Conflicting chains of command in Dutch Catholic nursing (1839-1966)

Annelies van Heijst

Zusammenfassung

Konflikte in den Befehlsketten der katholischen Krankenpflege in Holland (1839-1966)


Catholic and Protestant origins of Dutch nursing

Since medieval times, nursing the sick, the weak and the elderly was a widely established and religiously based practice in Western Europe. Founders of institutes and care giving personnel, too, were driven by religious motivations. They believed that looking after the sick and financing these provisions was part of their obligation as Christians. From the twelfth century onwards, Catholic nuns belonged to the forerunners of nursing care in the public domain. All over Europe, they founded guesthouses and other provisions in which the sick and the poor found a refuge. There, a religious regime was prevalent: the institute had a religious name; its care giving staff maintained a religious life-style; the order of the day was structured by religious events such as prayer and mass; and priests paid regular visits to the residents. The people who acted as care givers were either members of religious orders or lay-people. They were called ‘in fathers’ and ‘in mothers’ (binnenvaders and binnenmoeders). Supported by their assistants, they took care of the managerial and caring work. So-called ‘out fathers’ and ‘out mothers’ (buitenwaders and buitenmoeders) had a governing task and formed a board of trustees or ‘regents’ (regenten). They organized and financed their institutes, set up the regulations and made the decisions about the admittance or refusal of the poor and sick. Sometimes the boards of these chari-

1 Van Heijst (2008), pp. 11-19; Vis (2008).
table organizations were directed by the municipality; sometimes they were private organizations through which citizens looked after their coreligionists.

Since the Reformation the situation changed. In overall Catholic Western-European regions, teams of charitable religious together with their assistants kept on carrying out the care giving. In Protestant regions, however, the boards of guesthouses and orphanages had difficulties in finding suitable personnel. The work was left to people who were neither practiced nor very dedicated and in fact often needed shelter themselves. As a consequence, the practice of care giving deteriorated here. This was also the case in the Low Countries.

The Republic of the Seven United Netherlands (1588-1795) was the result of a revolt of the northern Dutch provinces against their Catholic Spanish rulers, led by the Protestant William the Silent. Ever since the takeover in Amsterdam in 1578, the Dutch state was predominantly Protestant, which left long-lasting marks on the nation as a whole. Although tolerated, Catholics in the Republic in fact had to endure repression and were treated as second-rate citizens. They were denied public office and restricted in setting up societal organizations. Furthermore, they encountered difficulties in exercising their religious ceremonies. When in 1578 nuns and religious brothers were banned from guesthouses and other institutes for care-depending people, the provisions for the poor and the sick eroded.

It was not until 1795 that this situation changed. Then, due to French intervention, the Batavian Republic was installed. Its legislation reflected the ideals of the Enlightenment and the French Revolution. Freedom of public religion was officially granted to all denominations. From that time on, Catholics and Jews were allowed to establish organizations of their own and were free to exercise their religion in public. During the nineteenth century, the civil rights of the Catholics were also restored, allowing them to gain full citizenship. In the emancipation process that followed, they took pride in establishing societal and ecclesiastical organizations of their own. In 1809, the population of the Netherlands consisted of 58 per cent Protestants, 38 per cent Catholics and a mixed minority of Jews, Liberals and Socialists. Most Catholics lived in the southern part of the country, while Protestants lived mainly in the West and the North, Jews formed a small, but distinct denominational community, most of them living in towns and cities. The by far largest group lived in Amsterdam. The multi-form religious city of Amsterdam, in the western part of the country, played a major role in the rise of professional nursing in the Netherlands.

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3 Van Leeuwen (2000).
6 Vis (2008).
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markably, Catholics set the professional standard there. In 1839, a group of nun-nurses was called to Amsterdam because of their excellent reputation: they established a small guesthouse for the elderly and began to give district care. Their work functioned as an exemplary model for the Protestant Society of Nursing. It was the latter organization that in 1878 co-established the first trajectories of training for nurses. Consequently, Protestant women who were involved in this organizational initiative, like Jeltje de Bosch Kemper and Anna Reynvaan, became the icons of nursing. Their Protestant background was not viewed as being a very important feature; on the contrary, their efforts for the professionalization of nursing were emphasized. At that time, nursing was still perceived as an activity for which women were especially equipped because of their gender; women, especially those from the (upper) middle class, were thought to have a (moral) ‘calling’ for this type of work.

When more and more hospitals began to develop their own training program for nurses, the need for centralization came up. In due course, the neutral Association for Nursing Care (Bond voor Ziekenverpleging) was established, in which hospitals of all denominations participated. The Association was founded in 1893 and became a main factor of hospital reform. From then, it still took some decades for a standard curriculum and exam to be acknowledged as the proper basis for nursing training. In the beginning, the state left the development of professional medical and nursing care to the professionals themselves. The state only came up with regulations and arrangements when things were settled by the Association for Nursing Care. It wasn’t until 1921 that the Dutch government acknowledged the nursing exams.

On an international scale, historians seem to appreciate the nuns’ contribution to the practice of nursing, as the work of Nelson, McCauley and Peckham Magray shows. Dutch historians, however, tend to have a negative view on nuns in nursing. Either the nuns’ role is ignored or they are denounced as being unprofessional. Dutch Protestant women, however, are praised as the forerunners of nursing. In the following, we will reconstruct the origins of this historical depiction.

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7 Archive Sisters of Charity of Tilburg, Chronicles. Saint Bernard’s.
13 Binnenkade (1973); Van der Mey (1980); Dane (1985); Wiegman (1998).
The rise of the modern hospital and the trained nurse

During the 1870s, the traditional guesthouse began to disappear and the modern hospital was dawning. Consequently, the practice of nursing underwent a profound change. In a modern hospital patients could cherish the hope of being healed. Earlier in time, medical doctors simply would not have had that option. The only thing possible in those days was nursing the sick. From the second half of the nineteenth century onwards, the body of medical knowledge grew and medical instruments became available. Therefore, medical doctors began to be in need of the help of qualified nurses, women who understood medical practice and were able to carry out the medical doctors’ instructions.

However, medical doctors did not value, or even notice, the body of knowledge that nurses had built up throughout ages of nursing. The ‘tacit knowledge’ of nurses had never been put into words; it had arisen from long-term experience in daily practice and was handed over from one generation of nurses to the next. Experienced nurses were living role-models. Part of this ‘tacit knowledge’ was articulated by Florence Nightingale in her “Notes on Nursing” (a book which was also informed by new medical insights on hygiene). In her early years, Nightingale had been trained by the Sisters of Mercy in Paris and the Deaconesses of Kaiserswerth in Germany. When tracing the history of nursing, this oral and practice-based tradition of nursing should be taken into account. If not, many generations of nurses are disregarded and thus the false impression is being created that qualified nursing did not begin until the 1870s, when doctors took the lead of the training.\(^\text{14}\)

In the opinion of the medical doctors who founded the first trajectories of training, nurses had a lot to learn. The doctors considered themselves likely candidates for teaching. Therefore, they were the ones to develop training programs that were taught in hospitals. These consisted predominantly of medical courses, complemented by one or two taught by a female nurse. Much weight was given to theoretical knowledge and nurses were disciplined so that they would obey doctors’ orders.

The late start in training of nun-nurses

From 1878 onwards, the modern hospital arose in the Netherlands; by 1945, about half of all Dutch hospitals were Catholic. In a Catholic hospital nuns occupied the leading positions, except for medical issues. Nuns did the nursing, sometimes assisted by lay-nurses, maids and servants who cleaned and cooked. Before 1878, nun-nurses were not officially trained. Even so, their approach (like that of Protestant deaconesses) bore many characteristics of professional work. They took care of strangers and worked in a team so that the continuity of nursing was guaranteed; they

\(^{14}\) Van Heijst/Derks/Monteiro (2010), pp. 188-327.
received payment in return; drawing on collectively and personally acquired insights they worked systematically; and they learned from practical experience.

When the nursing training programs started, thousands of Dutch Catholic nuns were already nursing in hundreds of guesthouses and psychiatric wards, homes for the elderly and the disabled. Some of these religious communities went as far back as medieval times. The nuns could not spare the time to get trained, since that would have disrupted their work. Therefore no nuns were sent to the training programs in the 1880s and 1890s. Having not sufficient time certainly was a motive, but another cause remained more obscure. The nuns did not see the need of being trained, since in the Catholic milieu they held the monopoly of nursing. Meanwhile, hundreds of lay-women – also Catholic ones – became trained nurses.

As a result, Catholic nuns remained behind and therefore they were stigmatized as being ‘unprofessional’. It was not until 1901, that eleven nun-nurses in Amsterdam took the training and passed the exam. They were the first trained nun-nurses in the Netherlands.\textsuperscript{15} The group lived and worked in the Catholic Onze Lieve Vrouw Gasthuis, a newly built hospital that, when opened in 1898, was the largest in the city. They all were members of the congregation of Sisters of Carolus Borromeus of Maastricht, headed by mother Alphonsine van Haeff. The latter, who played an important part in the group’s attending the formal training, was a trained pharmacist herself. From that time on, a new standard was set. It spread all over the Netherlands, from one sister congregation to the other. When Catholic nuns began to acknowledge the fact that they had been reluctant in catching up with this new development, they set up training programs of their own. In the early days of the 1900s, these trainings were only accessible to nuns. After some years, however, also lay-nurses were welcomed.

<table>
<thead>
<tr>
<th>Lay-nurses of unspecified denominations</th>
<th>Catholic nuns</th>
<th>Deaconesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,674</td>
<td>2,201 (60%)</td>
<td>1,055 (28%)</td>
</tr>
</tbody>
</table>

\textbf{Table 1: Dutch female nurses in 1912}\textsuperscript{16}

The monopoly of nun-nurses in the Catholic milieu made it difficult for the lay-nurses to get employed in a Catholic hospital. Catholics generally assumed that nuns were the most dedicated and qualified nurses. Furthermore, the salary in Catholic organizations was low. The formerly higher level of professionalization of lay-nurses did not contribute much to their position, because by 1912, the nun-nurses had become equally qualified. Yet, compared to the (much larger) group of lay-nurses, only a slightly

\textsuperscript{15} Archive Sisters of Charity of Carolus Borromeus, Nr. 2166: Diary OLVG (1901).

\textsuperscript{16} Archive Bond voor Ziekenverpleging, No. 114: Enquête (1912).
higher percentage of nun-nurses were trained. Even further behind were the Deaconesses, because compared to the nuns and the lay-nurses, many of them were untrained.

<table>
<thead>
<tr>
<th></th>
<th>Diploma</th>
<th>No diploma</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,201 lay-nurses</td>
<td>734 (33%)</td>
<td>1,467 (66%)</td>
</tr>
<tr>
<td>1,055 nun-nurses</td>
<td>344 (34%)</td>
<td>711 (66%)</td>
</tr>
<tr>
<td>418 deaconesses</td>
<td>40 (10%)</td>
<td>378 (90%)</td>
</tr>
</tbody>
</table>

Table 2: Dutch female nurses with a diploma in 1912

Religious and professional chains of command

Simultaneously to this development, other reasons appeared that can explain the damaged public image of Dutch nun-nurses and their absence from the history of professional nursing. We will only focus on hospitals and not look into other healthcare institutions in which nuns worked. In the hospitals, the distribution of power caused the trouble and hence led to the negative public image of nun-nurses. Two regimes of power clashed: the religious regime and the professional one.

Guesthouses of the old days had operated under a religious regime that was based upon spiritual values and supervised by clerical men and women religious. In modern hospitals, however, another logic was applied, namely that of a professional regime which followed from modern medicine. This transformation did not take place overnight, but took many decades. During the long phase of alteration, several types of conflicts arose in Catholic hospitals. Through rumor and slander these became known in the outside world, causing severe damage to the reputation of nuns. The difficulties were related to various chains of command, as will be pointed out next.

General organizational outline

Congregations of charitable nuns were hierarchically organized in a very strict way. The nuns had a double task in life. Inside the convent they were supposed to lead a monastic life of prayer; outside the convent many of the nuns labored in works of mercy, especially in the field of mission, education and health care that brought them right into society. The work was carried out in Catholic institutions, where nuns occupied the leading positions. In the last decades of the nineteenth century, when the modern hospital arose, nuns either owned the hospital (bearing the full financial risk of its exploitation), or they were connected to the hospital through a collective contract between the congregation and the board of regents that governed it. The first model is called ‘ownership’, the second model is known as a ‘contract hospital’. In the Netherlands, the latter type was the most common. About two-third of all Catholic hospitals were ‘contract hospitals’.

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17 Archive Bond voor Ziekenverpleging, No. 114: Enquête (1912).
Power struggle amongst the nuns

In order to understand the dynamics in a hospital served by nuns, we first have to trace the distribution of power amongst the nuns themselves. On top of the hierarchal pyramid of the nuns’ community was the general mother superior. Together with her council, she resided in the motherhouse of the congregation. Next to the motherhouse, the congregation had various satellite houses. There, nuns lived in a convent that was often situated in the hospital that they served. Each of these convents was headed by a local mother superior. She was responsible for the sisters’ of her convent living according to the founding texts, the Rule and Constitutions of the congregation. Since the mother superior embodied the highest authority, nuns had to obey her categorically. This authority was of a spiritual nature: in the voice of the superior mother, the nuns were supposed to hear the voice of God.

A number of nuns living in a convent had their working place outside the actual convent; such was the case for nun-nurses. They nursed the sick and therefore were in the hospital for the main part of their day. To make matters complex, there, the hospital mother superior was in charge. She functioned as the superior of the nuns in the hospital and as head of all non-medical personnel; in other words, she was the co-director of the hospital. Even so, her power over the nuns was limited, because as religious and according to Canon Law, she and the nun-nurses of her staff were placed under the command of the local mother superior. If the hospital mother superior gave a nun-nurse permission for something and was overruled by the superior of the convent, the latter had to be obeyed.

This signals that the religious regime was valued as the most important. Requirements that followed from the practice of nursing were perceived as subordinate to demands that followed from spiritual obligations. Sometimes, the mother superior of the convent was a wise woman who did not overrule the instructions of the hospital’s superior. In those cases, there were no or just minor problems. Sometimes, clashes were absent because one and the same nun embodied both tasks, i.e. she was the mother superior of both the convent and the hospital. This applied to mother Alphonsine van Haeff, the pioneer mentioned above, who was the superior of both the nuns working in the Onze Lieve Vrouwe Gasthuis and those living in the hospital’s convent. On the other hand, there are numerous examples that show a more ambivalent practice, in which the division of hierarchical power caused tensions and right-out oppositional demands. Often, a reasonable nun-nurse who was the mother superior of the hospital and gave priority to what was professionally needed was then overruled by the mother superior of the convent.

It can be concluded that many nun-nurses who worked in hospitals experienced anxieties and even conflicts between the demands of their religious and professional duties. Nun-nurses were supposed to give priority to the
religious obligations that were ordered by the superior of the convent, even when the superior of the hospital had instructed otherwise or their professional ethics objected to the religious tasks given. It was a source of frequent and profound frustration and anger. If the nun-nurses disobeyed the instructions of the superior of the convent they would fail as a nun; if they abstained from what was professionally needed they would fail as a nurse. Since they held both identities at the same time, this was a diabolic dilemma.

<table>
<thead>
<tr>
<th>In charge</th>
<th>Congregation</th>
<th>Convent</th>
<th>Catholic Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General Mother Superior →</td>
<td>Local Mother Superior →</td>
<td>Hospital Mother Superior</td>
</tr>
</tbody>
</table>

Table 3: Power structure of the religious regime for nun-nurses in a Catholic hospital

Power struggles between nun-nurses and medical doctors

Medical doctors got entangled in power struggles as well. In the traditional guesthouse, medical doctors had only been passing by. They paid visits to the sick every now and then, but were not continuously present. This changed when the modern hospital came into existence. Because medical attention was vital for successful healing, a medical doctor became chief of the hospital. He was the ‘medical-superintendent’ who was held accountable by the hospital’s board. Depending on the type of hospital, the board consisted either of regents (Catholic lay men coming from the upper societal strata, and presided by a clergyman), or of nuns (i.e. the general mother superior of the congregation that owned the hospital, her council, and a clergyman who assisted the nuns).

On the work floor, the medical-superintendent was assisted by the already mentioned hospital mother superior, who was co-director. The latter was responsible for directing the nursing activities and household matters. Next to her, there were matrons: nun-nurses put in charge of the hospital’s wards. Although the matrons had to supervise all kinds of nursing activities, their leading positions often were the result of their religious status and not of their capabilities as nurses. It goes without saying that numerous clashes resulted from this typical distribution of power.

Firstly, there were clashes pertaining to the way the hospital was governed – especially in those cases where the hospital was owned by the sister congregation. Then, the medical-superintendent was held responsible by the general mother superior and her council, even though the latter had no medical or nursing expertise. On a regular basis, substantial decisions had to be discussed, be it financial issues, appointing new medical doctors, renovating or expanding the building, and buying medical instruments. Sometimes the board of nuns accepted the demands of the medical-superintendent, demands that followed from medical logic. But frequently difficulties arose due to the unequal and hybrid division of government, terms of reference and expertise. Sometimes the board of nuns simply would not listen to
medical argumentations, because they thought they knew best. Furthermore, congregational interests were not always congruent with those of a specific hospital. A board had not only one hospital to run, but an entire congregation of sisters, including other satellites, other hospitals and often numerous schools as well. Making decisions for the whole enterprise could imply having other priorities than those of a specific medical-superintendent.  

Other types of disagreement could occur within the hospitals themselves. These conflicts often arose between the medical-superintendent on the one hand and the hospital mother superior on the other. If the latter was not professionally trained, or just a stubborn woman, she did not understand the need of doing things the way the doctor ordered them. This included his instructions to the nursing staff or household staff. In view of that, medical doctors then had to fight to get proper assistance and consequently, the treatment of patients could be hindered or even endangered. In Amsterdam’s Catholic Onze Lieve Vrouwe Gasthuis, medical-superintendent Nico van Spanje found mother Alphonsine van Haeff at his side. As mentioned earlier, this trained nurse was the superior of the convent (which housed in the hospital) and also the superior mother in the hospital. She teamed up with Dr. Van Spanje and made sure there were no tensions between religious and nursing practice. The success of this hospital can therefore be attributed to this well-functioning team of a doctor and a nun-nurse.  

A third type of disparity occurred when the medical-superintendent was supported by the hospital mother superior, but met by opposition from the mother superior of the convent. As explained earlier, the latter was the nuns’ highest direct authority. So, if the mother superior of the convent overruled any instructions of the leaders in the hospital, the staff of nun-nurses had to obey her. Subsequently, all types of tension and conflict troubled the working place. Furthermore, these could not be kept silent. Maids, servants and assisting lay-nurses in the hospital sensed the anxiety and talked about it, thus causing public rumors.

<table>
<thead>
<tr>
<th>Medical-superintendent of the hospital (for general medical matters)</th>
<th>Model of contract hospital</th>
<th>Model of ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted by the hospital mother superior (for nursing and household matters)</td>
<td>Board of regents (lay-people preceded by a clergyman)</td>
<td>Board of nuns (and their spiritual director, a clergyman)</td>
</tr>
</tbody>
</table>

**Table 4:** Power structure concerning the board of Catholic hospitals

It can be concluded that in the Catholic hospital run by nuns, there were basically conflicting regimes of religious and professional power. These conflicts arose from an inadequate distribution of power. For many dec-

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rades, religious claims were made in a professionalizing context. The religious regime was stronger and surpassed the professional one. This should be acknowledged as a structural problem. When wise and harmonizing people were involved, the problems were toned down, but on the other hand they were fueled when less managerial talented people were in charge. By and large, these coincidental factors did not really change the structural side of the matter.

**Power struggles between lay-nurses and nun-nurses**

A final type of conflict arose between nun-nurses and lay-nurses. Again, these conflicts were tied up with the ambiguous blending of religious and professional power. From the 1880s onwards, lay-nurses had been given limited contracts at Catholic hospitals. They were frequently hired and fired, often only employed for short periods in times when the hospital was short of religious personnel. These Catholic lay-nurses were united in a Union, established in 1905. There, their limited rights were vocalized and discussed, such as their lack of opportunities to make a career in Catholic hospitals, as the leading positions would always go to nuns. This was even the case when the latter were untrained or evidently less trained and less experienced as lay-nurses. It contributed to the public image of nuns being not fully qualified. Only if there were no sufficient nun-nurses available, lay-nurses were appointed head of a ward.

<table>
<thead>
<tr>
<th>Co-director of the hospital</th>
<th>Head of the various wards</th>
<th>Personnel working on the wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>One nun-nurse</td>
<td>On each ward a nun-nurse (if that was impossible, a lay-nurse was appointed)</td>
<td>Some nun-nurses Lay-nurses Maids and servants for cleaning and cooking</td>
</tr>
</tbody>
</table>

**Table 5: Power structure of nurses in the hospital**

The fact that nuns were automatically put in charge reflected their higher ecclesiastical position. Until the second Vatican Council (1962-1965) clergymen and member of religious orders were considered as more elevated as lay-Catholics. The religious hierarchy dictated all other hierarchies. In the course of the twentieth century, this began to change. The nuns realized that the only rationale on which they could continue to occupy leading positions was to get adequate training. Otherwise, their dominance would no longer be legitimate. Governmental regulations supported and reinforced this tendency. In the 1940s and 1950s, the nuns began to profile themselves as fully professionally qualified. This indicates the level of influence that the professional regime, by then, had reached. Even so, it still was no exception for trained lay-nurses to work under the supervision of a nun-nurse who was less qualified or even unqualified. Right until the 1980s, when the last nuns were working in Dutch hospitals, they were given the leadership, be it under the condition that they had the diplomas they needed.
Managerial responses

The frequency and nature of these conflicts in Catholic hospitals were acknowledged at the highest level of the Church organization. In 1905, a Catholic Union for lay-nurses was established by a medical doctor and a priest, who both felt that this group was in bad need of support. This signals both the articulate and built-up societal discontent and the deprived position of lay-nurses in Catholic culture. In 1926, the Dutch bishops showed concern, although not so much about the position of lay-nurses but about the damaged public image of Catholics. They established a national platform, the Saint Canisius Association, which existed until 1966. All Dutch sister congregations involved in Catholic health care were to join. The union consisted of the councils of sister congregations, i.e. the general mothers superior. It can hardly be labeled as an adequate response. On annual meetings, clergymen overloaded these members of the Saint Canisius Association with learned spiritual talks, which did neither shake the nuns’ world-view nor their policy. In fact, most of the Dutch general superiors were not ready to adapt existing power structures, since that would have undermined their own religious authority as well. It was not until the 1940s and 1950s that some medical doctors were invited as key-note speaker at the Saint Canisius Association’s meetings. These fiercely underlined the need of professionalization of nun-nurses. By that time, the majority of the nun-nurses working in the hospital acknowledged that need themselves, unlike many mothers superior outside the hospital who stuck to their Rule.

The religious power structure remained intact until the second Vatican Council, when all religious orders and congregations were urged to renew their Rule and adapt their life-style to modern times. By then, however, it was already too late. Dutch nuns had become an aging social group that was rapidly losing its leading positions in all societal domains and had been surpassed by lay-professionals on all fronts.

Conclusions

Looking back in time, the year 1878 appears to be the turning point in the history of Dutch nursing. Then, the modern hospital began to arise. Until that day, the largest part of nursing had been religiously based. Nonetheless, the female tradition of religious-motivated nursing, as carried out by nun-nurses, is not integrated in the historical canon of Dutch nursing. Two things are missing in the historical picture; a tradition of women has been ignored, and a religious tradition has been stigmatized on false grounds.

Considering the gender factor, it can be stated that male doctors caused a shift in the domain of nursing that traditionally had been developed by women. When medical doctors entered the modern hospital they needed nurses they could rely on, so they began to train them. Newly trained nurses positioned themselves as higher qualified and looked down on their nursing predecessors. Consequently, generations of untrained nurses, amongst
whom were many nuns, were marginalized and ultimately neglected. Their expertise and tacit knowledge was not valued. In conclusion, through the male and medical influence the aspect of female competence that underpinned ages of nursing practice became disregarded.

Simultaneously, nursing in the context of a religious regime became labeled as the opposite of ‘professional’. The adequacy of this judgment can be doubted, however, when the characteristics of professionalism are taken into account. Nun-nurses did draw on a body of knowledge, as was a prerequisite of professionalism. Furthermore, they worked in teams, they transferred their expertise, were supervised and paid for their work, be it a small sum. In other words: nursing in the context of a religious regime was an organized and systematized care provision for unknown people. There was, however, a specific type of professionalism at stake here. Their skills and knowledge were not medically informed, nor articulated in print or theory. All was transferred orally and practice-based. In addition, nun-nurses, as well as their lay-colleagues, did demonstrate devotion and know-how in dealing with the sick, the weak and the elderly.

Looking closely at the discourse of professionalism, it can be argued that this triggered two side effects. Firstly, it despised the religiously based competence that used to underpin the practice of nursing. Secondly, it valued theoretical knowledge much higher than tacit knowledge, although the latter was relevant for nursing as well. Overlooking this, the suggestion can be made to avoid the opposition between ‘unprofessional and religious’ versus ‘professional and secularized’ care. This opposition runs through the historiography of Dutch nursing, but it is in fact a simplification that overlooks the complexities of the past and has created false antagonisms.

Another set of conclusions concerns the chains of command. Between 1870 and the 1960s, Dutch Catholic hospitals became the scene of various types of conflicts. The time of profound change began when the religious regime, which was still dominant in most Catholic hospitals at the turn of the century, had to compete with the professional regime of medics and trained nurses. New types of disagreement came up, as two chains of command were simultaneously applied in the modernizing hospital. On the one hand, there were chains of command based on religious principles and values, while on the other hand, there were those derived from professional principles. This article has shown how power struggles arose amongst the nuns themselves, between medical doctors and nuns, and between lay-nurses and nun-nurses. These conflicts originated in two rivaling regimes, the religious and the professional one, which were valid at the same place and the same time. In the 1920s, the Dutch bishops tried to control the damage by raising the Saint Canisius Association. The episcopate did not succeed, however, since the clergy had no direct influence in hospitals. In 1966, the Saint Canisius Association was liquidated; it marked the end of the era of the religious regime.
It is important to acknowledge the structural dimension of these conflicts, although individual aspects mattered as well. People working in a Catholic hospital were likely to clash because of their different hierarchical positions, which rooted in either the religious or the professional regime. Yet, clashes could be mitigated if individuals were wise and knew how to get along. In the course of the twentieth century, nun-nurses who worked in a hospital acknowledged that the professional regime should be given priority. But it was too little, too late, and they were not able to convince their fellow-nuns outside the hospital. This is a rarely acknowledged tragedy.

All conflicts arose in the ever-changing setting of a Catholic hospital during a long period of transgression. The changes taking place took almost a century. When medical doctors and trained nurses invaded the modern hospital, the religious regime was not suddenly replaced by a professional regime. From the 1870s until the 1960s, two regimes co-existed, or rather co-conflicted, next to each other. Finally, the professional regime triumphed. All that time, conflicts caused a lot of pain in the hearts and minds of the people concerned. Hopefully, historical insights may shed light on the views of the combatants and their joined devotion to the sick.

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