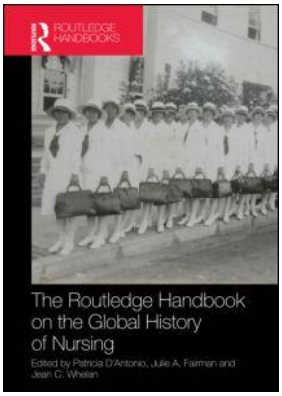

Routledge Handbook on the Global History of Nursing

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Publication details
https://www.routledgehandbooks.com/doi/10.4324/9780203488515.ch9
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Published online on: 24 May 2013

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CONFLICTING CHRISTIAN AND SCIENTIFIC NURSING CONCEPTS IN WEST GERMANY, 1945–1970

Susanne Kreutzer

The "scientification of the social sphere"[1] is a key aspect in the development of twentieth-century Western societies. Experts in human sciences – representatives of disciplines as diverse as medicine, law, economics, psychology and social sciences – gained interpretive power with regard to social reality, interpersonal relationships and personal wellbeing. For nursing in West Germany this process began comparatively late. While scientification and rationalization were included in the socio-political agenda for private households as early as the 1920s, the field of nursing did not follow suit until the 1950s.[2]

This noticeable resistance to the scientification of nursing had its roots in the motherhouse-bound organizations of Catholic sisters and Protestant deaconesses. In Germany, the motherhouse principle became the dominant form of organized nursing in the nineteenth century. It was based on a simple exchange principle: women who entered committed to devote their lives to the sisterhood and to the sick and needy. In return they received an education and the assurance of lifelong provision. Up until the early 1950s in West Germany it was understood that nurses would be single and be prepared to work out of a sense of charity. A "good" nurse possessed a wealth of practical experience rather than a sound theoretical education.

The picture changed dramatically in the second half of the 1950s. With the growing medicalization, mechanization and specialization of healthcare, the tasks expected of a "good" nurse took on a different character. Practical experience and Christian ethos, highly valued until then, rapidly lost their legitimacy, with nursing turning into an activity that had to be planned and organized to conform to scientific principles. Such reforms were part of the 1960s' *Zeitgeist* with its firm belief in planning, progress and technical feasibility.[3] At the time the hope of being able to control social processes with the help of a scientific planning system informed the history of West Germany as much as that of its European neighbors.[4]

In the 1950s radical changes in the life plans of younger women also considerably affected the field of nursing. The traditional image of the devoted "act of charity" was no longer congenial to an emerging consumer society. The celibate state of the Christian sisters grew less acceptable too, since a woman's lifestyle that was not defined by marriage had lost its social legitimacy.[5] "Being just a sister" was no longer attractive. The development away from celibacy for nurses went hand in hand with the departure from being "just a housewife." Women were no longer expected – nor were they willing – to pursue the ideal of a single vocation, whether it concerned the needs of patients or those of a family. A modern woman's life plan encompassed the possibility of having a job, a husband and children.[6]

Driven by the shortage of nurses and its dramatic exacerbation around the year 1960 – mostly due to the expansion of the hospital system – nursing grew to be a legally regulated woman's profession with union-agreed salary scales and regulated working hours. The tremendous rate at which the professional image of nurses changed within just a few years reflects the development of West German society as a whole at the time. The period of postwar reconstruction was followed in the second half of the 1950s by a phase of unprecedented prosperity. At the same time a fundamental change occurred, impacting on almost all areas of society; a change that is referred to with terms such as detraditionalization, liberalization, democratization, individualization and secularization.[7]

This chapter investigates the reconceptualization of nursing, with an emphasis on the conflicting implementation of scientific principles in a context dominated by Christian nursing traditions.[8] Christian and scientific concepts were, however, not *per se* incompatible. The denominational sisterhoods also conveyed theoretical knowledge in line with the regulations of the nursing law.[9] But the sisters and deaconesses had considerable reservations when it came to enforced scientification since they prioritized other forms of knowledge, including nursing ethics and practical knowhow. The general training schedule for deaconesses illustrates this clearly: students first received practical training on the wards for a year, followed by religious instruction. The theory of nursing was concentrated in one teaching block with examination at the end of the training.[10]

The present chapter demonstrates that a dramatic shift occurred in the 1960s with regard to the conception of authoritative nursing knowledge. According to Brigitte Jordan, authoritative knowledge is the knowledge that is seen as dominant in a field and that has the power to define "facts." In healthcare, that could include the question of whether a person is sick or healthy, competent or incompetent. Authoritative knowledge is recognized by the majority of agents in a particular field as the natural, only sensible form of knowledge. Authoritative knowledge is powerful not because it is correct but because it counts.[11]

This chapter explores the shift in how authoritative knowledge was conceived, using the example of a group of sisters located at the interface between traditional and modern nursing values: The Agnes Karll Association. The Association, re-formed and re-funded after 1945, has a history of being the first "independent" sisterhood, the Professional Organization for German Nurses (*Berufsorganisation der Krankenpflegerinnen Deutschlands*),

initiated by Agnes Karll in 1903.[12] The Professional Organization for German Nurses gained international acclaim because of Karll's active involvement in founding the International Council of Nurses with nurses from the United States and United Kingdom.[13] The organization was dissolved in 1938. After World War II, former members reorganized as the Agnes Karll Association and it went on to be instrumental in the professionalization of nursing after 1945.

This chapter throws light on the nursing concept of the Agnes Karll Association. How did traditional Christian, experience-based views of nursing relate to those founded on scientific standards? To which related sciences did the women refer and how did the logic of scientifically planned and organized nursing establish itself? And what does this say about the role of women in West German society?

The dominance of the sisterhood principle

The dominance of the motherhouse-bound sisterhoods had considerable impact on the organization of "independent" nursing professionals, defined as those who had no motherhouse affiliation. The Agnes Karll Association's forerunner, the Professional Organization for German Nurses, did not completely abandon the sisterhood principle when it was founded in 1903. Like the motherhouses, the organization provided a uniform for its members, instituted an employment agency and ensured adequate sickness and retirement provision for its nurses. The image of a sisterhood was seen as an essential means of gaining recognition along with the religious sisterhoods. Being addressed as "sister," a privilege that had so far been reserved for members of denominational sisterhoods, was considered particularly important. By forming associations the independent nurses were able to call themselves "sister," a form of address that, to this day, is used as a synonym for female nurses.[14]

After 1945 the Agnes Karll Association held on to this organizational tradition, re-founding itself as a sisterhood. Just like the motherhouse organizations, it entered into contracts with hospitals to regulate the deployment of its nurses. These contracts also allowed the association to take charge of the nursing school that was attached to the hospital and to have a say in the training of new nurses. The nurses were employed either by the Agnes Karll Association or by the hospital operators. Unlike deaconesses and denominational sisters, who were sent out by their motherhouses, the Association's nurses could choose where they wanted to work.[15]

There were other independent sisterhoods apart from the Agnes Karll Association. They were usually smaller and regionally organized. The only organization that was comparable to the Agnes Karll Association in size and reputation was the Association of Independent Sisters (*Bund freier Schwestern*), a sisterhood that formed part of the German public service and transport workers' union (*Gewerkschaft Öffentliche Dienste, Transport und Verkehr*). While the members of the Agnes Karll Association usually came from Protestant middle- or upper-middle-class families, the Association of Independent Sisters recruited its members primarily from a social-democratic, unionist, often atheist, working-class milieu. While the organization advocated a union-regulated wage system for nurses, it was skeptical about the professionalization of nursing. But among the

independent sisterhoods it was the Agnes Karll Association that assumed a pioneering role in the professionalization of nursing.[16]

Starting point: The Agnes Karll Association and the conception of "good" nursing

Given the influence of Protestant deaconesses and Catholic sisters in post-war Germany, "independent" nurses, who were not associated with a motherhouse, were under pressure in Germany to prove that they also were "good" nurses who were concerned primarily with the patients' wellbeing. After the war the situation of independent nurses grew even more sensitive since the Western occupying powers suspected them of having actively supported the Nazis' extermination policies; they saw the denominational motherhouse sisterhoods of Caritas and Inner Mission as less complicit.[17] Although the Professional Organization of German Nurses was dissolved in 1938, many of its members transferred to its Nazi-controlled successor organization (*Reichsbund deutscher Schwestern und Pflegerinnen*) that merged with the national socialist "brown sisterhood" in 1942 (*NS-Reichsbund Deutscher Schwestern*). It was therefore not possible to distinguish at the end of World War II between former members of the Professional Organization and "brown sisters."[18] The Agnes Karll Association especially had the reputation of having accepted formerly devoted Nazis.[19] Thus, the association's direction strove to emphasize Christian principles because a Christian ethos was considered to guarantee "good" caring nursing practice.[20]

The leadership of the Agnes Karll Association shared one of the central tenets of Christian nursing: caring for both body and soul. While physicians were concerned with the symptoms, diagnosis and treatment of illness, the nurses, according to the tenet, devoted themselves wholeheartedly to the patients' entire personality. Conveying a sense of comfort and security to patients was seen as an essential healing factor.[21] The relationship between physicians and nurses was therefore not hierarchical but complementary. This applied particularly to Christian hospitals where, up until the second half of the twentieth century, physicians had to fight to establish their scientifically based biomedical understanding of health and illness.[22] "Love for the sisterhood," that is, the ability to treat nurses with respect, was one of the main criteria of employment for physicians in these hospitals, a fact that did much for the recognition of the nursing profession.[23]

The publications of the Agnes Karll Association tended to emphasize that the reputation of a hospital depended equally on the head physician's expertise and the atmosphere in the house that the nurses created.[24] In order to be able to do justice to that responsibility for the atmosphere, the nurses also needed to feel comfortable in their place of work. Like other sisterhoods, the Agnes Karll Association therefore aimed at staffing hospitals exclusively with its own nurses.[25] This was meant to facilitate the establishment of a community of nurses who supported each other and were able to convey to both sisters and patients the feeling that they were in good hands.

It was consequently an important aspect of the Agnes Karll Association's training concept for nurses that it valued not only the acquisition of technical knowledge but

especially the development of a nurse's "personality." A "good" nurse had to be a nurse "at heart." This "heart" – and in this respect the association shared the fundamental precepts of the conventional, experience-based training concept – was best developed if nurses lived and worked together in a community, learning from the example of more experienced sisters and benefiting from the general atmosphere in the hospital and nursing school.[26] Far into the 1960s, women considered it natural to leave nursing once they were married.

Because nurses carried so much responsibility for the patients' physical and mental needs, they had to be in close contact with the patients and highly committed to their work. Even though the Agnes Karll Association insisted that nurses had time to themselves outside working hours, it refused to bring their working hours into alignment with those of other salaried professions. Eight-hour work days were not considered feasible in nursing because the continuous contact with patients was seen as essential to the process of recovery.[27] The close contact between nurses and patients was enhanced by the longer periods that patients spent in hospital: 25 days on average in the early 1950s.[28] In the mid-1960s patients still remained hospitalized for an average of 21 days, which was longer that the comparable 14 days in the United States and Sweden.[29]

It would, however, not do justice to the Christian nursing concept to discuss only its emphasis on devoted care. Beyond the care aspect, the continuity of contact was essential so that nurses could gain competence in patient observation including the monitoring of moods, appearance, sleep and appetite as well as changes to a patient's weight, temperature, respiration and elimination. From the nineteenth century up to the 1950s the close observation of patients had, across sisterhoods, become the specific domain of the nursing staff and the essence of its independence. In 1952, for example, the Federation of German Nurses' Associations (*Arbeitsgemeinschaft deutscher Schwesternverbände*), as the umbrella organization of all German sisterhoods including the Agnes Karll Association, firmly refused to consider leaving the distribution of food to assistant staff, arguing that it was most important for nurses to be aware of what their patients ingested.[30] As long as the provision of care was based on the personal needs of patients, with their exact and continuous observation being its distinguishing feature, the assistant staff should only perform tasks outside the patient room.[31]

Neither the ability to make patients feel comfortable and secure nor the experience-based and often intuitive observation of patients was easily definable according to criteria of scientific rationality. The importance of these aspects for the healing process was even less measurable. That did not pose a problem in the Christian view of nursing; on the contrary, the particular proficiency of nursing lay in the fact that it was based on a – specifically feminine – "mystery" that eluded penetration and imitation.[32] It was that mysteriousness surrounding the nurses' activities that accounted for the profession's specialness and independence in the Christian view.

The radical changes of the 1960s: The scientification of nursing

Postwar medical history in West Germany was not marked by "major" inventions but by growing specialization and mechanization.[33] The logic of a biomedical view of illness that was based on natural scientific concepts established itself also in Christian hospitals in the 1960s. Nursing was transformed into a process based on planning and on the criteria of scientific rationality.

The scientification process in nursing started in the mid-1950s with the labor sciences, a discipline that could justify its importance with the growing shortage of nurses. The labor sciences, which had a long tradition in Germany at the time, strove for the "optimization" of work processes.[34] In the field of nursing they could, however, only be established once the denominational sisterhoods with their views of what nursing should be like lost ground.

The denominational motherhouse sisterhoods had been suffering from recruitment problems since the early 1950s as the social norms for women changed and the labor sciences promised to provide solutions through more effective deployment of the nursing staff available. They introduced new concepts into the field of nursing that were derived from economic cost–benefit calculations. Efficiency was one of their key factors.

The rationalization of workflow in nursing was seen as the key to solving staffing problems. Frederick Winslow Taylor's concept of improving the productivity of work through a division of labor according to tasks and the standardization of process steps had reached the healthcare sector. When new hospitals were built it was seen as important to keep walking distances to a minimum and centralize routine functions such as the sterilizing of instruments in order to reduce labor on the ward. Nurses were to be relieved from non-nursing tasks, especially housekeeping jobs. But the envisaged differentiation between non-nursing and nursing-specific activities called the very foundations of traditional Christian nursing into question. Still in the early 1950s the Agnes Karll Association objected to the deployment of nursing assistants, a concept that had long become established in other countries, including the United States. There was to be no hierarchy of activities as superior or inferior in the immediate delivery of care.[35]

Yet the critical attitude about nursing assistants changed by the end of the 1950s. The rebuilding of hospitals was largely completed and with the growing prosperity of West German society the healthcare system expanded.[36] But the opening of modern hospitals was seriously jeopardized by the shortage of nurses. Hospitals that wanted to attract and keep new nursing staff had to adjust working conditions to the life plans of the next generation of women. The reduction of weekly working hours, introduced in 1956 and 1957, proved particularly effective. It paved the way for comprehensive rationalization in nursing because working hours became a valuable asset that had to be used efficiently. By 1959, even the Agnes Karll Association began to favor the introduction and regulation of nursing assistants.[37]

The successive introduction of functional care and the division of labor into specialized tasks facilitated the fundamental transformation of the nurse–patient relationship. Patients were no longer looked after by one nurse but by a number of

nursing professionals who were each allocated one specific task. The demands on staff nurses also changed profoundly. The hallmarks of a "good" staff nurse were no longer her motherly, caring qualities, but increasingly her ability to set up efficient duty schedules and organize the care rather than provide it.[38] The workflow rationalization and the restriction of duties led to a significant reduction in the amount of time available for traditional notions of nursing work that was not directly task-oriented. The concept of motherly, caring devotion rapidly lost importance in the 1960s. Critics, sociologists in particular, found that too much value was attached in the self-image of nurses to "mothering patients," and the role of the nurse was reduced to "a vague 'tending' to the healing process."[39] While bedside attendance and the ability to make patients comfortable made nursing so special in the older model, these activities were not really definable and certainly not divisible into functional work stages. Nurses seemed now in danger of losing their status as caregivers in the modern, mechanized and highly specialized healthcare system.

Psychology eventually offered a way out of this situation since it provided the possibility of restructuring the relationship between nurses and patients along scientific principles. In the 1950s, psychological concepts of different personality types were successively introduced into the realm of nursing. Nurses were expected to learn how to divide patients into scientifically defined types in order to be better able to judge their behavior and adapt care interventions to their particular personality type. It was recommended, for instance, that they separate patients according to the scheme of Carl Gustav Jung, the founder of analytical psychology, into introvert and extrovert types; or that they differentiate between the pyknic, gregarious type and the leptosomic, reserved type, based on the theories of psychiatrist Ernst Kretschmer.[40]

By introducing psychological interpretive patterns into nursing, the Agnes Karll Association followed the general trend at a time when other fields of Christian (mostly Protestant) social work also opened up to psychological theories.[41] Unlike in the United States, however, it was not psychiatric nursing that drove the psychologization process here, since psychiatric nursing appeared rather late in the German professionalization process.[42] In the 1960s psychology evolved as a key factor in the scientification of the nurse–patient relationship in Germany. The provision of care seemed no longer possible without basic psychological knowledge.[43] Knowing something about developmental psychology became an essential prerequisite for gaining an understanding of the patients' age-specific life themes and problems. Nurses were now expected to acquire basic counseling skills so that they were able to control and direct conversations rather then let them evolve "randomly" as they used to do.[44] The direct interaction with patients thus also became subject to efficiency considerations.

Psychology clearly came into its own as the conditions of the older, need-oriented nursing began to deteriorate so dramatically with the introduction of functional nursing. Psychology can therefore be seen as the vehicle that ensured that the patient as a person was not entirely lost from view in the modern hospital. In 1966, psychology began to be included in the training curriculum and examination regulations for nurses.[45] Psychological concepts were probably not put into practice in everyday nursing until

the 1970s, the "therapeutic decade,"[46] when the number of therapies offered to persons in need soared in all areas of psycho-social healthcare.

The growing adoption of psychological concepts from the 1960s onward gave rise to new demands in the field of nursing: sisters were now expected to learn to reflect on their own actions by developing awareness of their own feelings of fear, insecurity, aversion or affection. Following Sigmund Freud, the founder of psychoanalysis, nurses were now asked to gain clarity in their dealings with patients about possible transference and countertransference mechanisms in order to be able to control them.[47] This step toward self-reflection was important in that, by the 1960s, the traditional Christian care provision was increasingly suspected of encroaching on and abusing patients' private space.[48] Such criticism was characteristic of the general democratization of the society, whereby established authorities and hierarchical structures were increasingly called into question.[49] In the Christian care concept, patients were indeed highly dependent on the nurses assigned to them. That such a constellation did not have to result in the patient being made comfortable, but could also produce conflicts – for example, if the patients didn't get along with the nurse allocated to them – was a significant taboo in Christian nursing traditions. The introduction of psychological–therapeutic concepts therefore certainly filled a void in the traditional Christian nursing concept.

The character of care delivery changed dramatically with the psychologization and therapeutization of the patient–nurse relationship. Psychological concepts relied on the spoken word and prioritized cognitive awareness. Ritual, more sense-based ways of expression characteristic of Christian nursing traditions – such as songs, prayers, non-verbal religious practices, but also moments of quiet – were forced out of the nursing routine.[50] Since "knowledge of mental experience mechanisms" was declared to be the key skill in dealing with patients, the forms of devotion that had previously been practically acquired and were without scientific foundation were no longer valid or legitimate.

The scientification of the patient–nurse relationship and the arrival of the concepts of efficiency and targeted actions gave rise to a new view of nursing as an organized, well-planned process in the late 1960s. In 1969, *Die Agnes Karll-Schwester*, the journal published by the Agnes Karll Association, first presented the nursing process as a four-phase model consisting of data collection, planning, implementation of nursing interventions and evaluation.[51] The notion of the nursing process first appeared in the United States in the 1950s and, in the 1960s, it was further developed on the basis of the cybernetic model. Cybernetics was introduced in the 1940s and 1950s as an interdisciplinary science connecting technology, natural and human sciences and the humanities.[52] It saw human beings as complex functional mechanisms that were not fundamentally different from machines. With its key concepts of regulation, control, information and feedback, cybernetics restructured the field of nursing to conform to the logic of technology and mathematics. Feedback was its central aspect as it allowed for the success or failure of the nursing activity to be regulated and, if necessary, corrected.[53] The logic of the nursing process made it possible to speak about nursing like an engineer who aims at optimizing production processes with planned

interventions. In the 1970s the nursing process found its way into the nursing text books as a model; in 1985 it became statutory in West German nursing training.[54]

The nursing process has been widely criticized by some nursing scholars for its mechanical approach to problem solving, because it promotes an instrumental access to patients as "information and problem carriers," and ignores the importance of intuitive, experiential forms of knowledge.[55] It nevertheless became established in nursing as a "global concept" that is now being taught, discussed and implemented worldwide.[56] The nursing process is another example of the extent to which the scientification of nursing followed the logic of sciences that were alien to it, a logic that is unable to do justice to the specific qualities of nursing and to the special situation of sick, frightened and suffering human beings.

Nursing reform and the scientification of the social sphere

The scientification of nursing needs to be seen as part of a wider "scientification of the social sphere"[57] that was characteristic of the twentieth century. In nursing this led to a dramatic shift in the conception of authoritative knowledge. In Germany in the early 1950s, the knowledge nurses had of the close relationship between the body and the soul, the capacity for personal, caring devotion that was especially ascribed to women, and the competence in patient observation that nurses acquired in dealing with patients were seen as important curative knowledge. The legitimacy of this knowledge was not affected by the fact that it was largely based on intuition rather than objectifiable observations. The nurses' activities were special because of this "mysterious" aspect.

The fact that this concept was considered hopelessly antiquated by the end of the 1960s illustrates how rapidly the fundamentals of nursing were transformed. With the decline of the sisterhood principle, the old Christian nursing concept lost its organizational basis. The reformation of nursing from a Christian "act of charity" to a salaried profession undoubtedly opened up new perspectives for women, such as the possibility of a private life and the chance of getting away from work. But the reduction of working hours led to an overall workflow rationalization in nursing. The introduction of the labor sciences and their logic to the management of hospitals and nursing was the beginning of a paradigm shift in the healthcare system because the labor sciences were about efficiency, not "good" nursing or the wellbeing of patients. Economic efficiency is aimed at relating the deployment of means, such as labor, time or money, to the outcome in a way that is rationally calculable and profitable. It has no place for non-measurable, "mysterious" aspects.

With the arrival of functional nursing it was no longer possible for patients to receive continuous care from one nurse. For nurses it became increasingly difficult to acquire competence in patient observation and security in patient handling. From the point of view of the 1950s this meant that nurses had lost their key competence. With the establishment of a natural scientific understanding of medicine and the growing importance of laboratory tests and imaging techniques in the 1960s, the nurses' observations were reduced to the level of unscientific and therefore irrelevant

pronouncements.[58] Compared to the collected "hard" patient data the intimate, personal awareness of patients lost its validity.

The introduction of cybernetics to nursing, in the form of the nursing process, shows that the mechanization of nursing was not restricted to the increasing use of technical equipment. The workflow in nursing was also restructured according to technical production processes and the language of nursing was adapted to the scientific terminology of engineering. Psychology might have provided new, science-based concepts that made space for a personal nurse–patient relationship in the highly technologized hospitals, and the demand for self-reflection might have filled a real void in the conventional nursing concept. But the prioritization of the spoken word in psychology meant that the ear was trained while the eye – the observation of the patient's physical condition – became secondary.

All in all, the scientification of nursing created a new field of conflict that is referred to by German nursing scholars as *doppelte Handlungslogik* (dual "rationale of action"). How can the theoretical, science-based mainstream knowledge with its claim to universality be united with the hermeneutic approach that validates the specialness of individual patients and their subjective experience of illness? This contradiction, which underlies all actions in person-related service professions, is particularly problematic in nursing. Because of their focus on the patients' body, nursing professionals rely on implicit forms of knowledge that cannot be cognitively and rationally explained and that lost their significance with the scientification of healthcare. The two sides of the "rationale of action" – mainstream scientific knowledge and the specialness of the individual patient – are indeed not equivalent. Since mainstream scientific knowledge grew to be *the* authoritative knowledge in the second half of the twentieth century, the subjective knowledge of the patient no longer carried as much weight as it had in the past.

Up to now historical research on nursing, just like the history of science, has dealt primarily with what is new and modern in the process of social development. Phases of forced modernization in society are, however, always phases of forced obsolescence. The fact that non-objectifiable forms of knowledge lost their validity will be highly relevant for the history of nursing but also for the twentieth-century history of gender as a whole: scientification affected women and men in very different ways since women work primarily in person-related, caring fields where intuitive forms of knowledge that cannot be formalized play an important part. Research into the significance, ambivalences and conflicts of scientification processes and the various ways of entering science-based society in the world would be a worthwhile enterprise. A research perspective that challenges the establishment of a hierarchy between scientific and experience-based, intuitive forms of knowledge would lead to a significant reevaluation of progress and backwardness in nursing history, and would throw new light on the "scientification" process.

Notes

1 Raphael, L. 1996, "Die Verwissenschaftlichung des Sozialen als methodische und konzeptionelle Herausforderung für eine Sozialgeschichte des 20. Jahrhunderts," *Geschichte und Gesellschaft*, vol. 22, pp. 165–193.
2 See Wildt, M. 1994, *Vom kleinen Wohlstand: Eine Konsumgeschichte der fünfziger Jahre*, Fischer Verlag, Frankfurt/Main, pp. 116–123.
3 See Schildt, A. 2000, "Materieller Wohlstand – pragmatische Politik – kulturelle Umbrüche: Die 60er Jahre in der Bundesrepublik," Schildt, A., Siegfried, D. & Lammers, K.C. (eds.) *Dynamische Zeiten: Die 60er Jahre in den beiden deutschen Gesellschaften*, Hans Christians Verlag, Hamburg, pp. 21–53, here p. 48.
4 See Haupt, H.G. & Requate, J. 2004, "Einleitung," Haupt, H.G. & Requate, J. (eds.) *Aufbruch in die Zukunft: Die 1960er Jahre zwischen Planungseuphorie und kulturellem Wandel. DDR, ČSSR und Bundesrepublik Deutschland im Vergleich*, Velbrück Wissenschaft, Weilerswist, pp. 7–28.
5 See Heineman, E. 1996, "Complete Families, Half Families, No Families at All: Female-Headed Households and the Reconstruction of the Family in the Early Federal Republic," *Central European History*, vol. 29, pp. 19–60.
6 See Oertzen, C. von 2001, "Fräulein auf Lebenszeit? Gesellschaft, Berufung und Weiblichkeit im 20. Jahrhundert," *WerkstattGeschichte*, no. 27, pp. 5–28, here pp. 16–28.
7 See Frese, M., Paulus, J. & Teppe, K. (eds.) 2002, *Demokratisierung und gesellschaftlicher Aufbruch: Die sechziger Jahre als Wendezeit der Bundesrepublik*, Schöningh, Paderborn; Herbert, U. (ed.) 2007, *Wandlungsprozesse in Westdeutschland: Belastung, Integration, Liberalisierung, 1945–1980*, Wallstein-Verlag, Göttingen; Schildt, A., 2007, *Die Sozialgeschichte der Bundesrepublik Deutschland bis 1989/90*, Oldenbourg Verlag, Munich, pp. 30–53.
8 The chapter is based on the research project "Rationalization of Nursing in Western Germany and the United States. A Comparative History of the Exchanges of Ideas and Practices, 1945 to 1975," sponsored by the German Research Foundation.
9 In the early 1950s training took a year and a half and included 200 hours of theory.
10 See Kreutzer, S. 2008, "'Before, We Were Always There – Now, Everything Is Separate.' On Nursing Reforms in Western Germany," *Nursing History Review*, vol. 16, pp. 180–200, here p. 186.
11 See Jordan, B. 1997, "Authoritative Knowledge and Its Construction," Davis-Floyd, R. & Sargent, C.F. (eds.) *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, University of California Press, Berkeley, pp. 55–79, here pp. 56–61.
12 See Boschma, G. 1996, "Agnes Karll and the Creation of an Independent German Nursing Association, 1900–1927," *Nursing History Review*, vol. 4, pp. 151–168; Hummel, E. 1986, *Krankenpflege im Umbruch (1876–1914): Ein Beitrag zum Problem der Berufsfindung „Krankenpflege"*, Hans Ferdinand Schulz Verlag, Freiburg i. Br., pp. 101–170; Schmidbaur, M. 2002, *Vom „Lazaruskreuz" zu „Pflege aktuell": Professionalisierungsdiskurse in der deutschen Krankenpflege 1903–2000*, Ulrike Helmer Verlag, Königstein/Taunus.
13 See Tomes, N.J. & Boschma, G. 1999, "Above All Other Things – Unity," Brush, B. & Lynaugh, J. (eds.) *Nurses of All Nations: A History of the International Council of Nurses, 1899–1999*, Lippincott, Philadelphia, pp. 1–38, here pp. 26–30.
14 See Hummel, *Krankenpflege*, pp. 101–118; Schmidbaur, *Lazaruskreuz*, pp. 58–78.
15 See Kreutzer, S. 2005, *Vom „Liebesdienst" zum modernen Frauenberuf: Die Reform der Krankenpflege nach 1945*, Campus, Frankfurt/Main, pp. 37–39.
16 See Kreutzer, *Liebesdienst*, pp. 46–50 and 164–273.
17 However, the motherhouses subscribed to the basic assumptions of National Socialist policy regarding race and population policy. For example, forced sterilizations were carried out in deaconess motherhouses. See Lauterer, H.M. 1994, *Liebestätigkeit für die Volksgemeinschaft:*

Der Kaiserswerther Verband deutscher Diakonissenmutterhäuser in den ersten Jahren des NS-Regimes, Vandenhoeck & Ruprecht, Göttingen.

18 See Steppe, H. 1996, "Krankenpflege ab 1933," Steppe, H. (ed.) *Krankenpflege im Nationalsozialismus*, Mabuse, Frankfurt/Main, pp. 61–85, here 65–66.

19 See Kreutzer, *Liebesdienst*, p. 38; Schmidbaur, *Lazaruskreuz*, p. 150.

20 See Elster, R. 1956, "Bericht über eine Studienreise durch die Schweiz, England, Schottland, Schweden und Finnland," *Die Agnes Karll-Schwester*, vol. 10, pp. 96–99, here p. 99.

21 See Elster, R. 1951, "Ein Wort an unsere Examensschwestern," *Die Agnes Karll-Schwester*, vol. 5, pp. 213–214, here p. 213.

22 See Schmuhl, H.W. 2003, "Ärzte in konfessionellen Kranken- und Pflegeanstalten 1908–1957," Kuhlemann, F.K. & Schmuhl, H.W. (eds.) *Beruf und Religion im 19. und 20. Jahrhundert*, Kohlhammer Verlag, Stuttgart, pp. 176–194.

23 See Kreutzer, S. 2010, "Arbeits- und Lebensalltag evangelischer Krankenpflege. Organisation, soziale Praxis und biographische Erfahrungen", *1945–1980* (unpublished postdoctoral thesis, *Habilitationsschrift*).

24 See Rudolph, H. 1956, "Die Stellung des Krankenhauses in unserer Zeit," *Die Agnes Karll-Schwester*, vol. 10, pp. 326–329, here p. 328.

25 See Klitzing, A. von 1953, "Eröffnung der Vor- und Fortbildungsschule des Agnes Karll-Verbandes," *Die Agnes Karll-Schwester*, vol. 7, pp. 285–288, here p. 287.

26 See Plieninger, M. 1950, "Die erzieherische Bedeutung der Krankenpflegeschule: Vortrag auf dem Kurzlehrgang für Lehr-, Operations- und Stationsschwestern an Krankenpflegeschulen vom 27.–29.10.1949 in Stuttgart-Berg," *Die Agnes Karll-Schwester*, vol. 4, pp. 6–11.

27 See Schmidt, G. 1954, "Schwesternprobleme der Gegenwart," *Die Agnes Karll-Schwester*, vol. 8, pp. 7–9, here p. 7.

28 See Spree, R. 1996, "Quantitative Aspekte der Entwicklung des Krankenhauswesens im 19. und 20. Jahrhundert: ‚Ein Bild innerer und äußerer Verhältnisse'," Labisch, A. & Spree, R. (eds.) *„Einem jeden Kranken im Hospitale sein eigenes Bett": Zur Sozialgeschichte des Allgemeinen Krankenhauses in Deutschland im 19. Jahrhundert*, Campus, Frankfurt/Main, pp. 51–88, here p. 65.

29 See Anon 1965, "Verkürzte ‚Krankenhaus-Verweildauer' – ein Weg?," *Die Agnes Karll-Schwester*, vol. 19, p. 387.

30 See Kreutzer, *Liebesdienst*, pp. 256–257.

31 See Kreutzer, "Before," pp. 183–187.

32 See Rudolph, H. 1956, "Die Stellung des Krankenhauses in unserer Zeit," *Die Agnes Karll-Schwester*, vol. 10, pp. 326–329, here p. 328. At 6.6 percent the proportion of male nurses was relatively low in 1950. Male nurses worked primarily on psychiatric wards or all-male wards, mostly in urology departments. See Kreutzer, *Liebesdienst*, p. 20.

33 See Seidler, E. 1993, *Geschichte der Medizin und der Krankenpflege*, 6th edn., Kohlhammer, Stuttgart, pp. 240–242.

34 When, after World War I, North American nursing scientist Isabel M. Stuart proposed to standardize nursing practice in line with the labor-scientific principles, she was criticized in the United States for attempting to introduce the German model of heartlessness and brutal efficiency into nursing. See Reverby, S. 1989, "A Legitimate Relationship: Nursing, Hospitals, and Science in the Twentieth Century," Long, D. & Golden, J. (eds.) *The American General Hospital: Communities and Social Contexts*, Cornell University Press, Ithaca, NY, pp. 135–156, here p. 143.

35 See Cauer, M. 1950, "Von den menschlichen Anforderungen an die Schwester: Auszug aus dem Hand- und Lehrbuch der Krankenpflege von Fischer-Groß-Krick, Part 2," *Die Agnes Karll-Schwester*, vol. 4, pp. 5–7, here p. 5.

36 See Krukemeyer, H. 1998, *Entwicklung des Krankenhauswesens und seiner Strukturen in der Bundesrepublik Deutschland: Analyse und Bewertung unter Berücksichtigung der gesamtwirtschaftlichen*

Rahmenbedingungen und der gesundheitlichen Interventionen, Hauschild, Bremen, pp. 85 and 98–99.

37 See Elster, R. 1960, "Bericht über die 17. Hauptvorstandssitzung des Agnes Karll-Verbandes und die Delegiertenversammlung," *Die Agnes Karll Schwester*, vol. 14, pp. 342–344, here p. 344.

38 See Günzel, M. 1961, "Ist eine Ausbildung zur Stationsschwester notwendig?," *Die Agnes Karll-Schwester*, vol. 15, pp. 268–269, here p. 268.

39 Leich, H. 1962, "Aufgaben, Pflichten und Rechte der Oberin bei der Betriebsführung im Krankenhaus," *Die Agnes Karll-Schwester*, vol. 16, pp. 12–18, here p. 17.

40 See Höhn, E. 1952, "Die Bedeutung psychologischer Typen für den mitmenschlichen Kontakt," *Die Agnes Karll-Schwester*, vol. 6, pp. 10–11.

41 Kaminsky, U. & Henkelmann, A. 2011, "Die Beratungsarbeit als Beispiel für die Transformation von Diakonie und Caritas," Damberg, W. (ed.) *Soziale Strukturen und Semantiken des Religiösen im Wandel: Transformationen in der Bundesrepublik Deutschland 1949–1989*, Klartext Verlag, Essen, pp. 89–104.

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43 See Elster, R. 1961, "Das heutige Berufsbild in der Krankenpflege," *Die Agnes Karll-Schwester*, vol. 15, pp. 297–301, here p. 298.

44 See Kelber, M. 1964, "Die Kunst der Gesprächsführung im Einzelgespräch," *Die Agnes Karll-Schwester*, vol. 18, pp. 136–137.

45 "Ausbildungs- und Prüfungsordnung für Krankenschwestern, Krankenpfleger und Kinderkrankenschwestern," 2 August 1966, § 1, section 2, Bundesministerium für Justiz (ed.) 1966, *Bundesgesetzblatt*, Part I, Bundesanzeiger, Bonn, pp. 462–365, here p. 462.

46 See Ziemann, B. 2006, "The Gospel of Psychology: Therapeutic Concepts and the Scientification of Pastoral Care in the West German Catholic Church (1950–1980)," *Central European History*, vol. 39, pp. 79–106.

47 See Baumann, W. 1967, "Gruppenarbeit und Gruppendynamik in der Krankenpflege," *Die Agnes Karll-Schwester*, vol. 21, pp. 4–5, here p. 4; Kelber, M. 1964, "Die Kunst der Gesprächsführung im Einzelgespräch," *Die Agnes Karll-Schwester*, vol. 18, pp. 136–137.

48 See Dörrie, K. 1964, "Zur ‚sozialen Rolle' des Patienten," *Die Agnes Karll-Schwester*, vol. 18, pp. 132–135, here 135.

49 See Schildt, A. 1999, *Ankunft im Westen. Ein Essay zur Erfolgsgeschichte der Bundesrepublik*, S. Fischer Verlag, Frankfurt/Main, pp. 181–189.

50 See Ziemann, "Gospel," pp. 98–104.

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53 See Hörl/Hagner, "Überlegungen," p. 11; Friesacher, H. 2011, "Macht durch Steuerung: Zur Kybernetisierung von Pflege und Gesundheit," Remmers, H. (ed.) *Pflegewissenschaft im interdisziplinären Dialog: Eine Forschungsbilanz*, V&R unipress, Göttingen, pp. 343–367, here pp. 347–348.

54 See Juchli, L. 1979, *Allgemeine und spezielle Krankenpflege: Ein Lehr- und Lernbuch*, 3rd edn., Thieme Verlag, Stuttgart, pp. 19–23.

55 See Friesacher, "Macht," p. 348; Henderson, V. 1982, "The Nursing Process – Is the Title Right?," *Journal of Advanced Nursing*, vol. 7, pp. 103–109, here pp. 107–109; Hülsken-Giesler, M. 2008, *Der Zugang zum Anderen. Zur theoretischen Rekonstruktion von Professionalisierungsstrategien pflegerischen Handelns im Spannungsfeld von Mimesis und Maschinenlogik*, V&R unipress, Göttingen, pp. 313–331.

56 See Habermann, M. & Uys, L.R. (eds.) 2005, *The Nursing Process: A Global Concept*, Elsevier Churchill-Livingstone, Edinburgh, p. 3.
57 Raphael, "Verwissenschaftlichung," pp. 165–193.
58 See Eckart, W.U. 2005, *Geschichte der Medizin*, Springer, Heidelberg, pp. 270–277.