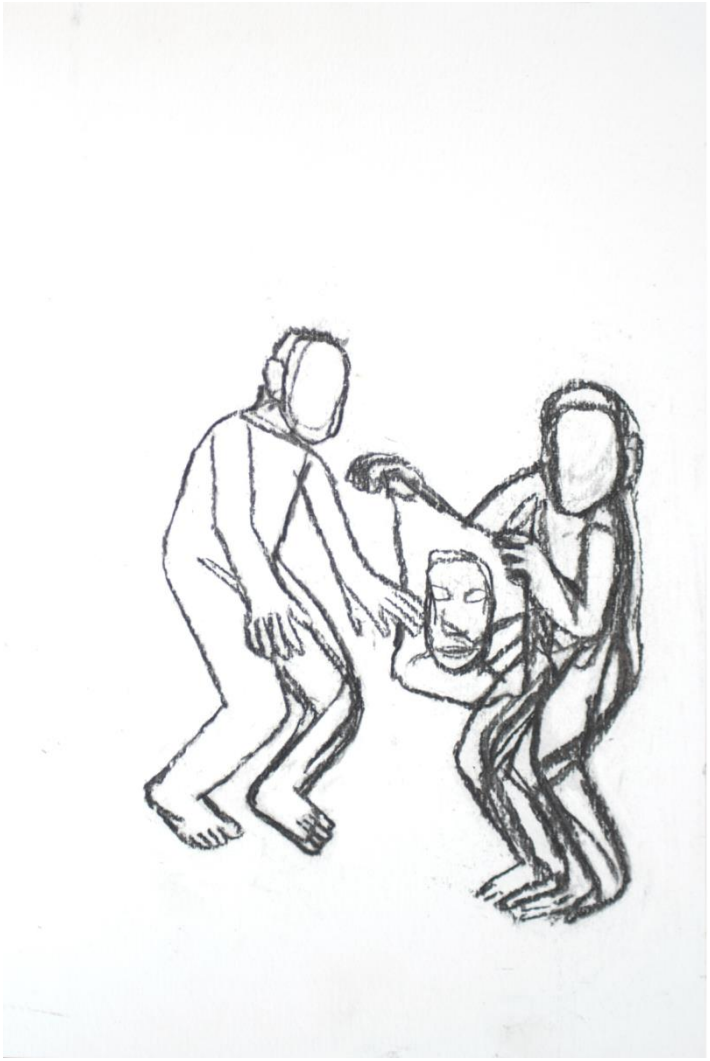
In Search of the ‘Whole Person’

Duty, Responsibility, and Identity in Nursing in the Netherlands 1955-1988

Summary



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The thesis (Dutch: Op zoek naar de ‘totale mens’. Taak, verantwoordelijkheid en identiteit van de verpleegkunde in Nederland: 1955-1988) will be appearing soon on the Florence Nightingale Institute website: www.fni.nl and also at www.proefschriftenverpleegkunde.nl
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Summary

Dutch nurses and nursing in general experienced a major identity crisis between 1955 and 1988. In the aftermath of the Second World War, this crisis arose both through societal changes in general and through developments in healthcare in particular. This dissertation argues that the nurse managed to wrestle free from this identity crisis through the development of a nursing theory that aimed at nursing the 'total human'. In this process, nursing models from the United States played a large influential role. This dissertation describes this development in six chapters, corresponding to the six types of nurses that existed in the Netherlands between 1955 and 1988, these being: A-nurse in general (somatic) nursing, B-nurse in psychiatric nursing, Z-nurse in developmental disability nursing and the nurses across all fields: the healthcare assistant, MBO-nurse (secondary vocational) and HBO-nurse (higher vocational). This study is based on an analysis of the archival documents from the Ministry of Education and Science, the Ministry of Health, Welfare and Culture, the Central Council for Public Health and the State Supervision Inspectors for the Insane and Insane Asylums [Staatstoezicht op Krankzinnigen en Krankzinnigengestichten]. In addition, the study examined decisions and regulations that relate to the different laws affecting nursing courses. A great deal of attention was given to relevant articles and submitted letters that appeared in professional journals at the time, in particular the *Tijdschrift voor Ziekenverpleging*, *KLIK. Maandblad voor de Zwakzinnigenzorg* and the *Tijdschrift voor Bejaarden- Kraam - en Ziekenverzorging*. The many nursing textbooks in the period 1955-1988 were analysed as sources for the task, responsibility and identity of nursing. This approach offers both an extensive addition and a nuance to the surprisingly limited availability of scientific research into the history of post-war nursing in the Netherlands.

A-nursing (general somatic nursing)
The research period for this study begins with the Heelsum conference in 1955, where representatives from the healthcare industry concluded with great consensus that the A-nursing sector had to be re-organised to avoid further devaluation. The level of the A-education and of the educated nurses was dropping, due to the fact that a severe staff shortage led to the hiring of girls with inadequate pre-education. In this context A-nursing was barely able to develop. In practice, the doctor and head nurse were in charge. At the same time, the nurse in training was expected to put in a lot of hours in near-impossible working shifts. She was tasked with performing a great deal of household chores and to top this all off, she had to reside at the work location. Having a private life was hard to come by. Girls who did have sufficient pre-education were wise enough not to choose this line of career. Instead, they preferred a career in an office or a shop; a setting devoid of irregular shifts where they enjoyed their Sundays off. However, being employed as a nurse was a allowed way of breaking the 'shackles' of the parental home. After graduating, the nurses finished a respectable course that offered them both independence and self-sufficiency.

(Student)-nurses just required one thing; a great passion for their line of work to counter-act being at the bottom of the hierarchy. Still, (student)-nurses in the 1950s already felt the urge to emancipate by means of sending letters to the editorial board of the *Tijdschrift voor Ziekenverpleging* (Nursing Magazine). In these letters, they expressed their discontent at the caste-like regime in the hospitals; a regime that favoured the doctor and the head nurse. The magazine received these letters with open arms, but nothing much changed in practice. The doctors remained the dominant players and the nurses just tagged along without reasoning from their own nursing discipline. Nurses were an 'extension' of the doctors, who left them with more and more tasks. This flared up some heavy debate within the government. The Ministry for Public Health was not entirely keen on nurses performing medical-technical

tasks such as pricking a vein. However, these developments had continued long enough for a reversal to be near impossible.

While nurses took over some tasks from doctors at the 'top' spectrum of their role, new medical practitioners in the fields of social, psychological and agogic care increasingly took over the tasks at their 'sides'. Nurses, as it were, increasingly worked in service of these new professions. Whereas a nurse would formerly instruct a patient on how the latter should leave his bed after a hernia surgery, the nurse would now fill out a form to call for a physiotherapist. From the late sixties onwards, healthcare assistants at the 'bottom' took over basic medical care and household tasks from the nurses. This was done to alleviate the workload for the A-nurse, granting her more time for her own work and for more complex tasks. However, no one was too sure anymore what a nurse's 'own work' actually was. A discussion was brewing that nursing had lost its identity, and its future. People hastily scrambled at various levels to define the task, responsibility and identity of nursing. In the seventies it became apparent, partially due to the discussion if nursing was an actual profession, that nursing was still a legitimate practice. Prominent nurses began to defy the doctors, showing that they, as nurses, knew a thing or two. There was no hesitation to use the theory of Florence Nightingale for that purpose. The American citizen Virginia Henderson was a guide and cornerstone throughout these times. Using the Henderson model, the somatic basic needs were mapped out, as well as the psycho-social and spiritual needs. 'The total human'. The Dutch nursing industry quickly found that an identity could be gained by developing an own theory/model. The last legislative change in 1986 therefore had the nursing industry basing itself on nursing visions and nursing methods

In this quest for a professional identity, A-nurses had to account for the standards 'Europe' would set for exchangeable diplomas. In order to gain European acknowledgement, plenty was left to do to get the A-course at a European level. They would get there, step by step. The diploma to be an A-nurse received European recognition as a ‘responsible general nurse’: indicated in Dutch as ‘verantwoordelijk algemeen ziekenverpleger’, which refferred to its male form. This is something remarkable, however, given how the male nurse was a minority position in the A-field, including in the Netherlands. That said, despite its numerical inferiority, the male nurse in the Netherlands managed to find its way to higher positions at a comparatively higher rate than his female counterpart. Following the Second World War, the male nurse underwent an emancipation process inside a woman-governed world. This emancipation did take place at the expense of the female nurse, during a second wave of feminism at that time. The first chapter postulates the question if this happened because women also based themselves on traditional men/women role models, or because the predominantly male staff in the appointment committees simply favoured men. This is worth further investigation.

B-nursing (psychiatric nursing)

The quest for the task, responsibility and identity of B-nursing was vastly different from A-nursing. While A-nurses mostly sought to break free from the dominant doctors, B-nurses wished to actually make gain a foothold by making use of newly developed treatments by doctors/psychiatrists. Within legal frameworks, a modernisation took place in 1959 within the theory and practice books of the B-courses. Socio-therapeutic tasks slowly and gradually became a part of B-nursing. Within the psychiatric field, these innovations were at that time mostly observable in Wolfheze. The medical director of Wolfheze Van der Drift began a socio-therapeutic project in the 1950s that culminated in a socio-therapeutic centre in 1961; something we would now refer to as small-scale living. Van der Drift aimed to use human interaction as a therapeutic tool. For that purpose, he employed girls without any background in nursing. In the 1950s, Van der Drift was a pioneering psychiatrist when it came to

therapeutic methods. This was also evident in his contributions to textbooks for the B-courses. At the same time, he continued to rely on medical, somatically-aimed treatment methods. The second chapter therefore explains how Van der Drift used his textbooks to provide B-nursing with modern therapeutic methods, but that personally he employed non-nursing staff for his socio-therapeutic project. Wolfheze can be regarded as a major link in the transition to a new era, an era within which criticism on the so-called 'medical model' grew and reformists in psychiatry began to plead for a 'social model', instead.

Nurses, too, began to actively campaign for such a social model in psychiatry. This chapter pays considerable attention to the actions by Aktiegroep Willem in 1970. This action group by (student)-nurses from the Willem Arntsz Hoeve in Den Dolder aimed to achieve innovations in the B-courses that were not based on medicine. They wanted to see their profession tasked less with safeguarding a patient's hygiene, serving the meal, administering medicine, or assisting with electroshocks and isolation. Instead, they wanted more opportunity to simple converse with patients, to interact with them in a more 'human' way, to not prance around in a uniform but in regular clothes - in short, to be active in a (socio)therapeutic way. National support for these actions was great amongst B-nurses. In addition, the actions received plenty of media attention. Contemporary historiography attributes a great deal to the innovations that Aktiegroep Willem was supposedly responsible for. This study puts some nuance on the role of this action group. In hindsight, their actions at most accelerated the changes that were already inevitable. The action group surfed the wave of a movement that had already begun. A 'silent revolution' took place in the 1960s. The government already announced far-reaching and progressive changes for B-nursing, recorded in a 1969 report. Nearly all of these changes were implemented in the legislation for B-nursing in 1970 and 1975. These changes in B-nursing were in line with the trends of the so-called anti-psychiatry that flared up in psychiatry at the time. According to reformists, psychiatric treatments were in need of revision and they should certainly not be based on a medical model. Jan Foudraine was very prominent in the Netherlands. His book *Wie is van hout… Een gang door de psychiatrie* (1971) largely influenced the B-nursing, while the book barely garnered any attention whatsoever in the influential *Tijdschrift voor Ziekenverpleging*.

The drive for anti-psychiatric trends, or critical psychiatry, did not gain much sympathy from those who stuck to the medical model. It was thus not uncommon for one psychiatric institute to cling to a conservative medical model, while another institute was saturated by a far-reaching climate of democratisation and experiments in the treatment culture. This ‘new’ nurses plead for more democracy, but in practice they did not convey their will to 'old-fashioned' co-workers in that same democratic way they vied for. Activists, sympathisers and influential B-nurses saw the innovations on a therapeutic level as being enriching to B-nursing. Still, in hindsight, the inclusion of new (socio)therapeutic tasks contributed more to the identity crisis. After all, did these new tasks even belong to B-nursing? Would the B-nurse still go by its title of nurse? The second chapter concludes that by embracing a 'social model' in psychiatry, B-nurses ended up within a new, extended arm construction. Not as the extended arm of the doctor/psychiatrist that adhered to the medical model, but as the one of the doctor/psychiatrist who supported the anti-psychiatric movement. After all, anti-psychiatry was a development within psychiatric medicine and not within nursing. In addition, the B-nurse began to serve as the extended arm of new professional practitioners like the clinical psychologist. While B-nurses began to assume a more prominent role in the second half of the 1960s, the first discussions arose by nurses like H. (Hendrik) Vermaas in the late seventies to detach from the doctor/psychiatrist and psychologist. It was not until the legislative change of 1986 that the B-nurse had to approach the psychiatric patient from nursing theories/models. This did not please every nurse, but it was the beginning of a road leading to an own identity.

Z-nursing (developmental disability nursing)

Z-nursing was a young course compared to the A and B versions. In 1958, a number of institutes for people with developmental disabilities set up Z-training because there was a demand for clarity in the diffuse home training courses. It is quite remarkable that Z-nursing from its very start was not based on the medical model, but rather on pedagogy and psychology. This put the training well ahead of its time. However, the actual working-floor was far from being adjusted to that vision. This was mostly due to departmental management still being controlled by A and/or B nurses who still adhered to the medical tradition. These nurses followed a doctrine of peace, purity and frequency. It was not until the 1970s that institutes slowly began to adapt to the new pedagogic and psychological insights. The Z-training received legal status in 1977. The third chapter concludes that the Z-nurse was both a nurse and held a teacher function. Two training courses in the care for the people with developmental disabilities were combined: the Pedagogical Worker course and the Z-nurse course. This meant that after the first two years, a pedagogical worker could be deployed who would then be able to refer to him or herself as a Z-nurse in the third year. Similar to B-nursing, we can ask the question if this still involves nursing, as right until the last legislative change in 1986, the Z-course spent more hours on agogic subjects than on actual nursing.

The Z-course thus focused mostly on pedagogy. On the initiative of director Carel Muller, the institute for the people with developmental disabilities Dennendal, part of the Willem Arntsz Hoeve in Den Dolder, actually wanted to get rid of the pedagogic policy. They worked in an atmosphere of anti-pedagogy, given how Muller and his followers were of the opinion that people with developmental disabilities could be whoever he/she pleased. The Z-course in Dennendal was granted the freedom by the Meeting of Institute Directors for the Developmental Deficiency Nursing to experiment with project-based teaching, where it was no longer the teacher who decided what needed to be taught. Subjects from daily practice were what supplied subject matter. This allowed for students, next to the official curriculum, to write an essay about the thinning project in Dennendal. This project entailed that people with developmental disabilities needed not adjust to society, but society had to adjust to the people with developmental disabilities. As such, people from within 'normal' society settled on the Dennendal terrain. While the students did a good job, the project still failed. Exams were rejected by the directors because they were organised by Dennendal itself without any official delegates. Carel Muller's anti-pedagogy policy did not end well. Pressured by severe societal unrest, the Dutch government evacuated the Dennendal pavilions in 1974 and the experimental Z-course was terminated.

However, Dennendal did manage to shake up the Z-field of nursing. This field would never be the same again. More democratisation processes went underway in the institutes; eventually followed by integration projects for people with developmental disabilities. The legislative change in 1986 ensured that for the first time, the Z-course was allocated more hours for nursing than agogic subjects. More focus was placed on the nursing side of Z training. The subject matter reserved room for 'nursing theories' and even for 'nursing scientific research'.

Healthcare assistance

The fourth chapter shows that the course for healthcare assistants (ziekenverzorgenden) has two paths of origin. The hospitals appeared to have a maze of aids employed without any status. Conference members in Heelsum 1955 raised comments to create a course for Nursing assistants (VERA), so the hospitals could orderly manage this situation. A few nursing institutes for the prolonged ill had started a healthcare assistant course of their own several years earlier. Both courses were designed to take away some of the workload for nurses when

it came to basic care and household tasks. The benefits would be on all sides: the A-nurse would win more time for more complex tasks, the shortage of nurses would be remedied, and the A-nurse would be shielded from further devaluation because those with lower credentials could move to healthcare assistance. The conference members in Heelsum suggested to have the healthcare assistance course in the nursing institutes fit into the VERA course (instead of vice versa). The diligent Voorlopige Verplegingsraad (Preliminary Nursing Council) designed a course for girls who would be titled healthcare assistants (‘ziekenverzorgster’) instead of VERA given how the former title would be more acceptable next to the already existing family and maternity assistant (‘gezins- en kraamverzorgster’).

Things passed much differently than the people in Heelsum and the Nursing council originally expected. The freshly educated healthcare assistant began to operate in the scope of the nurse; mostly out of frustration because of her subordinate position. The government was ultimately left with no option but to blow the whistle. Simultaneously, healthcare assistance began to develop into an own professional group, separate from nursing. The course that was meant to act as an assistant to the regular nurse began to plot its own course because of the (doubly) aging society. The healthcare assistant became an expert in the methodical nursing and caring for the elderly and chronically ill, creating situations where nurses were actually subordinate to healthcare assistants.

This fourth chapter describes how the government quested to ascertain what healthcare assistance should be about. Quite some attention was paid to J.A. van den Brink-Tjebbes. Indeed, this attention was justified, as she greatly contributed to nursing in the Netherlands in its full breadth whilst at the same time further developing healthcare assistance. What is more, she was the first Dutch person to develop a nursing theory that served as a guiding principle in 1980s lecture for the whole of nursing, including HBO-V. Her theory, developed from a 'lower' level within nursing, namely the level of healthcare assistance, was of large influence on the whole of nursing. For Dutch nursing, Van den Brink-Tjebbes was an essential link in finding the ‘total human’ in nursing, as her model with the eighteen aspects of self-care allowed for a methodical total (psycho - social - spiritual - somatic) image of the human being.

MBO-nursing (nursing across all fields, secondary vocational)

For the first time in the Netherlands, nursing courses were launched as part of the regular full-time attendance system in 1972. Secondary vocational education saw its first MBO-V open in Eindhoven. Within two years, four more schools were added to that list. The MBO-V was meant to replace the above-mentioned inservice-courses in a bid to solve the issues that were rampant in them. For example, students who finished secondary education could enrol in the course immediately, negating the gap between leaving secondary education and the mandatory entitlement age for the inservice-course. The student was allowed to be a student during internships rather than a supposed full-fledged employee that the inservice student was expected to be. Furthermore, the MBO-V graduate could be employed across all fields. It all sounded great in theory - but reality turned out different. From a government position, the conditions for this full-attendance course were insufficiently arranged, placing the MBO-V in a vacuum with the course not knowing how to proceed. Besides, a three-year MBO-V course proved incapable of producing widely-oriented nurses. The schools wanted a four-year course, allowing for students to gain more practical experience across all fields. The government was not too keen on this, because the MBO-V had to be incorporated into a future secondary service and healthcare education system (MDGO). Because the MBO-V could not meet the demands of a nurse, the course was relegated. The course continued as MDGO-Nurse. This MDGO-VP nurse proceeded on a so-called secondary expert level, the same level as the healthcare assistant. The MBO-V existed for over a decade, but were it up to the

schools, the MBO-V's of the 1970s would still exist to this day and the MBO-V level nurse would have easily integrated into the new classification system at level 4 in the mid-90s.

This fifth chapter elaborates on the MBO-V being somewhat of a failed experiment, but argues that the ten years of its existence contributed greatly to how nursing was perceived. This course showed that not only could nursing be offered in a wide spectrum through vocational education at full-time attendance institutes, instead of inservice education, but that it could additionally be offered with the help of other disciplines. While the Z-course also based itself on pedagogy, the MBO-V in Rotterdam offered the entire course by using the pillars stages of life and agogics (pedagogy, andragogy, gerontagogy). The medical-nursing knowledge and social cultural training were important supports. MBO-V lacked tradition, enabling schools in the experimental phase to find their own paths, and they definitely did so. With that said, by no means were MBO-V graduates accepted everywhere with great enthusiasm. Institutes and inservice trained nurses did not always appreciate these new nurses. Indeed, they carried a broad view on nursing, but when it came to bearing responsibility and actual nursing skills, they were far from experts. After graduating, MBO-V workers were subject to a lengthy training period before being able to operate on the same level as their inservice co-workers in their respective fields.

HBO-nursing (nursing across all fields, higher vocational)

While many historians would think otherwise, this dissertation argues that the nurse managed to wrestle free from her identity crisis by the advent of HBO-V. HBO-V institutes were set up in Leusden and Nijmegen, the same time as the first MBO-V in 1972. For the first time, nursing was taught at a higher vocational level. Different from MBO-V, the HBO-V received adequate conditions from the government to be off to a good start. Indeed, it took some searching to get nursing available at a higher vocational level, but it was successful. The preliminary Commission HBO-V drafted a report in 1969, posing the question what nursing should actually look like. The report signalled a paradigm shift in nursing. Nursing was now dealing with scientific ambitions.

From the very first moments, HBO-V based itself on nursing theories and models. It then became clear that the Americanisation had definitively reached nursing. For example, the first textbooks used in HBO-V were translated books from America based on the likes of Virginia Henderson. In the 1980s, the Dutch Van den Brink-Tjebbes temporarily found her way into HBO textbooks with the authors De Jong and Kerstens, but these two also moved on to a theory by the American Dorothea Orem in the second edition. Using (for instance) Orem, it was clear-cut what belonged to the professional domain of the nurse and what did not.

Themes

(Nearly) every chapter in this dissertation has focussed on the themes of nursing skills, eating/meals and dying/death. This was done to see how the nurse developed herself in the thirty-three years that this thesis spans. For instance, tasks like venepuncture and applying a peripheral IV revealed that these skills were not taught in basic training, but nurses did perform them in practice. While these skills were but a small part of practical nursing, they were amongst the things most discussed. Governments were not very keen on nurses performing these skills. The government even kept a reserved stance when it came to the catheterisation of a man's bladder, a task that was 'traditionally' part of the nurse's portfolio.

A seemingly simple theme like eating/meals made it obvious how (perceptions of) nursing in practice developed between 1955 and 1988. A further division of labour began to surround the meal. Eating/the meal clearly showed that nurses moved from nursing functionally or action-oriented, towards nursing methodically according to a nursing model. The eating itself received attention if the patient had a self-care deficit on that front. There

was also a different kind of development visible when nursing a terminally ill patient. Whereas the nurse originally worked intuitively, somatically, functionally and action-oriented when nursing a terminally ill (terminal aid), from the 1970s onwards they also began to work in a more supportive fashion (terminal care). They were taught this by using other disciplines like social sciences and the humanities.

The Nursing Professional profile of 1988 was the endpoint of this study. All responsibilities, tasks, operations, knowledge and skills were included in it. It also distinguished between functioning on the primary and secondary expert level. The nurses were able to determine for themselves which nursing theories they wished to apply. Textbooks therefore were not limited to just one theory.

For instance, the Nursing Professional profile of 1988 mentioned that professional nursing practice required knowledge and insight into models and theories that were developed for nursing. This thesis has demonstrated that this allowed the nurse and the healthcare assistant to define their own tasks and responsibilities; irrespective of the doctor and new professional groups. In other words, the nurse had found her identity. Using an own theory/model, the nurse and healthcare assistant were able to gain a detailed picture of the total human by questioning him for self-care deficits on psycho-social-spiritual-somatic fronts. This makes sense in 2016, but after the end of World War II it took until 1988 for nurses and healthcare assistants to finally wrestle free from professional workers that nearly signalled the end to nursing.