Deaconesses in Nursing Care
International Transfer of a Female Model of Life and Work in the 19th and 20th Century

Edited by Susanne Kreutzer and Karen Nolte

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Deaconesses in nursing care. A transnational history

Susanne Kreutzer / Karen Nolte

Introduction

The academic discipline of history is currently focusing on transnational phenomena. Transnational history investigates the "different levels of interaction, connection, circulation, intersections, and interlacing" of a phenomenon that exceeds the framework of national boundaries.[1] Hence, it is not merely a comparative history but an approach that, in addition to the comparative perspective, focuses on analysing the transfer "of material objects, concepts, and cultural semiotic systems […] among different and relatively clearly identifiable cultures that can be delimited against each other, resulting in a cultural mix and interaction".[2]

As well as unlocking new research questions, the transnational approach has led to the emergence of new historical research areas and topics. Using the concept of "transfer history",[3] there has been a growing interest in historical studies of religious communities because they were early "global players".[4] Internationally, sisters – just like missionaries – belonged to the best-connected professions of the nineteenth century. Originating usually in France, many Catholic sisterhoods settled in numerous other European and non-European countries. Likewise, Protestant deaconess motherhouses became a popular German export in the nineteenth century. More than half of the apostolic congregations in England during the 1880s came from France; others came from Belgium, Ireland, Italy, Germany, the Netherlands and Austria. Institutions and foundations of English origin constituted only a minority.[5]

Yet, what happened when nursing care organisations and the concepts of nursing that they embodied began their international journey? This anthology examines this question, focusing on the example of Protestant deaconesses who worked as nurses. At the centre we have a nursing organisation that was founded in the 1830s in Germany, but was subsequently exported to many European and even non-European countries. If the deaconess motherhouses wanted to stand a chance of survival in these countries, they had to adapt to the specific cultural and societal contexts. Because of these adaptation processes, the deaconess motherhouses are particularly suitable for an international comparative and transfer history. Simultaneously, only the transfer and subsequent contact with the other culture can illuminate the specificity of the

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1   Patel (2005).
2   Middell (2000), p. 8.
3   Paulmann (1998), pp. 649–685; Espagne (1999).
4   Mettele (2006); Habermas (2008); Hauser (2011).
5   O'Brien (1997).

various traditions of nursing that had been shaped within their own nations and were now engaged in a transfer abroad.

The foundation of the model of deaconesses in Kaiserswerth, Germany

The community of deaconesses was conceptualised during the first half of the nineteenth century by the pastor Theodor Fliedner (1800–1864) in Kaiserswerth near Düsseldorf. From the outset it could be regarded as a "transnational space".[6] Young women from petit bourgeois and lower classes moved from all parts of Germany to Kaiserswerth to be trained in nursing care.[7] After a brief but thorough training period covering the care of body and soul, they were sent out to work in hospitals, clinics, community care, and private care in all parts of the German Reich, but also to other countries. Fliedner's concept of a community of deaconesses followed the model of the Catholic *Sisters of Mercy* and simultaneously recalled early Christian traditions of female work within the parish.

The Protestant motherhouse system regarded itself as a community of faith, service and life for unmarried women. It was based on the simple principle of exchange: the young women received thorough training and the security of lifelong provision for retirement, if they in return were willing to dedicate their lives completely to service in the community and to work with people who were unwell and in need.[8] In this way, the motherhouse assumed parental custody and control over the young women. The leaders of the motherhouse were the principals, i. e. a married couple. In Fliedner's model it was the theological principal and his wife (later the Mother Superior) who served the community as "parents". The sisters were regarded as the daughters of the motherhouse. In nineteenth-century Germany, belonging to such a surrogate family was a crucial prerequisite for guaranteeing the necessary amount of respectability for young unmarried women living and working away from their original families. In contrast to Catholic nuns, who bound themselves to their order with a vow, deaconesses could leave the community again. However, the leaders of the motherhouse were interested in binding the thoroughly trained deaconesses to the community for their entire lifetime.

The work of the deaconesses took place in the context of Protestant efforts to solve the *social question* that, as a result of industrialisation, was becoming more pressing in the nineteenth century. The work of the deaconesses was conceptualised as aid provided as part of the so-called *Inner Mission* to the impoverished population. Fliedner and other protagonists of the *Inner Mission* believed that poverty and disease could largely be attributed to a lack of faith. For that reason the deaconesses had to take care not only of the physical but also the spiritual well-being of their patients. Joint care of body and soul was

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6   Soine (2013).
7   Schmidt (1998).
8   Köser (2006); Schmidt (2005), pp. 33–44.

the key to the deaconesses' understanding of nursing care. In addition to nursing care, the deaconesses were also engaged in numerous areas of welfare, education, and community work.[9]

In other countries, deaconesses were also used to remedy social shortcomings, to take care of Protestant parishes, and to lead the 'heathens' to the Christian faith. Thus, as early as the middle of the nineteenth century, the first deaconesses were sent to Palestine and to the Lebanon as part of the so-called *Outer Mission* or placement abroad.[10] The idea was to perform the same missionary work as the *Inner Mission*, but in another country or "outside". Not only in the German speaking regions but also in many other countries, institutions for deaconesses were founded, following the model in Kaiserswerth. Sometimes the initiative for these houses came from German motherhouses; sometimes local women used the Kaiserswerth concept to set up the institutions.

The evaluation of the deaconess model is highly controversial among scholars. The studies on the history of deaconesses in nursing care that were published in the 1990s emerged within the context of research on women and followed the parameters of emancipation and self-determination current at that time. Hence, these studies emphasise the normative constraints and repressive patriarchal character of the communities of deaconesses.[11] This thesis of suppression, however, adheres to a one-dimensional concept of power and does not explain why so many young women joined the community of deaconesses. In recent years there have been an increasing number of studies that have analysed the internal logic of the communities of deaconesses. For instance, the theologian Silke Köser follows Max Weber in her argument that a power relationship has to be borne by both parties: the rulers and the ruled. She shows how the principal couple at the deaconess motherhouse in Kaiserswerth managed to establish the hierarchical structure and subsequently the power of the principals in the deaconess motherhouse by creating a specific motherhouse culture and a collective deaconess identity. According to Köser, crucial factors in establishing this "collective identity" were the specific dress of the deaconesses, the initiation of the deaconesses through a confirmation ceremony, the celebration of the community through continuous correspondence with the nurses who worked elsewhere and, finally, the regular return of deaconesses to the motherhouse.[12]

In addition, the nursing care provided by the deaconesses has been more closely analysed in recent years. These studies reveal that in the Christian tradition, nurses enjoyed a high level of autonomy and appreciation.[13] In particular, this applied to the institutions belonging to the motherhouse, which had been set up by communities of sisters who thus also owned them. In these

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9   Nolte (2013), pp. 167–82.
10   Kaminsky (2010); Habermas (2008).
11   Bischoff (1994); Schmidt (2005).
12   Köser (2006).
13   Kreutzer (2014); Nolte (2013); Weber-Reich (2003).

houses, the physicians did not manage to assert their claim to leadership until late into the second half of the twentieth century.[14] In addition, the Christian understanding of disease gave the carers a high status because, according to this concept, disease affected not only the body but also the soul of the patients. At the end of the nineteenth century, physicians increasingly focussed on the physical aspect of a disease, i.e. its symptoms, diagnosis, and treatment, while the nurses' task was to consider the personality of the patient as a whole. Due to the significance given to personal attention and the efforts to provide spiritual counsel, the nursing staff secured its own autonomous and highly respected area of duty. For this reason, the relationship between nurses and doctors was not regarded as hierarchical but as complementary, and the work of the nursing staff was situated between the tasks of the physicians and the pastors.

So far, there has been no systematic study of the extent to which this model was transferred to other countries and adapted to the new surroundings. There has been some research on the history of deaconesses in nursing care and the organisation of the motherhouses in several individual countries. There are also some initial comparative studies available that address the transfer of the communities of deaconesses, emphasising nursing care in the Scandinavian countries and the United States.[15] However, a systematic, comparative perspective on the transnational development of the communities is lacking. In which countries did deaconess motherhouses successfully establish themselves? Where were they doomed to fail and how can we explain the differences? To what extent was the German model adapted to the new national context during the transfer process and which social factors had an impact? Of particular interest are the different gender relationships, the frameworks provided by welfare states, and the dominant denomination in the various countries. Looking at these issues, we will link the history of deaconesses to overarching issues in the history of the respective societies.

Research on the history of deaconesses in nursing care is conducted in various disciplines: history, history of medicine, history of nursing care, and in diaconal institutions. The differences in research situations and research questions are reflected in the present publication. The goal of this book is to provide a single space for a dialogue between the multifaceted research projects. It is structured as follows:

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14 Schmuhl (2003).
15 Andersson (2002); Christiansson (2006); Kreutzer (2010); Kreutzer (2012); Malchau-Dietz (2013); Markkola (2011); Markkola (2013); Martinsen (1984); Nelson (2001); Okkenhaug (2013); Soine (2013).

Germany – Foundation era of German deaconess motherhouses

Karen Nolte's article, in the first part of this volume, draws on Köser and discusses the self-understanding and everyday practice in nursing care experienced by the deaconesses in Kaiserswerth. In the German social and historical context, the life and working model of a deaconess was attractive not only because of the comparatively good training and "womb-to-tomb" social security it provided for women, but also because of the deaconesses' competencies, which allowed them to exceed professional boundaries in their everyday work. After all, these boundaries were regularly redefined in the regulations and instructions because of the practical experiences the deaconesses shared with their principals.

Deaconesses worked in all areas of nursing, as *Annett Büttner* illustrates in her article on the work of deaconesses in voluntary nursing care on the battlefield. She shows that denominational nurses played a pioneering role in the development and establishment of voluntary war nursing in the nineteenth century. Büttner describes the incredible challenges that the sisters and brothers had to face in the daily reality of war. By standing the test of the field, however, they increased acceptance of voluntary nursing on the battlefield. Furthermore, secular nursing care on the battlefield in Germany was organised following the denominational model.

Matthias Honold investigates the specific understanding of nursing care that emerged in the institution for deaconesses in Neuendettelsau, which had been founded in 1854 by the pastor Wilhelm Löhe (1808–1872). It was the first deaconess motherhouse to be founded in the countryside rather than in a town. Indeed, Löhe was inspired by the Kaiserswerth model when he founded his community of deaconesses. Yet, in contrast to Kaiserswerth, Neuendettelsau also welcomed and trained women who did not want to become deaconesses. In addition, the institution in Neuendettelsau focussed more on theoretical aspects in its curriculum.

Outer Mission – The transfer to Palestine

The second part of the book deals with the work of deaconesses in the Outer Mission in Jerusalem. *Uwe Kaminsky* introduces the deployment of Kaiserswerth deaconesses in Jerusalem as part of their *Orientarbeit* (*work in the Orient*). The purpose of this work overseas was not to convert the heathens but to strengthen the Christian communities that were already there by building hospitals, orphanages and schools. While the efforts to win new deaconesses from the local population in Jerusalem were hardly successful, in Germany the *Orientarbeit* had a strong promotional effect. Kaiserswerth's work in the 'Holy Land' not only prompted people to donate money, it also boosted the attractiveness of the deaconess model, in particular for daughters from the higher social classes.

Ruth Wexler investigates the work of deaconesses in the *Leper Home* in Jerusalem and thus sheds light on a dual transfer: influenced by the model in Kaiserswerth, Hermann Plitt (1821–1900) established a deaconess institute within the context of the Moravian Church in 1866, which in 1883 moved from Gnadenfeld (Upper Silesia) to Niesky (Saxony). In 1874 the first deaconess from the motherhouse was sent to Jerusalem to care for lepers. Until 1950 there were approximately 50 deaconesses who worked in the *Leper Home* in Jerusalem. Wexler analyses the challenges that the sisters had to face in these completely different work and life conditions and how they tackled them.

Scandinavia – A successful transfer of the German model

The third part of the book focuses on the significance of Scandinavian deaconess motherhouses. *Susanne Malchau Dietz* illustrates that the model from Kaiserswerth was particularly successful in the Protestant countries in Scandinavia. This success story also influenced the structure of the motherhouses in the United States that had been established in the nineteenth and early twentieth centuries with the goal of taking care of the relevant immigrant communities. There were 11 deaconess motherhouses, four of which were of German and seven of Scandinavian origin. Using the example of the *Danish Deaconess Home* in Brush, Colorado, Dietz reveals the strategies that were used to recruit deaconesses from Denmark. She also shows how personal conflicts and power struggles could place a massive strain on everyday life in the communities.

Pirjo Markkola examines the significance of deaconesses for the history of caring for the poor and health care in Finland. The first Finnish deaconess motherhouses were established in the 1860s in the south of Finland, in Helsinki and Viborg. These still followed closely in the footsteps of the Fliedner model. They offered the first systematic training in nursing care in Finland. In contrast, the institutions for deaconesses that were founded in the 1890s in Sortaval and Oulu did not adopt the motherhouse model and only offered a significantly shortened training in community care. The reference motherhouse here was not Kaiserswerth but the *Lovisenberg Deaconess House* in Norway. Markkola reveals that community care that was subsidised by the state and Church became the main area of work for the deaconesses. She argues that the self-understanding of the deaconesses, which involved being responsible for both physical and spiritual matters, gave them the necessary flexibility to adapt to changing conditions in the twentieth century.

Limits of transfer – Great Britain and the United States

The fourth and final part illuminates the less successful history of transfer and investigates the reasons why the deaconess motherhouses gained only marginal significance in some countries. In the United Kingdom, institutions for deaconesses had been evolving from the beginning of the 1860s but they re-

mained rather small and were of less significance by comparison. Using the examples of the *London Diocesan Deaconess Institution* and the *Evangelical Protestant Deaconess Institute and Training Hospital*, *Carmen M. Magnion* illustrates that these institutions could not succeed in the highly competitive medical marketplace in the United Kingdom and found themselves in dire straits in terms of funding. When, towards the end of the nineteenth century, the secular model of voluntary hospitals became fully established, there was hardly any demand for deaconesses as nurses in hospitals. The sisters could now work only in community care or in convalescent homes, where their pastoral care was still in demand.

Doris Riemann examines the foundation of the deaconess motherhouse in Baltimore in 1885, which specialised in community care, and she comments on the enormous difficulties of this transfer. While the deaconesses there initially looked to the German model and trained deaconesses in the care of body and soul, from the very beginning the motherhouse suffered from having too few new applicants. Furthermore, as early as the beginning of the twentieth century, the understanding of care that the deaconesses promoted came under massive pressure to become more academic and professional. Riemann shows how the deaconesses subsequently departed from their traditional understanding of care and transformed the female diaconate into a modern profession.

Finally, *Susanne Kreutzer* compares the development of the deaconess motherhouses in Germany, Sweden and the United States and uses one example from each country for her investigation: the *Henriettenstiftung* in Hanover, the *Ersta* institution for deaconesses in Stockholm and the *Philadelphia Deaconess Motherhouse* in Pennsylvania that specialised in hospital care. Kreutzer not only analyses the transfer of the German life and work model of the deaconess to those countries, but also the transformation from the formerly holistic understanding of caring for a unity of body and soul into an academic, professional and scientifically based concept of nursing. She analyses these developments within the specific context of each of the modern welfare states.

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