, did children of all ages become part of the job title, when it was changed to "Säuglings- und Kinderkrankenschwester" (infant and children's nurse).[13] To what extent the early job titles, which referred only to the care of very young children, were an actual representation of the work in children's hospitals, is a question that requires clarification. After all, the children's hospitals where pediatric nurses worked are very likely to have cared for older children too, not only infants.[14] However, the caring for babies was apparently deemed the qualifying core competency for quite a long time.

4 The Role of Infection Treatment and Control

The acceptance of pediatric nursing as an autonomous discipline was apparently a process that took several decades. The successes in reducing infant mortality were celebrated publicly and probably boosted the perception of pediatric nurses as competent experts. The triumph against infectious diseases in children sparked public euphoria in a similar way. The implementation of infection control measures, especially the introduction of nationwide vaccinations and antibiotics by about 1970, constituted only the climax of this development. Classic infection control had become part of nurses' competence since the spread of asepsis and antisepsis in the last quarter of the 19th century. It therefore seems possible that the successful repression of epidemics promoted and perhaps also shaped the professionalization processes in pediatric nursing. Admittedly, the same could also be argued to some extent for adult nursing.[15] Nevertheless, it seems reasonable to attribute special importance to infection control in pediatric nursing: Vaccination campaigns were primarily aimed at children, and hospital architecture features such as separate isolation or infection buildings, hygiene locks and

[10] Hähner-Rombach 2018, pp. 151, 160, 166–167.
[11] Blessing 2015.
[12] Wegmann 2012.
[13] Hähner-Rombach 2018, p. 151.
[14] See Eckart 2010 for example.
[15] Nolte 2020.

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modular glass boxes for isolation were found more frequently in children's hospitals.[16] Besides prevention, diseases such as poliomyelitis, diphtheria, and whooping cough required specialized care. They also resulted in lengthy stays in children's hospitals and often even more protracted stays in children's sanatoriums or rehabilitation facilities. Infectious diseases thus provided children's nurses with many possibilities to claim professional expertise.

5 Changing Childcare Ideals

The lengthy hospital stays in the first half of the 20th century and their eventual drastic curtailment in the second half of the century point to another set of issues: the shaping of relationships between pediatric nurses and their patients. Beginning in the late 1960s (in the English-speaking world about 15 years earlier), new models of parent-child attachment began to take hold.[17] Previously, it was considered not only possible but also desirable for pediatric nurses to replace the primary caregiver for children of all ages.[18] And in fact, separations of weeks or even months made sense from the perspective of infection control. In Germany, however, the prevention of nosocomial infections remained a major argument against admitting relatives, even after the risks of serious harm from infectious disease had been steadily minimized by the1970s.[19] Isolation probably produced very specific forms of care relationships within the social space of the hospital. And allowing parental involvement during the course of the 1980s probably resulted in a profound change to the pediatric nurse's core competence.

Interestingly, childcare ideals shifted away from authority-oriented to partnership-oriented models around the same time. Whether this change is related to the opening of the children's hospitals is a question that has yet to be answered. In Germany, this is a relevant issue, as there is currently growing public interest in the history of children who experienced violence during the 1950s and 1960s in hospital settings. Publicly organized curative and convalescent care was a mass phenomenon in Germany. Millions of children, including infants and toddlers, were separated from their parents for weeks or even months at a time for convalescent cures or sanatorium stays. The reports of physical and psychological abuse that happened during these stays have become legion. The perspective of pediatric nurses is crucial for an adequate assessment of these events but has yet to be taken into account.

6 Issues of Professionalization

Who cared for infants and children professionally? Particularly in the long period of time before the official establishment of the nursing profession, it is difficult to identify the various actors involved without projecting modern categories onto the past. Not surprisingly, there is a broad spectrum of these actors. This is especially true for the period before the first nursing schools were established, which was around 1890 in Germany. Here, it was not until 1923 that a state-recognized training program for infant nurses was established.[20]

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16 Photographic albums Nos. 1–3 of the Heidelberg University Children's Hospital, collection of the Institute of Medical History and Ethics, Heidelberg University.

17 Grossmann 2009.

18 Von Miquel 2022; Schmuhl 2023.

19 Internal documents from the Heidelberg University Children's Hospital, collection of the Institute of Medical History and Ethics, Heidelberg University.

20 Hähner-Rombach 2018, p. 148.

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Both the place of employment and the range of activities are likely to have shifted substantially over time. Pediatric nursing and education, for example, were intertwined to a greater degree than they are today. Around 1900, many women who had been trained at children's hospitals worked as educators in middle- and upper-class households or in residential education.[21] On the other hand, the majority of women who cared for infants and children in households or homes on a professional basis were probably not clinically trained pediatric nurses. This can be deduced from the fact that around 1900 there were only about a dozen children's hospitals and schools in the whole of Germany.[22] For a long time, pediatric nurses could not possibly have claimed a unique competence, let alone a monopoly, in caring for children, even in hospitals. Even after the first children's hospitals were established in the last quarter of the 19th century, it would be decades before children were no longer treated in hospitals for adults. As a result, general nurses and orderlies may have been substantially involved in the care of children without being labeled as children's nurses. The relationship between infant care and the midwifery profession deserves special attention. A comparative or interwoven history of both professions would be a worthwhile perspective, in view of the numerous overlaps of competence (and conflicts). Probably not quite as conflict-laden but certainly also worthwhile would be to clarify the role of community nurses in the care of children. This somewhat arduous work of differentiation is nonetheless important to understand the process through which pediatric nursing became a profession.

But even after pediatric nursing had become the established profession of a clearly defined group, the question of who had access to the sick child remained central to their professional status. Starting around the 1960s, pediatric nursing underwent a number of further changes. The lengths of stay in children's hospitals were slashed over the course of the following decades to a fraction of what they were before circa 1970. Children's nurses not only had to get used to sharing access to the children with parents, they also saw some of their competence taken away by professional educators and hospital teachers.[23] This likely shaped the self-assertion struggles of pediatric nurses which took place during those same years. In contrast to English-speaking countries (and large parts of the world), pediatric nursing in Germany was until recently largely isolated from general nursing. Children's hospitals ran their own separate schools for nurses that led to a qualification which (at least on paper) qualified nurses to care for children exclusively. This meant that, conversely, general nurses could not simply practice pediatric nursing. Pediatric nurses did not participate in professional nursing associations but were organized in a subgroup of an association for pediatricians. There was no common nursing register to provide a basic shared professional infrastructure for the different branches of nursing. In the course of the modernization processes of nursing in the 1960s and 1970s, this special status came under serious scrutiny. But despite pressure to adapt to the international standard of generalized nursing training and professional organization, reforms failed due to the resistance of pediatric nurses and (arguably more

[21] Wegmann 2012, pp. 96–97; timeline consisting of excerpts from the annual reports of the Heidelberg University Children's Hospital. Archive of the School of Pediatric Nursing, Heidelberg.

[22] Archive of the School of Pediatric Nursing, Heidelberg.

[23] This is clearly reflected in a manuscript of a speech given by Matron Elisabeth Leist, head of the School of Pediatric Nursing, Heidelberg, collection of the Institute of Medical History and Ethics, Heidelberg University.

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importantly) because of objections from pediatricians.[24] In any case, this would make another promising perspective for research.

7 Summary

In summary, much of the history of pediatric nursing remains unexplored. Some basic trends give rise to research questions. For example, the emergence of pediatric nursing as a profession had to be reconstructed from a variety of practices associated with relationships between carers and children. The struggle against infant mortality, in particular, will in all likelihood turn out to be the nucleus of the semi-professionalization of pediatric nursing. Physical and mental abuse enabled by children's long-term isolation in clinics is currently the issue receiving the most attention, at least in Germany. Unlike in most other countries, the exceptionalism of pediatric nursing in Germany has prevented it from becoming part of a more general nursing profession until recently.

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[24] Stemann 1969.

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