Marketplace, Power, Prestige

The Healthcare Professions' Struggle for Recognition (19th – 20th Century)

Edited by Pierre Pfütsch

MedGG-Beiheft 70

Franz Steiner Verlag Stuttgart

Institut für
Geschichte der Medizin
Robert Bosch Stiftung

Marketplace, Power, Prestige

Medizin, Gesellschaft und Geschichte

Jahrbuch
des Instituts für Geschichte der Medizin
der Robert Bosch Stiftung

herausgegeben von
Robert Jütte

Beiheft 70

Marketplace, Power, Prestige

The Healthcare Professions' Struggle for Recognition (19th–20th Century)

Edited by Pierre Pfütsch

Franz Steiner Verlag Stuttgart
2019

Gedruckt mit freundlicher Unterstützung der Robert Bosch Stiftung GmbH

Coverabbildung:
„Geherbad“ aus dem Robert Bosch Krankenhaus, Stuttgart, 1940.
Quelle: IGM-Archiv

Bibliografische Information der Deutschen Nationalbibliothek:
Die Deutsche Nationalbibliothek verzeichnet diese Publikation in der Deutschen Nationalbibliografie; detaillierte bibliografische Daten sind im Internet über <http://dnb.d-nb.de> abrufbar.

Dieses Werk einschließlich aller seiner Teile ist urheberrechtlich geschützt.
Jede Verwertung außerhalb der engen Grenzen des Urheberrechtsgesetzes ist unzulässig und strafbar.
© Franz Steiner Verlag, Stuttgart 2019
Druck: Laupp & Göbel GmbH, Gomaringen
Gedruckt auf säurefreiem, alterungsbeständigem Papier.
Printed in Germany
ISBN 978-3-515-12294-8 (Print)
ISBN 978-3-515-12299-3 (E-Book)

Table of Contents

Pierre Pfütsch
An Introduction to Conflict Research: Illustrative Applications with Healthcare Professions in the 19th and 20th Century 7

Interprofessional Conflicts

Karen Nolte
The Debate on 'Nurse Anaesthetists' in West Germany during the 1950s and 1960s 21

Eileen Thrower
"An Extension of Nursing Practice": The Evolution of Midwifery in the United States as Evidenced in Georgia, 1970–1989 37

Pierre Pfütsch
Emergency Medical Services in Germany: The Conflictual Development of a Professional Field 59

Conflicts Within a Profession

Christoph Schwamm
Hegemonic Masculinity and the Gender Gap in Caregiving: The Contentious Presence of West German Men in Nursing since around 1970 79

Geertje Boschma
Negotiating Electroconvulsive Therapy (ECT) in Dutch Psychiatry: Cultural and Intraprofessional Tension over Biological Psychiatry, 1950–2010 97

Sylvelyn Hähner-Rombach †
Mothers on Children's Wards: Conflicts in German Paediatric Care from the mid-1950s to the late 1970s 137

Conflicts due to Changes in Social Conditions

Jane Brooks
From Wars on the Wards to Harmonious Hospitals:
British Nursing Sisters' Pursuit of Collaboration on Active Service
in the Second World War 165

Eyal Katvan
"Toothless Law": The Regulation (or 'Vaguelation') of Dentistry
in Mandate Palestine 187

Aaron Pfaff
Counselling Diabetics – The Hampered Development of
Educational Programmes for Patients with Diabetes in Germany 225

List of Authors 255

An Introduction to Conflict Research: Illustrative Applications with Healthcare Professions in the 19th and 20th Century

Pierre Pfütsch

Epistemological interest

Currently questions of the best possible care for the population are at the centre of discussion in both the healthcare system and within medicine. While the populations of Western industrial nations are only minimally growing, if at all, there are other factors that push healthcare to its limits. One reason is paradoxically the progress that was made in medicine, hygiene, and nutrition in the past 150 years, which has driven increases in life expectancy. At present, men born in Germany have a life expectancy of 78.18 years and women 83.06 years.[1] In other European countries the situation is similar. In France, life expectancy for men is currently 79.2 years and for women 85.5. In the UK, boys who were born in 2015 will live on average 79.2 years and girls 82.8 years.[2] Model calculation of the Federal Bureau of Statistics in Wiesbaden suggest, however, that boys who were born in 2017 in Germany will on average reach an age of 90 years and girls of 93 years.[3] Since an older age is often accompanied by more diseases and a deteriorating health condition, people above 65 years of age require more medical care and hence have more contact with the healthcare system.[4] In this phase of life cases of multi-morbidity also become more common, which means that consultants with numerous specialities are contacted. Due to the multi-morbidity, the disease patterns are also becoming more complex. Consequently, the healthcare system is frequented more often.

A second reason why the healthcare system is being pushed to its limits is the increasing use of preventative and health-promoting offers on the medical market. Since the 1970s, this development has been linked to the growing significance of health within societal discourse. In the industrial nations, health rose to the position of central leading category of all areas of life. The health scientist Ilona Kickbusch perfectly summarised this development with the term “health society”.[5] The reason for using various offers by the healthcare system cannot only be found in the need created by patients, but also in the fact that such offers exist. Until the 1980s, the focus in medicine was foremost to heal diseases. Yet, with the agreement of the Ottawa Charter in 1986, it has increasingly recognised the potential of disease prevention with the term “pre-

1 Cf. Statistisches Bundesamt (2016), p. 12.
2 Cf. Eurostat (2017).
3 Cf. Statistisches Bundesamt: Kohortensterbetafeln (2017), p. 16.
4 Cf. Barmer GEK (2017), p. 57.
5 Hartung/Kickbusch (2014).

vention" not only referring to maintaining people's health but also the financial potential of prevention as a market segment. The so-called "second health market" that covers health tourism, wellness offers and services that are not covered by the statutory health insurance is steadily growing in Germany and its importance is rising. In the federal state Hesse alone, there are 30,200 people who work in this area producing a turnover of 5.56 billion Euros per year. Between 2009 and 2012 the employment number rose by 8.6 per cent and the turnover by 17 per cent.[6] Providers of health services and the staff hence prefer to focus on this financially attractive market which has consequences, at least indirectly, for the primary healthcare. Due to the different distribution of resources, this imbalance can have a negative outcome regarding staff capacities and services available.

In addition to these developments in society at large there are also tendencies within the medical system that concern questions of medical care for the population. In Germany we have increasing shortages of doctors in rural areas resulting in a worse standard of care than in the cities.[7] Furthermore, the currently pronounced shortage of nurses also contributes to the fact that the care is at risk as the number of people in need of care keeps growing.[8] Facing this difficult development, the people responsible in the healthcare system have been searching for some time for funding options to prevent a lack of care.

In other Western countries this issue was discussed much earlier and hence, action was also taken much earlier. In Canada, already in 1970 the profession of "nurse practitioner" was introduced. Since 1977, this profession has also been in existence in the Netherlands.[9] Since 1989, in Britain there have been "practice nurses". In Canada, the "nurse practitioners" are registered nurses with an academic degree.[10] "Nurse practitioners" are responsible for serving their patients through all phases of the life, perform smaller examinations, interpreting certain diagnostic tests, documenting findings and managing the patient's medication while staying up to date with the latest research. Overall, these members of staff are the first point of contact for the patient, and they have an extensive medical knowledge and free doctors to focus on more urgent tasks. Similarly, the profession of the "physician assistant" that was established in the 1970s in the US serves to relieve doctors from tasks that a person with less comprehensive, yet specified training could do.[11] With the additional training of medical staff as "care assistants in the GP

6 Cf. Gesundheitswirtschaft Rhein-Main e.V. (2014), p. 51.

7 More specifically on the distribution of doctors in Germany: Albrecht/Etgeton/Ochmann (2015).

8 Current news on the shortage of staff in nursing: Maibach-Nagel (2018).

9 In the US there were already first courses on the topic in the 1960s.

10 On the history of nurse practitioners in Canada: Bryant-Lukosius et al. (2010).

11 On the history of the physician assistant in the US see the homepage of the Physician Assistant History Society (https://pahx.org, last accessed: 17/10/2018). Since 2005, Germany has introduced the first university degrees of "physician assistants". This is a three-year bachelor degree course in which the students acquire a broad medical knowledge. This opens up new opportunities for doctors and other healthcare institutions to delegate

practice" ("Versorgungsassistentin in der hausärztlichen Praxis"), in Germany, general practitioners (GPs) now also have the option to delegate certain tasks to specially trained staff. In this context the professionalisation or academisation of nursing plays an increasingly important role.[12] A current example of this process is the new (model) degree programme of "evidence-based care" that was introduced at the Medical School of the Martin Luther University of Halle-Wittenberg. Yet, these are only first attempts to face this issue. With these current topics that focus on issues of delegating or substituting doctor's services to other health professions we can already recognise areas of tension and conflict. Questions of responsibility and authority will be core areas of conflict.

Historians and social scientists like to research conflicts, tensions, and debates because they bear the potential to disclose information on the conflicting parties and the solutions of the conflict but also on the context of the conflict. This allows the analysis of values, opinions, and patterns of behaviour. The significance of the conflicts lies in their effect for social and societal changes. Conflicts reveal different perspectives, promote change, and serve to generate decisions. The political scientist and researcher of conflict Anton Pelinka thus rightfully claims that without understanding conflict we could not understand changes in society.[13] Furthermore, analysing conflicts enables us to predict conflicts in the future and the development of various constellations of conflict. A historical analysis of conflicts is particularly useful as we can better understand, reconstruct, and interpret current developments.

Conflicts can emerge on various levels and in completely different fields. Within the theory of conflicts, a conflict is defined as follows: various agents perceive their respective interests in a particular area as opposing.[14] The large political and sociological theories of conflict often discuss international conflicts and even wars.[15] Yet, research on peace and conflicts is not an independent academic field but an area of research that is multi-, inter- and transdisciplinary. For that reason, it does not only cover large conflicts such as nuclear crises and world wars but also conflicts within families, communities and structures of society.[16]

At the meso- and micro-level disciplines of work repeatedly appear as a rewarding research project within conflict research. Social history and the history of society are especially well suited for the historical analysis of conflicts

tasks, which previously could have only been performed by a doctor. For instance, in the accident & emergency department they can take the medical history of the patient and perform a physical examination, and they can also work in the operating room as an assistant.

12 Since the 1990s, the Robert Bosch Stiftung has been promoting academic degrees in nursing and has been scientifically supporting this movement. Robert Bosch Stiftung/Kommission (1992); Robert Bosch Stiftung (2000).

13 Cf. Pelinka (2016), p. 17.

14 Cf. Ide (2017), p. 9.

15 For instance: Ruf (2010). And: Geis/Wagner (2017).

16 Cf. Ide (2017), p. 8.

in the professional world because in society, work takes a central position. While presumably every profession and professional area have been marked by conflicts and tension, healthcare in particular is a rich area for research and analysis. On the one hand, health and diseases are central to human life. Every person who lives in an industrialised nation encounters the healthcare system during his or her life. People working in this area literally make life and death decisions for patients. The significance of healthcare as an area of work is also reflected in quantitative information. In Germany in 2015, 5.3 million people worked in the healthcare system.[17] These workers went through numerous training programmes with varying hierarchical levels. The professional world of the healthcare system today is the result of long processes of differentiation, elimination and negotiation. The differentiation of non-physician healthcare professions occurred in parallel with the specialisation of medicine and the development of medical technology, and accelerated at the end of the 19th century. At this time, academically trained doctors had already superseded their competitors with fewer qualifications such as barber surgeons.[18] They only had to fight longer battles with the "quacks" – a term made up by the doctors for non-academically trained healers. In 1903, the German Society for the Eradication of Quacks ("Deutsche Gesellschaft zur Bekämpfung des Kurpfuschertums") fought against the "freedom to heal" ("Kurierfreiheit") that had been announced in 1872.[19] With the foundation of medical associations and achieving the professionalisation that went along with it, the physicians had successfully fought for a position that from now on ensured their large influence in the official recognition of new health professions or professions that required new regulation.[20] They exert this influence to this day. For instance, since the introduction of the profession of doctor's assistant in the 1950s, the State Chambers of Physicians are the "responsible authorities" for the training and further education of medical staff, according to the German Vocational Training Act. Similarly, since increasingly women give birth at the hospital rather than in the private sphere of the home, midwives and doctors have also had a charged relationship. The issue is usually one of status and responsibility.[21] Even between physicians and nursing staff there are often conflicts because of their close collaboration. These conflicts very rarely came to light, as the psychologist Leonard Stein described in the 1960s using what he called the "doctor-nurse game". According to him, the collaboration between the (at the time mostly male) doctors and the (often

17 Cf. Statistisches Bundesamt: Statistisches Jahrbuch (2017), p. 10.

18 On the development of the position of physicians and their professionalisation, see Huerkamp (1985); Jütte: Geschichte (1997). On the social history of barber surgeons: Sabine Sander (1989).

19 On the debate between physicians and non-academic medicine: Teichler (2002); Jütte (1996).

20 The first medical association was founded in 1865 in Baden. Cf. Jütte: Entwicklung (1997), pp. 39–40.

21 More specifically on the training of midwives in Germany: Fallwell (2013); Schumann (2009).

female) nurses follows particular rules that do not question the authority of the doctor who has a higher rank in the hierarchy.[22] However, with the professionalisation of nursing, the relationship between doctors and nurses has been slowly changing which is why in the 1980s the "doctor-nurse game" no longer functioned as Stein had described it 20 years earlier.[23] This resulted in more conflicts coming to light more often.

The medical profession offers itself for the analysis of conflicts because scientific progress and the change of the social and societal frameworks had a huge impact on the professional landscape. Following the doctors' initiative to reduce the high mortality of mothers, at the end of the 19th century the profession of a childbed nurse was created. After their training, these nurses were supposed to professionally care for women after they had given birth.[24] However, in the second half of the 20th century, this profession disappeared again. Due to technical progress and improvements in hygiene the mothers spent less time at the hospital. Since the mortality of mothers was now very low, the care during the puerperium lost its justification. Substitution processes through other professions also played a role. Hence, midwives and paediatric nurses campaigned for taking on these tasks.[25] The discovery of new diseases could also result in the development of new working areas. The increase of patients with diabetes mellitus created a need for medical guidance below the rank of the doctor. Thus, slowly diabetes counselling emerged.[26] A more current example is the profession of the scrub nurse who has become necessary because of the increasing specialisation and technicalisation of surgeries. Already in the 1960s, the Netherlands introduced the profession of the "Operatie Assistant".[27] Another example is the emergence of the professional clinical coder. In Germany in 2003, only because of the introduction of a flat-rate per case that is based on the Diagnosis Related Groups (DRG), an independent profession at the interface of technology and medicine could be established. Since conflict research is not only interested in analysing a specific example but also wants to shed light on the context in society and the social framework in which the conflicting agents operate[28], conflict research is an excellent method to analyse the most diverse conflicts in medicine also from a historic perspective. Implicitly, professional sociological reflections play a part in all of these issues.

Beginning with these reflections this current volume serves to explain how and why conflicts emerged within medical professions at all. Who was involved, what coalitions were formed, how did the agents present themselves and what goals did they pursue? Furthermore, we are interested in the extent

22 Cf. Stein (1967).
23 Cf. Howell/Stein/Watts (1990).
24 Cf. Waller (2017), p. 114.
25 Cf. Waller (2017), p. 134.
26 Cf. Pfaff (2018).
27 Cf. Cerrahoglu et al. (2014), p. 212.
28 Cf. Pelinka (2016), p. 21.

to which such discussions contributed to changes in services on the medical market and what consequences this had on the demand side. Simultaneously, we want to consider the societal, social and scientific frameworks as central determinants of change.

Market, Power, and Prestige as Areas of Action

The question about the cause of conflicts and tensions plays a central role in all contributions. In recent years, conflict research has illustrated that the cause of conflicts is most often the distribution of scarce resources but can also lie in the demand for recognition.[29] For that reason and because conflicts are always also linked to questions of power[30], market, power and prestige will be analysed as central areas of action during the interaction of conflicting parties. The agents name the most diverse reasons for their actions depending on the context, yet a closer inspection reveals that the issue can always be linked back to the key areas of market, power, and prestige – and thus to the central elements of distribution of resources and recognition.

Hence, our objective is to open up topics of medical historical origin to address larger societal questions, and thus to utilise them for interdisciplinary historical conflict research. Consequently, the topics discussed here touch on historical but also social scientific and ethnological issues. In addition, medical ethics is also interested in questions of conflict research.

Corpus of research

The medical market and the conflicts occurring here have been the topic of medical historical research for a long time – sometimes more and sometimes less explicit. The Early modern period[31] and the 19th century have been especially well researched in this regard, as important consolidation processes of the medical market took place during these times. The professionalisation of the rank of doctors was accompanied by numerous conflicts with other groups of healers. Mainly natural healers, homoeopaths and alternative practitioners became the doctors' targets as these did not follow scientifically justified medicine.[32] Especially at the turn of the 20th century and during the time of the Weimar Republic doctors repeatedly demanded a statutory prohibition of the so-called "quacks" which fuelled the "quack debate" even more.[33] Other

29 Cf. Pelinka (2016), p. 17.
30 Cf. Pelinka (2016), p. 20.
31 Jütte (1991); Stenzel (2005); Ehrlich (2007).
32 On the history of the natural healing movement: Regin (1995). On the relationship of non-academic healers and the doctors see Faltin (2000). On the history of alternative healing methods: Jütte (1996).
33 Cf. Teichler (2002), pp. 27–31.

critical movements of current medical practice, such as the opponents of vaccinations, have also resulted in conflicts with academic medicine.[34] Despite its hegemonic position, academic medicine could never fully eliminate a certain medical pluralism from society.[35]

The 20th century also produced processes of differentiation and extinction within the health professions but the history of medicine has so far only shown little interest. An exception is here the history of nursing that has already discussed the power structures within nursing and also the conflicts between nursing and medicine.[36] The dimensions of gender and culture have been particularly addressed in this regard.[37] With the exception of possibly midwives, other health professions such as medical technical assistants, emergency medical technicians, diabetes counsellors, physiotherapists and/or occupational therapists have been largely neglected. Yet, they are a rewarding research project from a perspective of the history of professions due to their hierarchical position.[38] Since this topic is often addressed in current debates on medical care, as mentioned at the beginning, it illustrates its centrality and significance.

Structure

The current volume consists of three parts, arranged on the level of the agents. The first and second parts cover inter-professional and intra-professional conflicts, respectively. And since the framework for conflicts is as important as the agents themselves, the third part is reserved for this issue.

The first part focuses on conflicts between various professional groups or professions. In her article on negotiation processes between nurses and doctors, Karen Nolte uses the example of performing anaesthesia in the 1950s in West Germany. She illustrates how a practice that had previously been performed by nurses slowly became the doctor's task. Eileen Thrower discusses the inter-professional collaboration and the conflicts resulting from it. In particular, she draws on midwives, nurses, and doctors in Georgia in a historical perspective. Pierre Pfütsch focuses in his article on the professionalisation of the non-medical emergency services. He shows how the profession of an emergency medical technician emerged from originally a voluntary job and how it changed into a recognised profession in the Federal Republic of

34 Dinges (1996). In particular on the criticism of vaccinations: Thießen (2017).

35 The volume edited by Jütte provides a fine overview over the history of medical pluralism: Jütte (2013). On conflicts in medical subcultures: Mildenberger (2013).

36 D'Antonio (2010); Fish Mooney (2005). From a sociological perspective: Kirsten Sander (2009). In addition: Malleier (2014).

37 With the inclusion of the category of gender: Loos (2006). With the category of culture: Effelsberg (1985).

38 In addition to some articles on special professions in certain countries, I name as an exception: Twohig (2005).

Germany. He illustrates what impact various agents such as the doctors and aid organisations had in this process.

The second part of the volume discusses conflicts that occurred mainly within a professional group or profession. Christoph Schwamm discusses the history of men in nursing. He asks what masculinity actually meant in the West German professional nursing organisations and illustrates what transformations occurred there. With Geertje Boschma we enter history of psychiatry: she traces the negotiation and tensions around electroconvulsive treatment in Dutch psychiatry. Using the concept of generations, she traces conflict lines between different generations of doctors with regard to the use of this therapy. Sylvelyn Hähner-Rombach focuses on paediatric nursing and hence a special field within nursing that was characterised by the strong bond between patients and nurses. She traces the sources of conflicts between paediatric nurses and the patients' mothers. Using the opening up of the children's wards to mothers, she reveals that changes of management structures can controversially impact hierarchical parameters.

The last part of the volume is dedicated to the general framework of medicine and to the conflicts that result from this. Jane Brooks pursues the question what impact the war as a framework had on the professional role of nurses in Britain during the Second World War. She illustrates how the nurses who had been trained in a strongly hierarchical system developed highly cooperative work forms in collaboration with the doctors at a much larger scale than they would have been able to outside this exceptional situation of wartime deployment. The next article is Eyal Katvan's analysis of the regulation of dental care in British Mandate Palestine. Katvan looks at the development of the profession both from a legal and a medical perspective and points to their interconnections. Simultaneously he discloses the development and extinction of various professional groups within dentistry. Aaron Pfaff focuses on diabetes counsellors and thus directs our attention to a relatively unknown medical profession. He describes in the final article of the volume how the growing significance of diabetes mellitus in societal discourse and the development of the new market of medical technology in this area resulted in the creation of a completely new profession that had to adjust to existing structures.

Outlook

While the current edited volume addresses the most diverse facets, conflicts, agents, and spaces, we are aware of its limits with regard to its content. All of the articles focus on Western industrial nations and thus the distinct kinds of conflict and issues that have been shaped by Western medicine. When discussing the topic from a global historical point of view, Eastern European countries would be the next focus. Yet the countries in South America, Asia, and Africa would also have to be investigated. This could be an area of research in the future.

Another level for the investigation of conflicts in the healthcare system could and should be the transnational-comparative level. Such a perspective would initially compare conflicts, the context of their development, and the possibilities for solutions in the various countries. The central question is here mainly how the structures of care in the healthcare system impact the development of health professions. At this junction, a comparison between centralist and federalist or capitalist and socialist systems seems to have potential. Since the authors in this volume analyse mainly Western industrial nations, their articles here should also be understood as possible ideas for such a subsequent perspective.

Bibliography

Literature

Albrecht, Martin; Etgeton, Stefan; Ochmann, Richard R.: Faktencheck Gesundheit. Regionale Verteilung von Arztsitzen (Ärztedichte). HNO-Ärzte, Nervenärzte, Orthopäden, Psychotherapeuten, Urologen. Gütersloh 2015.

Barmer GEK: Barmer GEK Arztreport 2016. (=Schriften zur Gesundheitsanalyse 37) Siegburg 2017.

Bryant-Lukosius, Denise et al.: A Historical Overview of the Development of Advanced Practice Nursing Roles in Canada. In: Nursing Leadership 23 (2010), pp. 35–60.

Cerrahoglu, Yahya et al.: Auf den historischen Spuren der OP-Pflege. In: Im OP 4 (2014), pp. 210–214.

D'Antonio, Patricia: American nursing: a history of knowledge, authority, and the meaning of work. Baltimore 2010.

Dinges, Martin (ed.): Medizinkritische Bewegungen im Deutschen Reich (ca. 1870 – ca. 1933). (=Medizin, Gesellschaft und Geschichte, Beiheft 9) Stuttgart 1996.

Effelsberg, Winfried: Interkulturelle Konflikte in der Medizin. Medizinanthropologische Überlegungen. In: Würzburger medizinhistorische Mitteilungen 3 (1985), pp. 29–40.

Ehrlich, Anna: Ärzte, Bader, Scharlatane: die Geschichte der Heilkunst in Österreich. Wien 2007.

Eurostat: Life expectancy at birth, 1980–2015 (years) (2017), available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980-2015_%28years%29_YB17-de.png (last accessed: 17/10/2018).

Fallwell, Lynne: Modern German Midwifery, 1885–1960. (=Studies for the Society for the Social History of Medicine 13) London 2013.

Faltin, Thomas: Heil und Heilung. Geschichte der Laienheilkundigen und Struktur antimodernistischer Weltanschauungen in Kaiserreich und Weimarer Republik am Beispiel von Eugen Wenz (1856–1945). (=Medizin, Gesellschaft und Geschichte, Beiheft 15) Stuttgart 2000.

Fish Mooney, Sharon: Worldviews in conflict: a historical and sociological analysis of the controversy surrounding therapeutic touch in nursing. Ann Arbor 2005.

Geis, Anna; Wagner, Wolfgang: Demokratischer Frieden, Demokratischer Krieg und liberales "peacebuilding". In: Ide, Tobias (ed.): Friedens- und Konfliktforschung. Opladen; Berlin; Toronto 2017, pp. 131–160.

Gesundheitswirtschaft Rhein-Main e. V.: Entwicklungschancen des Zweiten Gesundheitsmarktes in der Rhein-Main-Region und Hessen. Gelsenkirchen 2014.

Hartung, Susanne; Kickbusch, Ilona: Die Gesundheitsgesellschaft: ein Plädoyer für eine gesundheitsförderliche Politik. 2nd ed. Bern 2014.
Howell, Timothy; Stein, Leonard; Watts, David: Sounding Board. The Doctor-Nurse Game Revisited. In: The New England Journal of Medicine 22 (1990), pp. 546–549.
Huerkamp, Claudia: Der Aufstieg der Ärzte im 19. Jahrhundert. Vom gelehrten Stand zum professionellen Experten: Das Beispiel Preußens. (=Kritische Studien zur Geschichtswissenschaft 68) Göttingen 1985.
Ide, Tobias: Einleitung: Konzepte, Themen und Trends der Friedens- und Konfliktforschung. In: Ide, Tobias (ed.): Friedens- und Konfliktforschung. Opladen; Berlin; Toronto 2017, pp. 7–32.
Jütte, Robert: Ärzte, Heiler und Patienten. Medizinischer Alltag in der frühen Neuzeit. München; Zürich 1991.
Jütte, Robert: Geschichte der Alternativen Medizin. Von der Volksmedizin zu den unkonventionellen Therapien von heute. München 1996.
Jütte, Robert (ed.): Geschichte der deutschen Ärzteschaft. Cologne 1997.
Jütte, Robert: Die Entwicklung des ärztlichen Vereinswesens und des organisierten Ärztestandes bis 1871. In: Jütte, Robert (ed.): Geschichte der deutschen Ärzteschaft. Cologne 1997, pp. 15–42.
Jütte, Robert (ed.): Medical Pluralism. Past – Present – Future. (=Medizin, Gesellschaft und Geschichte, Beiheft 46) Stuttgart 2013.
Loos, Martina: Symptom: Konflikte. Was interdisziplinäre Konflikte von Krankenpflegern und Ärztinnen über Konstruktionsprozesse von Geschlecht und Profession erzählen. Frankfurt/Main 2006.
Maibach-Nagel, Egbert: Pflegemangel: Ein wirklich großes Thema. In: Deutsches Ärzteblatt 115 (2018), p. A-505.
Malleier, Elisabeth: Alltag im Krankenhaus – Normen und Konflikte am Beispiel des Wiener "Rothschild-Spitals" um 1900. In: Medizin, Gesellschaft und Geschichte 32 (2014), pp. 51–68.
Mildenberger, Florian: Medikale Subkulturen in der Bundesrepublik Deutschland und ihre Gegner (1950–1990). (=Medizin, Gesellschaft und Geschichte, Beiheft 41) Stuttgart 2013.
Pelinka, Anton: Konfliktforschung. In: Diendorfer, Gertraud et al. (eds.): Friedensforschung, Konfliktforschung, Demokratieforschung. Ein Handbuch. Cologne; Weimar; Vienna 2016, pp. 17–34.
Pfaff, Aaron: "Man darf keine Kenntnisse beim Laien voraussetzen!" Die Genese der Diabetes-Beratungs- und Schulungsberufe. In: Hähner-Rombach, Sylvelyn; Pfütsch, Pierre (eds.): Entwicklungen in der Krankenpflege und in anderen Gesundheitsberufen nach 1945. Ein Lehr- und Studienbuch. Frankfurt/Main 2018, pp. 383–421.
Regin, Cornelia: Selbsthilfe und Gesundheitspolitik. Die Naturheilbewegung im Kaiserreich (1889 bis 1914). (=Medizin, Gesellschaft und Geschichte, Beiheft 4) Stuttgart 1995.
Robert Bosch Stiftung: Pflege neu denken. Zur Zukunft der Pflegeausbildung. Stuttgart 2000.
Robert Bosch Stiftung; Kommission zur Hochschulausbildung für Lehr- und Leitungskräfte in der Pflege: Pflege braucht Eliten. Denkschrift zur Hochschulausbildung für Lehr- und Leitungskräfte in der Pflege. (=Beiträge zur Gesundheitsökonomie 28) Gerlingen 1992.
Ruf, Werner: Islamischer Fundamentalismus. In: Imbusch, Peter; Zoll, Ralf: Friedens- und Konfliktforschung. Vol. 1: Eine Einführung. 5th ed. Wiesbaden 2010, pp. 309–332.
Sander, Kirsten: Profession und Geschlecht im Krankenhaus: soziale Praxis der Zusammenarbeit von Pflege und Medizin. Konstanz 2009.
Sander, Sabine: Handwerkschirurgen. Sozialgeschichte einer verdrängten Berufsgruppe. (=Kritische Studien zur Geschichtswissenschaft 83) Göttingen 1989.
Schumann, Marion: Vom Dienst an Mutter und Kind zum Dienst nach Plan. Hebammen in der Bundesrepublik 1950–1975. (=Frauengesundheit 8) Osnabrück 2009.
Statistisches Bundesamt: Statistisches Jahrbuch 2015. Gesundheit. Personal. Fachserie 12, Reihe 7.3.1. Wiesbaden 2017.