Women Religious and Nursing in the Renaissance
The Daughters of Charity and the Professionalization of Nursing
Susanne Malchau Dietz
Women Religious and Nursing in the Renaissance
The Daughters of Charity and the Professionalization of Nursing

Susanne Malchau Dietz
Contents

Preface ...................................................................................................................................5
Introduction ........................................................................................................................6
The Rule of St Benedict ..................................................................................................8
The Council of Trent: the Mandatory Enclosure of Nuns ........................................8
France and the Reformation .................................................................................... 10
Vincent de Paul and Louise de Marillac ...............................................................12
  Vincent de Paul .........................................................................................................12
  Louise de Marillac ..................................................................................................15
The Founding of the Company and Ecclesiastical Approbation .............................15
  The Founding Process .......................................................................................... 15
  Ecclesiastical Approbation ...................................................................................16
Ministry and Expansion ............................................................................................. 18
  Leadership and Organization ..............................................................................18
  Recruitment ...........................................................................................................19
  Medicine in the Renaissance ..............................................................................20
  Training in Nursing .............................................................................................26
  The Habit ..................................................................................................................30
  Home Nursing and Hospital Nursing .............................................................32
  Nursing versus Medicine ......................................................................................33
  The Hôtel-Dieu d'Angers .......................................................................................36
Concluding Remarks ....................................................................................................39
Epilogue: Catholic Nursing Congregations in Denmark ......................................40
  Establishment and Active Ministry ...................................................................40
  The Sisters of St Joseph .........................................................................................42
  The St Vincent Sisters ........................................................................................43
Notes ...........................................................................................................................45
Literature .....................................................................................................................48
Preface

In this book, Susanne Malchau Dietz has gathered the existing knowledge of nuns and nursing in Europe in the age of the Renaissance drawing on her own and international research. Her focus is the earliest skilled nursing as it was framed and practiced by the order of the Daughters of Charity.

The book partially questions earlier history that has called the age after the Reformation the “dark period of nursing”. It was a period where development partly stagnated in the wake of the abandonment of monasteries after the Reformation and the Counter-Reformation. Up till the Reformation in the 16th century, the poor, sick and needy would seek shelter and care in the monasteries. In the reformed countries of Northern Europe, the monasteries were closed and the care formerly provided by the monasteries practically disappeared. There were some small hospitals and nursing homes left, but the vast majority of the population had to fend for themselves when it came to illness and distress.

In the book, Susanne Malchau Dietz describes how small Catholic sister communities emerged in the wake of the Counter-Reformation; communities created to care for and nurse people in their own homes. The Daughters of Charity developed into a strong religious order that trained the sisters to become skilled nurses with high competency, not only in nursing but also in medical skills. They were the first trained nurses and to Florence Nightingale, they became a role model for modern nursing.

The book tells a story that today is forgotten by most. Therefore, the Danish Society of Danish Nursing History decided to have the book reprinted as a supplement to the Danish literature on nursing history with its deep roots in the catholic and protestant sisterhoods.

The book is a reprint with some updates of the 1st edition that appeared in 2010 following the exhibition on nursing in the age of the Renaissance at the Danish Museum of Nursing History in 2006, the Renaissance Year.

Grete Christensen
President of the Danish Nurses’ Organization
Chairman of the board of the Danish Museum of Nursing History
Introduction

To outsiders, nuns, convents and religious sisters tend to generate a certain mystique, prompting considerable curiosity. Life behind convent walls has traditionally been shrouded in myth and anecdote, more often than not involving coercion, sexuality and unrequited love. What these myths have in common is that they appear to offer explanations as to why a woman might end up in a convent in the first place and how, happily, she most often manages to escape it! In our present-day culture, the religious vocation is regarded as a wholly unnatural choice: the modern mind reels at the thought of renouncing family, marriage, children and not least carnal love (Malchau 2006).

As a historian, my aim is to demythologize such hackneyed notions by taking a considered look at women religious and their vocations, and by bringing into sharp focus the contribution that religious sisters made to the development and growth of nursing as a profession. Indeed, research in this area makes possible a further piece of demythologization in that it overturns the claim that Florence Nightingale (1820-1910) created the nursing profession single-handedly. Florence Nightingale lived, in fact, in a period marked by a growing recognition of the need for professional nursing. Moreover, in her deliberations about nursing, she drew significant inspiration from the Roman Catholic nursing congregations established in the Renaissance. It is in the Renaissance, then, that modern nursing had its beginnings (Malchau 2008).

In what follows, I begin by sketching the background to monasticism and the reforms the religious life underwent as a result of the Reformation and the Counter-Reformation in the sixteenth century. From there, the focus shifts to seventeenth century France and the first and most famous of the nursing congregations,
Daughters of Charity harvesting various medicinal herbs for use in preparing remedies, artist and date unknown.
(Reproduced with permission of the Daughters of Charity of St Vincent de Paul, Paris)
Les Filles de la Charité – the Daughters of Charity. I then outline and describe the Company’s founding and organization, as well as the sisters’ training and active ministry in nursing up to c. 1645. An epilogue gives the reader a brief overview of the history of Catholic nursing congregations in Denmark in the last century with particular attention given to the French nursing congregations of the Sisters of St Joseph of Chambéry and the Daughters of Charity, known in Denmark as the St Vincent Sisters.

The Rule of St Benedict

The beginnings of monasticism in the Western Church can be dated back to Benedict of Nursia (c. 480-547). He founded a monastic order in 529 in Monte Cassino in Italy and shortly before his death wrote *Regula Sancti Benedicti* [the Holy Rule of Benedict]. In this Rule he articulated what a lifelong monastic commitment, lived according to the monastic vows of *stabilitas* (stability), *conversatio* (fidelity to the monastic way of life) and *oboedientia* (obedience under an abbot), required. The perhaps better-known vows of poverty and chastity are intrinsic to the vow of *conversatio*, which covers the full observance of the monastic way of life as defined by a rule. One difference from later monastic orders was that Benedictine monks and nuns could not be transferred to other religious houses. The vow of stability committed them to remaining in one and the same monastery/Convent throughout their lives (Jensen 1998).

With the rule as a foundation, the Benedictine form of life required that, sequestered from the world, members of the order should engage in a constant search for God through penance and prayer. In practical terms this meant a judicious balance of prayer and work, with time being allowed for both. The two activities go hand in hand, but neither was to be pursued at the expense of the other. While the celebrated Benedictine motto *Ora et Labora* [Pray and Work] is not to be found in the rule, it effectively encapsulates its spirit (Jensen 1998, Gasquet 1966).

An important precept in Benedict’s Rule is that the monks should devote themselves to the care and treatment of the sick and others in need. To fulfil the rule it eventually became the practice for monasteries to have a *hospitium* (guest house for pilgrims) and a *hospitale pauperum* (hospital for the poor, sick and needy).

These dedicated buildings were situated outside the enclosure, as indeed was the case at the convent founded in Rupertsberg, Germany in 1150 by Hildegard of Bingen (1098-1179). Around the year 600, the first Benedictine religious house for women was founded in England (New Catholic Encyclopaedia 1979).

In the ensuing centuries, monasteries and convents sprang up throughout the Western world. The earliest religious houses in Denmark were set up in 1100, and iconic religious orders such as the Cistercians, Bridgettines, Franciscans and Dominicans soon became established in the country. In the late Middle Ages there were about 30 convents in Denmark (Langkilde 2000).
The Council of Trent: the Mandatory Enclosure of Nuns

Over time, the monastic communities underwent reform, often triggered by the changing cultural, political and ecclesiastical circumstances of the societies in which they were set. In the case of women’s religious orders, the changes imposed during the Renaissance\(^1\) were quite radical. This was also the era of the Reformation and Counter-Reformation,\(^2\) and in the sixteenth century convents were placed under the strict supervision of the ecclesiastical authorities. Life in convents had become something less than monastic, with the personal needs of individual nuns, their personal power and wealth, taking precedence over contemplation and spiritual life in community. A tightening up of discipline was called for and the Catholic Church’s reformatory Council of Trent initiated a process to that end. The council (which met in three distinct sessions between 1545-63) marked a watershed, its legacy permeating the following four hundred years of Church history. It mobilized Counter-Reformation efforts and effected numerous reforms, including the issuance of a set of decrees relating to the monastic orders and their members.

These Tridentine decrees placed all nuns under strict *clausura* (enclosure),\(^3\) a measure which at a stroke fundamentally changed convent life. Whereas previously nuns could come and go from the convents as they pleased, it was now decreed that they should be confined to the clausura (the cloister, or part of the convent which is reserved to the members of the religious community, who are thereby cloistered or ‘enclosed’). This constraint on their movements owed much to the Reformation, in that some of the ammunition deployed by Protestants against the Catholic Church related to the many rumours and reports in circulation relating to the immorality in convents. For the Catholic Church, it was crucial that these criticisms be countered and to this end, the council determined to subject all professed nuns to strict enclosure. No professed nun should under any circumstances leave the convent, not even should ill health require it; nor, incarcerated behind the convent walls, should she receive visitors or otherwise have contact with the outside world. Henceforth, the ingress of outsiders to convents was to be strictly regulated. In convent chapels to which the public were admitted, a screen was to be installed separating the public part from the nuns’ choir so that the nuns remained hidden from view. The same applied to the nuns’ parlour where a screen separated the nun from essential visitors such as, for instance, her confessor. A nun should be neither seen nor touched, and should a man transgress this rule, he faced exile or imprisonment. Existing convents that could not, through structural alterations, accommodate these constraints were closed and the nuns transferred to other convents.

The decree on strict enclosure had wide-ranging social and political consequences for women who were already in, or planning to enter, a convent. These were the daughters of the aristocracy for whom, more often than not, the espousal of the religious life was not of their own choosing. These women’s trajectories in life were pre-ordained to be either marriage or the cloister. Prior to the council of Trent, women in many convents had the freedom to come and go as they wished. They
could visit their family, receive visitors and in many respects enjoy the social life and material conditions of life associated with their social class. Clearly, the decree imposing strict enclosure on all nuns could only send shock waves through convents, for it meant that the premises underlying many women’s acceptance of the monastic life no longer held (Malchau 2006).4

At the personal level, the individual upper class woman saw a radical transformation in what was in fact the only alternative to marriage open to her: while still subject to a strict, rule-governed way of life, she was now to be deprived of all contact and commerce with the wider society. For society as a whole, these decrees were nothing short of calamitous, since nuns could no longer care for and serve society’s sick poor (Malchau 2006, Dinan 2001).

The new dispensation took effect in all Catholic countries and regions, and was still in force 70 years later in the early 1630s when a group of devout women made a commitment to devote their lives to assisting the sick poor. They did not identify themselves as nuns, but they formed communities and adopted a religious way of life which corresponded to that of the traditional monastic orders, although without the observance of enclosure. Within the space of a few years, they were serving as a model for other similar congregations, and yet they were in open breach of canon law. So how did they manage to pull it off?

**France and the Reformation**

The setting in which the new religious congregations emerged was seventeenth

![Francois Dubois’ contemporary depiction of the St Bartholomew’s Day massacre of Protestant Huguenots, 1572. Dubois was himself a Huguenot. The Granger Collection, New York.](image-url)
France's hegemonic status was achieved at a cost. The era of the Renaissance and the Reformation was a stark, turbulent period. Externally, the country was continuously at war with the Hapsburgs, who ruled Austria, Spain and Northern Italy. Internally, the country was torn apart by the bloody Wars of Religion between Protestants and Catholics (the monarchy siding with the latter); the teachings of the Reformists had won many adherents with the result that the Protestants (the Huguenots) had gained no small measure of political power. In 1598, peace was restored through the Edict of Nantes, which created parity of status between Protestants and Catholics in France while still favouring the Catholic faith to the extent of forbidding the establishment of Protestant churches in Catholic areas. When Louis XIV took control of government in 1661, he resumed the persecution of Protestants, leading many of them to flee the country (Lausten 1997).

The decade-long wars took a heavy toll on the civilian population and left a bitter legacy. Soldiers had ravaged and plundered everywhere, pillaging the peasants' crops. Taxes were hiked to fund the wars, leaving ordinary people destitute. As a
result, sickness, failing harvests and poverty reached alarming levels. People fled the countryside for the towns in an attempt to find a livelihood, but found no welcome there (Dinan 2006).

Given the inadequacy of existing poor relief, a categorization was devised to determine who was rightfully entitled to help: a distinction was made between “the deserving and the undeserving poor”. A ban on begging, issued in 1536 by King Francis I (1494-1547), directed local authorities to set “the deserving poor” (which included children, the old, expectant mothers and women generally) to work. To manage the poor, a system of social offices (bureaux de charité) and workhouses (hôpitaux généraux) was set up, which during the seventeenth century was further developed and consolidated and played a key role in the provision of poor relief. The workhouses were establishments where the “deserving poor” were helped and the “undeserving poor” (mostly men), such as tramps and beggars, were incarcerated. Stigmatized as lazy and immoral, they were held to be the authors of their own misfortune (Dinan 2001 and 2006, Jones 1985).

This system signalled the emergence of an entirely new attitude to the poor. Throughout the Middle Ages, poverty had been seen not as a problem but as an opportunity for the well-to-do to perform “good works” and so further their salvation. It was a virtue to be poor, since Christ had himself been poor on earth. Now it was no longer a virtue. It was a problem that needed tackling! (Dinan 2006).

Against this background, the humanism of the period showed its mettle with public opinion recognizing the need to come to the aid of the needy. One initiative aimed at addressing the problems was the founding of a new type of non-enclosed congregations or confraternities for women who sought to dedicate themselves to helping the poor, the sick and the marginalized.

**Vincent de Paul and Louise de Marillac**

The first and still best known of these new confraternities was the Company of the Daughters of Charity, founded in 1633 by the priest Vincent de Paul and the widow Louise de Marillac. For both, it became a lifelong commitment to relieve the deprivation and poverty that riddled society (Dinan 2006).

**Vincent de Paul**

Vincent de Paul was born in the village of Pouy in Gascony in south-western France in 1581. He grew up in a hardworking small farmer’s family where the adults and the family’s six children all had numerous duties and chores. Vincent, whose primary task was to herd pigs, soon showed himself to be exceptionally bright. His father noticed this, and when a local lawyer made the same observation, Vincent’s future was decided. Vincent would study. It was a given that Vincent would receive a clerical education since this was the only option open to a boy not of high birth. And so with his father’s permission, Vincent began to study theology at the age of sixteen. He began his schooling in a nearby Franciscan monastery before going on to continue his studies in Dax and Toulouse. At nineteen he was ordained to
the priesthood while continuing to study theology in the years that followed. In 1605, he found himself caught up in a dramatic incident when, on a sea voyage to Marseilles Turkish pirates seized the vessel he was aboard. He was taken prisoner and spent two years as a slave in Tunisia before escaping and returning to France (Purcell 1989, Jones 1989a).

In 1612, Vincent de Paul was appointed spiritual advisor and tutor to the household of the influential Gondis, Françoise-Marguerite de Gondi (1584-1626) and her husband Philippe-Emmanuel de Gondi (1581-1662), General of the Royal Galleys. Madame de Gondi was known for her deep commitment to charitable work, enterprises into which Vincent de Paul was soon drawn, becoming confessor to the local population and seeking to lead them in the ways of faith. He also had access to General Gondi’s galley slaves and improved their conditions of life. He was said to have “won their hearts”, leading many of them to convert to Catholicism (Purcell 1989, Jones 1989a).

Vincent de Paul soon realized that, to be truly effective, charitable work needed to be properly organized, and in 1617 he founded the Confrérie de la Charité – the Ladies of Charity – a lay association or confraternity of well-to-do Parisian women who were committed to charitable endeavours and to spreading the gospel among the sick poor in the capital. There was a problem, however. The involvement of upper class ladies in activities of this kind was frowned upon by polite society. Their husbands’ support was singularly lacking, and resistance to their charitable efforts was only reinforced by the fact that the city’s poor districts were periodically haunted by the plague. The Ladies’ sought to overcome this hurdle by sending their servant girls instead and the arrangement continued on these terms. How-
Marguerite Naseau, the first Daughter of Charity, artist unknown.
ever, neither Vincent de Paul nor the Ladies themselves found this solution wholly satisfactory (Dinan 2006, Jones 1989a).

In 1625, Vincent de Paul founded the Congregation of the Mission at Saint-Lazare, a community of priests and brothers, whose apostolic ministry was the evangelization of the rural poor. They became known as Lazarists, a name coined from the town of Saint-Lazare, where their first seminary was situated. The congregation flourished, and in Vincent de Paul’s lifetime eleven seminaries for the training of Lazarists were established. The Lazarists worked with the Ladies of Charity and were instrumental in creating new Confraternities of Charity at the district level (Dinan 2006, Jones 1989a).

Louise de Marillac

Louise de Marillac was the product of an extramarital relationship between the nobleman Louis de Marillac and (it is believed) a servant girl. She was born in 1591, by which time her father was a widower. Little is known about her mother, but it is likely that she died young. It was unthinkable that little Louise should be a part of her father’s household, but he assumed responsibility for his natural child in other ways. When, in 1595, he remarried, he placed his then three-year-old daughter in a royal Dominican convent where a great-aunt was a nun. When Louise lost her father at the age of thirteen, the family placed her in a boarding house where she learnt housekeeping as part of her preparation for marriage. However, Louise was set on becoming a nun and at the age of 15 she applied for admission to a strict Capuchine convent. She was rejected, ostensibly on account of her delicate health, although it may well have been her illegitimate status that decided the matter. A condition of admission to convent novitiates was having been born in wedlock.

Indeed, Louise’s uncles had other plans for her, and in February 1613 they arranged for the 22-year-old Louise to marry Antoine le Gras, secretary to Queen Marie de’ Medici (1575-1642). In October of the same year a son, the sole issue of the marriage, was born and christened Michel Antoine le Gras. Louise was now fully occupied as wife and mother, but her circumstances changed when, in 1625, she was widowed at the age of 34. The pursuit of other goals was now open to her. Moreover, the status of widowhood meant that she was no longer under the dominion of the male heads of the family but could decide over her own life (LaFleur 1996, Dinan 2006).

Now it was around this time that Louise de Marillac came into contact with Vincent de Paul, who in 1624 became her spiritual director and inspirer. Her earlier desire to become a ‘traditional’ nun seems to have been abandoned but she had not relinquished the desire to live according to monastic practices. During the extended period during which she nursed and tended her husband she made the so-called vow of widowhood to serve God and live out the monastic vows of poverty, chastity and obedience. Her vocation would be to serve the neediest in society.
The Founding of the Company and Ecclesiastical Approbation

The Founding Process

With the support of Vincent de Paul, Louise de Marillac began the pursuit of her vocation. In 1627, she placed her thirteen-year-old son in a boarding school and began to assist Vincent de Paul in the organization of the work of the Ladies of Charity. In 1629, she embarked upon her first independent mission, which consisted of supervising the Ladies in the town of Montmirail. Other tasks followed, including the foundation of a string of confraternities of Ladies of Charity. Vincent de Paul and Louise de Marillac soon found themselves working in close partnership. Together they hit upon a solution to the problems that had manifested themselves in the organization of the Ladies of Charity who, as we have seen, were denied access to those whom they sought to help. The solution, reached around 1630, involved Louise de Marillac's opening her home to young women and girls from the country (the daughters of artisans and small farmers) who wished to devote their lives to the service of the poor. In contrast to the women from the nobility and the aristocracy, these young women were used to interacting with the poor on a daily basis and were well acquainted with their hardscrabble lives. They were accustomed to hard work and humble living conditions and were highly motivated. These girls were sent out to care for the ailing poor in their homes and, unlike the Ladies of Charity, they braved the notorious districts unflinchingly. As a result, the duties of the Ladies of Charity were confined to organizing the work carried out by these young women – later, sisters of the Company (LaFleur 1996, Dinan 2006).9

In 1633, Vincent de Paul gave his permission for Louise de Marillac to give the young girls she housed spiritual counselling and practical training in nursing. This initiative marked the founding of a congregation or company of religious sisters. It received the name *Les Filles de la Charité* – the Daughters of Charity (Dinan 2006, Jones 1989a).10

The first sister in the newly formed Company was Marguerite Naseau (1594-1633). A poor, uneducated shepherdess from the country, she was endowed with the qualities that the Ladies of Charity had lacked. She was a model of female piety, competent in cooking and nursing and a patient teacher. The founders of the congregation had noticed these qualities in her around 1630.

*Let me [Vincent de Paul] know whether that good young women from Suresnes who visited you before and spends her time teaching girls, has come to see you as she promised me last Sunday?*” (LaFleur 1996, p. 48).

Marguerite Naseau’s religious vocation was unfortunately of brief duration. She died in 1633 of the plague, which she contracted from a young victim she had nursed. But she came to epitomize the Daughters of Charity and remains one of the Company’s iconic figures (Dinan 2006, Jones 1989a, Vincentian Encyclopedia 2009).
Ecclesiastical Approbation

By navigating around the Catholic Church’s strict enclosure rules, Vincent de Paul and Louise de Marillac had succeeded in founding an unenclosed religious congregation, but it took no little ingenuity to gain ecclesiastical approbation for it. The decrees of the Council of Trent relating to the enclosure of nuns were still in force in 1633, and religious orders that failed to satisfy this requirement were either closed or restructured by the Church. Numerous examples attest to this. Vincent de Paul himself had been involved in and supported a number of attempts to found unenclosed women’s congregations and would have acquired no small expertise in identifying the relevant ‘minefields’ – expertise which he put to good effect in steering the Company of the Daughters of Charity through a protracted approbation process.

It might well be asked why the official approbation of the Church was so important. Might not these women simply have formed a lay association? This, however, was never an option. They sought a life in community that shared significant affinities with that of a formal religious order and it was this shared conception of the religious life that infused the Company’s spirituality and activities with meaning. Moreover, the conventions of the time meant that membership of a religious community was the only way in which these young women might be offered a socially respectable form of life.

One of Vincent de Paul’s major assets was that he was respected and highly regarded by his contemporaries in ecclesiastical, royal and political circles alike. Indeed, in 1630 he was said to be one of the most influential figures in Counter-Reformation France. As advisor to the power-wielding Cardinal Richelieu, he had close connections with society’s movers and shakers and was supported and respected by the royal household – both by Louis XIII and the young Louis XIV. He engaged actively with the influential aristocratic women who made up the Ladies of Charity. And it was experience, high office and influential friends that were needed to pull off the seemingly impossible: to obtain ecclesiastical approbation for the Company of the Daughters of Charity.

In 1645, Vincent de Paul applied to the Archbishop of Paris for official approbation for the Daughters of Charity as a religious congregation, citing their impressive achievements. The success of this enterprise was facilitated by the fact that the request was conveyed by the archbishop’s assistant (and nephew) Jean-François-Paul Gondi de Retz (1613-1679), one of Vincent de Paul’s former pupils in the Gondi family. In framing his request, Vincent de Paul concealed the fact that the Daughters constituted a kind of unenclosed religious, ministering to society’s needy, stressing instead that the new confraternity was a ‘lay confraternity’, whose supervision, upon Vincent de Paul’s death, would pass to the diocese. In keeping with this conception, he made consistent use of an appropriate terminology, referring to a community of sisters rather than an order of nuns, to the fact that they would live in houses and not convents, that vows would be made annually and not permanently and that their training would be undertaken in a seminary
and not in a novitiate, overseen by a serving sister and not a prioress or abbess. In other words, every effort was made to highlight the differences from enclosed nuns. Even the habit reflected this distinction since it resembled the typical garb of countrywomen at the time.

The archbishop granted his approbation to the congregation but Vincent de Paul regretted the part of the agreement that stated that it would at some point pass to diocesan control. It was important that it should be self-governing, and it would be ill served as a nationwide organization (which it was already) if it fell under the control of one diocese.

In 1650, the official document of approbation mysteriously disappeared – it is thought that some shrewd person had a hand in this. Vincent de Paul turned once again to the Archbishop of Paris, an archbishopric which had been given to his predecessor's assistant, now Cardinal de Retz. Vincent de Paul requested that the organization should remain under the jurisdiction of the Lazarists.

Cardinal de Retz, at this point in political exile in Rome, was keen to retain the support of the diocesan clergy. The fact that Vincent de Paul had resisted French diplomatic pressure to forbid the Lazarists in Rome to support the cardinal was one of the reasons why, on 18 January 1655, Cardinal de Retz gave the congregation his blessing and granted his approbation for its placement under the jurisdiction of the Lazarists. In 1660, Pope Clement IX approved the confraternity as an unenclosed congregation. It was described as a community of laywomen and not as a religious order of nuns in the traditional sense (Dinan 2006, Jones 1989a).

The Council of Trent's decrees had been skilfully circumvented. It had taken nearly 30 years, but with the threat of enclosure ever held at bay, for the Company of the Daughters of Charity to gain the full approbation of the Church. More broadly, however, this meant that a new type of women religious had come to stay. A wide array of new congregations was established modelled on the Daughters of Charity, one of which was the Sisters of St Joseph.

Ministry and Expansion

Leadership and Organization

Their monastery being generally no other than the abode of the sick; their cell, a hired room; their chapel, the parish church; their cloister, the streets or wards of hospitals; their enclosure, obedience; their grate, the fear of God; and their veil, holy modesty – they are obliged on this account to live as virtuous a life as if they were professed in a religious order (Dinan 2006, p. 46).

The above quotation reflects Vincent de Paul's own conception of the newly established congregation's mission and its parallels with and contrasts to enclosed orders of nuns. It fell not to Vincent de Paul, however, but to Louise de Marillac to consolidate and assume day-to-day responsibility for the congregation, taking care that it fulfilled its dedicated purpose.
With precisely that end in view, she ran the Company of the Daughters of Charity as a strongly centralized organization. The Lazarists assumed, as noted above, overall charge of the congregation, but its day-to-day management (after Louise de Marillac’s death) fell to a sister elected by the community itself.

At the motherhouse in Paris, home to the Company and its administrative headquarters, the head sister, “the Sister Servant”, was in charge. The motherhouse constituted the lynchpin and reference point for all the sisters’ activities both during and following the initial period of formation and training. It was the central hub from which they were dispatched and to which they returned in between postings to poor districts or to institutions. When the sisters grew old or fell sick they were cared for at the motherhouse.

An important task for the superior of the congregation was responsibility for the recruitment and training of new sisters, with the aim of ensuring a uniformly high standard of service. The management of a training programme for a community of sisters was something unprecedented, and stood in contrast to the organization of formation in the novitiates of enclosed orders.

It also fell to the superior of the motherhouse to deal with approaches from institutions interested in employing the sisters. When such requests were granted, she would negotiate written contracts with employers. These contracts were very detailed, covering everything from the sisters’ material and spiritual conditions of life to the nature and extent of their work remit. Tasks that the sisters were not to take on were also specified, such as, for instance, the nursing of well-to-do citizens.

Initially, Louise de Marillac assumed the running of this complex organization single-handedly but over time some of her most trusted sisters became involved. She was responsible for the recruitment of new sisters and for their formation and training in the motherhouse. She supervised the sisters’ various workplaces in Paris and the Parisian basin, scrupulous, down to the last detail, in her care for each sister’s needs and well-being no matter where that sister might be posted. When the order began to expand rapidly, she entered into agreements with institutions (for instance, hospitals) keen to employ the sisters. And lastly, she secured the congregation’s finances through prudent investments, taking advantage of her free access to the court and association with nobility of the highest rank, from which circles were drawn some of the Company’s foremost patrons (Dinan 2006, Jones 1989b).

**Recruitment**

Clearly, not every young woman was suited to the tasks to which the Daughters of Charity were committed. Famine, plague, contagious diseases and wars stalked the land. Mortality rates were high, not least among the very poor who even ‘at the best of times’ lived in grim squalor. The stench in hospitals was intolerable, even for a healthy person. All this meant that the criteria set for the admission of an aspirant Daughter of Charity were of crucial importance and indeed the archetypical Daughter of Charity was described as “patient, saintly, laborious, discreet, committed – and tough” (Jones 1989a, p.89).
It follows, then, that a young woman seeking admission to the congregation needed to be exceptionally robust, healthy and resilient, both mentally and physically. Another requirement was that she should have irreproachable morals, while the final, key criterion was that she should be drawn by a deeply felt religious vocation to dedicate her life to the service of the sick poor, and to this end was possessed of the requisite qualities of humility and selflessness. Moreover, in contrast to Louise de Marillac, she should be born in wedlock.

Young women with these qualities, who in seeking admission to the congregation were dubbed *aspirantes*, very often came from modest rural backgrounds. The Lazarists and the Ladies of Charity helped recruit them. Young women from the towns were considered ineligible since it was assumed that their morals were less than impeccable.

The young women who were admitted began a trial period as *postulants*. The postulancy lasted a month or longer and took place in a local community house in the postulant’s own locality. Those who satisfied this probationary period became *novices* and were sent to the motherhouse in Paris where most of their formation and training took place. In 1647, the motherhouse set up an independent seminary (novitiate) for the formation and training of the novices under a novice mistress. In 1659 and 1685, two such seminaries were established outside Paris.

For those sisters whose training and spiritual formation was complete, Louise de Marillac adopted the principle that none should be posted to her hometown, with the result that homesickness was a familiar phenomenon among the sisters. Further, sisters were regularly switched around between communities to avoid the forging of strong mutual attachments since these would distract from their dedicated task of aiding and nursing the poor. Sisters were also forbidden contact with enclosed nuns in case they were tempted to consider that form of life as an option for themselves (Dinan 2006, Jones 1989a).

**Medicine in the Renaissance**

Medicine as practised in the Renaissance delivered the framework for the sisters’ knowledge of medical lore and skills. The clinical challenges the era faced included widespread diseases such as smallpox and the plague epidemics. In addition, the period saw the emergence of new contagious diseases such as typhus (louse-borne) and syphilis.

The medical profession comprised two tiers. The ‘lower tier’ consisted of surgeons and barber-surgeons. Their speciality, ‘surgery’, was regarded as a craft, the requisite skills being acquired through an apprenticeship. Surgeons confined themselves to dealing with the surface of the body, treating conditions such as fractures, burns, tumours and ulcers by using invasive procedures. A good surgeon was defined as one who had the heart of a lion, the eye of a hawk and the hands of a woman. The battlefield was considered the school of surgery *par excellence* (Porter 1997). The upper tier in the medical hierarchy comprised the leading learned philosopher-physicians. They appropriated the fruits of Renaissance humanism with its glorification of antiquity and set about ‘rediscovering’, as it were,
And. Matthioli Comm.

Stratiotes milfolium


Millefolium Maius

Millefolium Minus

Stratiotes in bunc usque diem Millefolium cognomen retinet. Planta est officinis notassima, in aliquo proprionem, in pate, & circa feminam, lignoque calsibus, dorente maioribus, plures ab una radice productibus, quibus solis inquit suis novellarem pennam simulans, filiae frigio, cumino amala. Flores eius densiores umbellae suffletentur, candidi, etiam nonnamquam in purpurea tubectent. Ex his utique notis palam est, communius usque Millefolium null adiunct possis, quum Stratiotes, de quo hic agitur, non aitum, ubi Brasaeolum existimat. Myriophyllum insigni a Dioscoride descripserat. Sequi futer Myriophyllum cauline est tener, fugularis, unicantus radice: folis plurimis, levibus, feminulis similibus. Quem non omnino siffalor, specie fuisse est tenuis, Stratiolum hunc, & superiorum persimilium Galenus lib. vii. simplex medicamentorum, ad de utricul, arbis usus ita diversi. Stratiotes aquatricium quidem humida, & frigide facultate est: terrae acro nomum habeti substritione: puncte se, & ulteri glutinare potest, & ulceribus esse utilis. Sunt qui coeoro ad sanguinis erupitiones utantur, & alishulas.
Page from Pietro Andrea Mattioli’s work, Commentarii in libros sex Pedacii Dioscoridis
the great medical writers among the ancients such as Hippocrates\textsuperscript{14} and Galen.\textsuperscript{15} On the basis of the dictum \textit{ad fontes} [back to the sources], they embarked upon fresh translations of the ancient Greek texts, helping to promote the belief that the medical lore of antiquity was uniquely true and scholars its rightful guardians and interpreters (Porter 1997).

Hippocrates and Galen’s key to the essential causes of diseases, the pathology of the humours, thus enjoyed a revival, becoming the cornerstone of a conception of medicine as a nature-based discipline (now decoupled from medieval faith and superstition).

The pathology of the humours was extended and elaborated by Galen, building on Hippocrates’ and Aristotle’s (384-322 BC) writings. According to this theory, the world was made up of four elements: fire, air, earth and water. Similarly, the human body contained four cardinal fluids: blood, yellow bile (from the liver), black bile (from the spleen) and phlegm (from the brain). The ideal balance obtained when the body mustered an equal amount of each fluid, although in practice it was often the case that an individual would have an excess of one or more. The surplus fluid determined the individual’s temperament or character. These were likewise fourfold: the sanguine, the phlegmatic, the choleric and the melancholic.

So, with health and vitality held to be a function of the four elements, the four cardinal fluids and the pneuma inhaled with each breath, illness was regarded as a sign of an imbalance, with the elements and resultant temperament indicating

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{four-humors-zodiac.png}
\caption{The four humors in relation to the four elements and zodiacal signs. Book illustration in “Quinta Essentia” by Leonhart Thurneisser zum Thurn (gen. Leonhard Thurneysser). (Wikimedia)}
\end{figure}
where the imbalance lay. Treatments tended to take the form of herbal remedies aimed at reconstituting the body’s proper equilibrium (Gotfredsen 1964, Porter 1997, Den Store Danske 2009, Europæisk urtemedicin 2009).

The revival of the medical theories of antiquity led to a spotlight being shone on the remedies – herbal remedies – currently in use, with physicians now intent on recovering the original medicinal plants used by the Greeks and Romans, or at least on finding serviceable substitutes that could be cultivated or gathered locally. The major classical compendium of antiquity’s medicinal plants, De Material Medica, drawn up in the first century AD by the physician Pedanios Dioscorides, became the subject of intense scrutiny. However, climatic differences between the Eastern Mediterranean, where antiquity’s medicine evolved, and Northern Italy or Central and Western Europe meant that neither the medicinal plants that could be cultivated nor those that could be gathered in the wild were necessarily identical to those referred to in Dioscorides’ work.

This focus of interest led to a botanical renaissance, which in turn had implications for the practice of pharmaceutics. The Italian physician Pietro Andrea Mattioli (1500-1577) put recent findings into systematic order by writing “commentaries” on Dioscorides. This book, embellished with more than 500 lifelike woodcuts
of plants, first appeared in Italian before being translated into Latin and several other languages. It passed through 60 editions with roughly 35,000 copies printed all told.

Mattioli’s work was followed in the sixteenth century by a number of others, including those authored by, respectively, Otto Brunfels (1488-1534), Hieronymus Bock (1498-1554) and Leonard Fuchs (1501-1566), all featuring original woodcuts of a high standard. The endeavours involving the identification and cultivation of medicinal plants were also systematized in the earliest botanical gardens (at the respective universities of Pisa (1544), Padua and Florence (1545) and Bologna (1567)). Although in the seventeenth century, herbals were beginning to be replaced by specialist botanical works and pharmacopoeias, popular herbals continued to appear (Den Store Danske 2009, Ib Friis - Pers. com.). Expertise in the cultivation of medicinal plants was thus of crucial importance in contemporary treatments (Porter 1997). The reinterpretation of the therapeutic methods of antiquity did not, however, substantially change the routine methods of treatment developed in the Middle Ages and which were still in use, such as, for example, bloodletting, the application of leeches and administration of enemas.16

Moreover, anatomy was on the brink of becoming an established discipline, thanks in no small part to the artists of the Renaissance, Leonardo da Vinci (1452-1519) and Michelangelo Buonarroti (1475-1564) in particular. Fascinated by the form of the body, they developed the life-like, naturalistic technique that was such a striking feature of the illustrations that accompany the sixteenth century’s anatomical texts. A notable example is the anatomist Andreas Vesalius’ (1514-1564) famous work De Humani Corporis Fabrica [On the Workings of the Human Body] of 1543. This work’s remarkable illustrations of the dissected body posing in elegant and realistic postures are attributed to the artist Jan Stephan van Calcar (1499-1546c.) It should perhaps be mentioned that the anatomical studies were carried out on the corpses of executed criminals. The Church had no objections to this practice provided the criminals ultimately received a Christian burial.

The studies of human anatomy made it abundantly clear that anatomy and surgery needed to be integrated into learned medicine. Rather than simply engaging in speculative theory, doctors needed to be more hands-on. The road to sound medical knowledge lay in the dissection of dead bodies – those of humans as well as of animals. In this realization lay the future development of medical science as we know it today (Gotfredsen 1964, Porter 1997).

Training in Nursing

With this brief excursus into Renaissance medicine at an end, our focus returns to the training of the Daughters of Charity. Only after the successful completion of their novitiate did they begin their training in the theory and practice of nursing. This systematic training programme was complemented by a course of formation in the spirituality of the congregation.

The sisters’ training in nursing (and medicine) included practice in the delivery of home nursing, the relevant skills being acquired through hands-on experience in
the homes of the poor, as well as experience of hospital nursing acquired through caring for sick and elderly sisters. Further, in accordance with contemporary medical practice, the sisters were trained in apothecary skills. This training was carried out in the motherhouse’s dispensary, where sisters learned to cultivate, treat/ process and use medicinal plants, and to perform various techniques such as the application of leeches. Lastly, the sisters were taught general housekeeping skills, cooking, kitchen gardening and stockmanship.

Complementary to this, the sisters also learned to live in accordance with the spirituality of the congregation, so that it would become a perceptible reality both within the community and in the sisters’ interactions with the wider world. To this end, weekly meetings of the sisters were held, aimed at fostering a sense of community and unity of moral purpose. These might take the form of an examination of conscience led by Louise de Marillac or of conferences delivered by Vincent de Paul.

This spiritual component was very important to the Daughters of Charity since they neither could (nor indeed should), as did cloistered nuns, devote themselves to contemplation in a quest for perfection. Instead, they were to balance contemplation and the service of the poor, and this complementarity – of spiritual and apostolic engagement – was something the sisters were to learn in the course of their formation. The essence of their spirituality was a commitment to following in the footsteps of Christ and of seeing the recipient of their ministry as Christ himself: to see the crucified Christ in the bedridden invalid.

This reconceptualization of the consecrated life for women religious pushed the parameters of traditional understandings. Up to this point, concern for the weak had always been subordinated to the search for personal holiness. By contrast, a Daughter of Charity was always to give first priority to the sick person who called for her, even if it meant interrupting her prayers, since she was “to leave God for God” (Purcell 1989, p. 144). The patient took priority, not because he or she was more important than God but because he or she ‘was’, in a sense, God himself. Following the example of Jesus, the sisters were to seek out the sick and minister to them.

By means of such maxims, Vincent de Paul and Louise de Marillac valorized manual labour. Practical nursing became spiritualized toil. Corporeal/material aid and spiritual needs became inextricably interwoven. The Company’s rules prescribed that sisters were not only to serve the poor through the provision of corporeal care and the distribution of food and medicine but also in spiritual matters. Since they were to remain unflaggingly committed to bringing those they served closer to the true faith, there was nothing incongruous about the ritual washing of the patient’s feet taking precedence over the nursing of the body. In the provision of nursing care, the individual’s salvation was of crucial importance. So from a broader perspective, the extent to which the sisters contributed to an ambitious goal – formulated by the Church – which was the evangelization of those at the margins of society, needs to be recognized.
Daughters of Charity at work in the dispensary, artist and date unknown. (Reproduced with the permission of the Daughters of Charity of St Vincent de Paul, Paris)
Daughters of Charity serving soup to patients, artist and date unknown. (Reproduced with the permission of the Daughters of Charity of St Vincent de Paul, Paris)
one. A roughly nine-month formation period was required to equip them for their mission.

Life as a Daughter of Charity was hard, but so it was for all single women at the lower end of the social spectrum in the early modern period. The benefits to the individual sister included membership of a community on which she could depend for the rest of her life. She had a home, a stable income, clothes to wear, security in old age and a better social position than might otherwise have been her lot (Jones 1989a and 1989b).

**The Habit**

The design of the habit was no casual decision on the part of Louise de Marillac and Vincent de Paul. A variety of considerations determined this choice since the sisters’ appearance in the public realm was important to the long-term success of the new congregation.

They opted for the simple costume of peasant farmers’ wives in the version worn in the Paris region. This modest outfit would serve as a reminder to the sisters that they had dedicated their lives to the service of the poor while at the same time ensuring that they were not mistaken for enclosed nuns. In contrast to the farmers’ wives, whose costumes would sport individual features, the sisters’ habit would be one and the same for all, underscoring a common identity (Dinan 2006).

A further consideration favouring this choice was that it would afford the sisters easy access to the poor by enabling these latter to perceive the sisters as their equals at the bottom of the social hierarchy. And lastly, the costume, like the widow’s costume of the time, would enfranchise them to circulate freely in the public realm. The individual sister could not, however, as widows might, roam at will. She was dispatched by the motherhouse: here it was decided where she would live and work. A sister’s circulation in public space was in that respect – like that of a farmer’s wife – determined by specific needs and demands (Dinan 2006).

Political considerations too played into the design of the habit. It was crucial that the sisters should have access to those needing their help, and the habit ensured that they conformed to contemporary norms governing appropriate female conduct in relation to social class. So not only did the sisters not transgress contemporary social conventions, they helped consolidate them (Dinan 2006).

The habit of the first sisters consisted of a white-collared, grey serge dress with a white linen scarf forming a headpiece, to be worn if circumstances required. This resulted in their being referred to as ‘the Grey Sisters’. It took the sisters some time to reconcile themselves to the plainness of the habit. They were not short of ideas as to how it might be improved but Louise de Marillac rejected most of them. They did, however, succeed in getting the headpiece altered on health grounds. Since it provided no protection against rain and cold, a bonnet was added to the habit, again, of the kind worn by farmer’s wives. Moreover, the bonnet was to be of a standard design so that all the sisters continued to be identical in dress (Dinan 2006, Kuhns 2003).
This introduction of a headpiece marked the beginning of the transition to the cornette, which over time became the symbol and ‘trademark’ of the Daughters of Charity across the world. It was in 1750 that the cornette acquired its eye-catching starched wings, probably intended to imply that their wearer was protected and

*The St. Vincent Sisters Louise and Laënnec, working in Denmark c. 1960. (Andersen et al. 2005 p. 27)*
shielded from all worldliness while at the same time suggesting an association with higher things. Over time, the colour of the habit changed from grey to blue (Dinan 2006, Kuhns 2003). The sisters wore this habit until 1964, when it was re-designed along more modern lines, with the cornette giving way to a simple veil (Katolsk Ugeblad 1964a).

**Home Nursing and Hospital Nursing**

The primary task of the Daughters of Charity was to care for the sick in their homes in the poorest districts of Paris. Indeed, that the delivery of nursing care in the home was a wholly new phenomenon is illustrated by a passage in a letter written to the Daughters of Charity:

*Up to the present, nobody has ever seen the sick poor nursed in their own homes. ... this work was reserved for you. You were destined by God from eternity to be numbered amongst the first.* (LaFleur 1996, p. 58).

In 1638, the Company expanded geographically, with the setting up of the first establishment (community) of nursing sisters outside Paris. Other similar establishments soon followed. A strictly enforced rule governing the creation of establishments of sisters dedicated to nursing care in the home dictated that sisters should never be sent out singly – a sister community would comprise at least two sisters.

Soon the sisters began working in a wide variety of institutions including schools, children’s homes, prisons, lunatic asylums and hospitals. While the Company itself founded some of these, others were institutions that employed the sisters in a managerial capacity. Over time, hospitals, not least, came to be a major employer of the sisters (Dinan 2006).

Throughout the Middle Ages, one of the functions of hospitals (and monasteries) was, as noted above, to offer shelter to travellers and pilgrims, to succour and protect the poor, orphans, the old and infirm, and to nurse the sick and dying. In the course of the seventeenth century, this system underwent sweeping reforms. Many small (local) parish hospitals closed, and instead a large number of poorhouses, the so-called hôtitaux-généraux, where the undeserving poor were ‘warehoused’ were opened; further, the number of Hôtels-Dieu hospitals where the sick were treated increased significantly (Hickey 1997).

The founding period of the Daughters of Charity in the seventeenth century spanned the transition phase between the old and the new hospital system. Accordingly, there were three types of hospitals where sisters offered their services: local hospitals (usually attached to a parish) which cared for the parish’s poor, old and sick, Hôtels-Dieu hospitals, which cared for the sick and were open to all (except for cases of certain diseases) and finally, the workhouses – the hôtitaux-généraux (Dinan 2006).

Initially, Louise de Marillac was opposed to – indeed, sought to prevent – the employment of sisters in hospitals. One reason for her opposition was the fact that the hospitals of the time were notoriously filthy and immoral institutions. Further,
she felt that hospital employment would distract the sisters from their primary ministry, the care of the sick poor in their own homes, which were much safer environments for invalids than hospitals. Moreover, in a hospital the sisters would not come into contact with those so ashamed of their poverty that they would never approach such an institution (Dinan 2006).

Her reservations were further reinforced by her low opinion of the competence and skills of doctors and surgeons, and she was apparently not alone in her scepticism. When her son fell ill in 1651, Vincent de Paul wrote to her urging her to take medical advice.

...people think that doctors kill more patients than they cure... Nevertheless, when one is ill, one should be submissive to the doctor and obey him. Perhaps, Mademoiselle, what you consider harmful is really good for him (Dinan 2006, p. 103).

Louise de Marillac remained unconvinced. And given her lack of faith in the medical profession, it was difficult for her to view its members as professional partners. Moreover, she saw medical treatment and nursing as two sides of the same coin and her sisters’ training embraced both. The rules of the congregation clearly attest to this, by describing in detail how sisters were to reach a diagnosis and begin a course of treatment, as exemplified by the following precept:

When the fever persists they shall let blood from the patient’s foot, then begin once again to let blood from the arm until the fever goes down. The sisters shall be very careful not to administer any remedies while a patient is shivering or sweating (Dinan 2006, p. 105).

This indicates that the sisters treated disease by using both invasive techniques and medicinal remedies. We may also conclude that the apothecary sister played an important role in the community in that it was she who prescribed the correct medication for the sick and decided when a doctor should be called. There is, then, every reason to believe that the sisters were conversant with current medical discourses and practices. But the ultimate ownership of these practices was in dispute. Sisters and physicians (doctors and surgeons) were in several instances at odds with each other in matters concerning treatment (Dinan 2006, Jones 1989b).

Nursing versus Medicine

The historian Colin Jones (1989b) points out that in much of the research on the nursing carried out by the Daughters of Charity, the allegation is made that the sisters were more concerned to save souls than to ensure good physical care and treatment (a view also held by Florence Nightingale). Even though the sisters, as noted earlier, placed a strong emphasis on the spiritual aspects of their care, Jones dismisses this slur as anti-Catholic propaganda, which, over time, imperceptibly assumed the status of truth. The same is true, in his view, of popular conceptions of the sisters that associated them with quackery, superstition and charlatanism: a view that the medical profession, as it became more established in the nineteenth century, was content to perpetuate. The fact of the matter is, however, that the Daughters of Charity, who, as already noted, practised medicine within the same
Daughters of Charity letting blood from a patient, artist and date unknown. (Reproduced with the permission of the Daughters of Charity of St Vincent de Paul, Paris)
Daughter of Charity sweeping the floors, artist and date unknown. (Reproduced with the permission of the Daughters of Charity of St Vincent de Paul, Paris)
frameworks of medical understanding as doctors and surgeons, had considerably more clinical experience than doctors ever mustered over the course of their training. It also needs to be borne in mind that the difference made by a course of treatment once a person had fallen ill was limited, a hard truth covered by the two professional constituencies’ respective dicta to the effect that ultimately Nature/God disposes.

It was stated in the Daughters of Charity’s rules and again in the various contractual agreements set up that sisters were to follow doctors’ prescriptions and instructions, but in fact, many of the hospitals in which the sisters worked were not served by doctors or surgeons, or by few at best. Indeed, doctors failed to take their obligations to the hospitals for the poor very seriously. That attitude changed in tandem with the development of medicine as a science-based clinical practice in which hospitals played an important part.

A measure of early interprofessional rivalry probably sprang from the fact that the fields of these two groups of practitioners, sisters and doctors, overlapped. So in addition to their respective bids for public recognition there was an underlying gender and power struggle going on over professional demarcations in an evolving health system (Jones 1989b).

The Hôtel-Dieu d’Angers

Louise de Marillac gradually dropped her opposition to the employment of sisters in hospitals and in 1640 entered her first contractual agreement to supply sisters who, in addition to delivering nursing care, would take on the day-to-day running of the hospital Hôtel-Dieu in Angers (one of France’s oldest hospitals, its founding dating back to 1175). The other party to the agreement was a group of hospital administrators, four laymen who called themselves ‘the Fathers of the Poor’. Their appointment by the authorities was no index of their qualifications, however. Indeed, since what the hospital needed above all was a reliable, well-trained, affordable workforce, the arrival of nursing sisters must have been seen as something of a godsend. And given that the hospital was in an appalling state in every respect – recall here the description of the hospitals of the period given above – the sisters’ first task was to effect a thorough physical and spiritual cleansing of the entire establishment and its occupants (Dinan 2006).

The sisters were responsible for the day-to-day management of the hospitals and the nursing of the sick, except for patients with venereal disease and pregnant women (Dinan 2006). These latter were under the care of the midwife, who was authorized by the Church to administer baptism in casu necessitatis (emergency baptism), which confers on the infant sanctifying grace: an important provision given the high mortality rate at the time (Savona-Ventura 1995, Catholic Encyclopedia 2009).

The Fathers were well apprised of the fact that the sisters were trained in the use of herbal remedies which they prepared themselves, and that they performed minor procedures such as blood lettings and the like. These sisters, along with those posted elsewhere, maintained a regular correspondence with Louise de Marillac.
in order to keep up with developments in the medical world. Louise de Marillac wrote, for instance, to a highly skilled sister in another congregation:

*I beg you...to teach our sister how to let blood. Especially teach her well the dangers involved with the arteries, nerves and other areas. Remember, if you think you have opened an artery, to draw a great quantity of blood and to put a coin in the compress in order to make the ligature* (Dinan 2006, p. 107).

Of equal importance was the task of providing patients with spiritual counselling. Angers lay in a Protestant area, and in deciding to employ the sisters it was probably not irrelevant that the hospital’s administrators were thereby assured not only of a competent medical approach to treatment and care but also of the presence of a formative Catholic influence and the availability of spiritual counselling. Indeed, the sisters were instrumental in bringing about a number of conversions from Protestantism.

The upshot, then, was that, the hospital in Angers was thereafter able to deliver competent treatment and nursing care to its patients in a setting shaped by Catholic values. However, given the ambiguities of the employment contract regarding provisions for the sisters’ distinctive form of life and organization, problems arose. There was a lack of clarity over the respective parties’ roles and expectations. The sisters expected to have time for their devotions but little allowance was made for this. The sisters were seriously exploited as cheap labour: their workload was onerous and took a heavy toll on the health of many. But despite this, they remained at the hospital in Angers, their numbers constantly increasing. Louise de Marillac, for her part, kept a close eye on the situation and had numerous clashes with the Fathers of the Poor over the sisters’ responsibilities and workloads. The Fathers, meanwhile, continued to importune Louise de Marillac to send more sisters to the hospital while at the same time placing sisters in positions that had very little to do with the care of the sick.

<table>
<thead>
<tr>
<th></th>
<th>1600</th>
<th>1640</th>
<th>1648</th>
<th>1670</th>
<th>1793</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>1.400</td>
<td>2.400</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daughters of Charity</td>
<td>8</td>
<td>10</td>
<td>14</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeons</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Aids</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Servants (incl. cooks, butchers, and gardeners)</td>
<td>46</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washerwomen</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vineyard workers</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day laborers (an ever changing body)</td>
<td>?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Table 1: Numbers of patients, sisters and other staff at the hospital in Angers 1640-1783* (Dinan 2006, p. 110-111).
Table 1 gives a somewhat incomplete survey of the number of patients, sisters and other staff at the hospital in Angers. Zeroing in on the year 1645, we may note that a mere ten sisters were responsible for the care and treatment of 1,400 patients annually in an as yet imperfectly defined partnership with just one surgeon and one doctor. In addition, they were responsible for the management of a large and complex staff, which was surely indispensable to the functioning of the hospital as an independent institution.

The Daughters of Charity cut their professional teeth in Angers, putting what they had learned there to good effect when setting up subsequent contracts with a wide range of hospitals, large and small (Dinan 2006, Jones 1989a).

In 1660 – the year preceding the death of their founder – the Daughters of Charity were running 18 hospitals. By 1700, they were in charge of 72 more, apparently going from strength to strength since it is known that between 1750-1790 some 54 more were added to the tally. This intensity of focus on hospitals owes much to the Company’s second generation of leaders who – perhaps partly on account of the loss of the charismatic founders but also because the congregation was growing so rapidly – opted for a more bureaucratic and less flexible leadership style. This led to their placing sisters in large hospitals rather than in small establishments devoted to the delivery of nursing care in the home. In 1660, there were roughly 100 communities of sisters. In 1711 there were 250, scattered across the whole of France and Belgium – communities whose sisters served in a wide array of institutions, including schools, children’s homes, home nursing services and hospitals (Dinan 2006, Jones 1989a).

Johannes Beerblock’s painting “The Old Sick Ward of St John’s Hospital, Bruges” 1778, depicts Augustinian sisters tending the sick. (Musea Brugge, Belgium)
Both founders of the Daughters of Charity died in 1610. Posterity would hail Vincent de Paul as "the first social worker", an accolade which is wholly merited considering that the creation of the Company of the Daughters of Charity was just one of his social-caritative enterprises (Jones 1989a). It is only more recently that Louise de Marillac has been recognized as a co-founder of the Daughters of Charity, but present-day historiography fully acknowledges her key role. The Catholic Church has canonized both: St Vincent de Paul in 1737 and St Louise de Marillac in 1934 (The Vincentian Encyclopedia 2009). Their charitable endeavours were wide-ranging and groundbreaking. Today both are widely regarded as being among the most striking and significant figures that the seventeenth century produced (Dinan 2006).

**Concluding Remarks**

It is wholly justified to claim that the founding of the Daughters of Charity marked a watershed in the history of nursing, given that this congregation pioneered formal training in nursing – and by so doing launched nursing as a profession as early as 1633.

The Daughters of Charity blazed an inspirational trail for the creation of a variety of nursing congregations in France, which, like their prototype, organized themselves precisely as religious congregations dedicated to active ministry, aiding society’s poor, sick and needy. Collectively, these congregations transformed the provision of health care in France. They turned hospitals into safe, clean environ-
ments, and responded to the corporeal and spiritual needs of the poor in a professional and compassionate manner. Such claims echo those that led to Florence Nightingale’s acclamation as the foundress of modern nursing in the nineteenth century. Few are aware, however, that similar initiatives had been pioneered in the seventeenth century (Dinan 2006).

The Reformation, which split the European continent into Catholic and Protestant areas, is central to this story. It led to the suppression of the monasteries in the lands or areas where Protestantism took hold, thereby removing at a stroke the care for the sick poor that religious orders had traditionally provided. In Catholic countries, a similar situation obtained in that the Counter-Reformation’s imposition of clausura on all nuns meant that they could no longer work beyond the convent walls. The Daughters of Charity were thus founded at a time when nursing provision in Europe was at an absolute low (Dinan 2006). But together with other nursing congregations, they turned the situation around in Catholic countries. Protestant countries had to wait until 1836 to see similar initiatives emerging. These took the form of the creation by the Lutheran pastor Theodor Fliedner (1800-1864) and his wife Frederike Fliedner (1800-1842) of an institute for Lutheran deaconesses and a hospital that incorporated a school of nursing, thereby establishing a Protestant counterpart, in Kaiserwerth, to the Catholic nursing congregations. Within a few decades, the deaconess movement had spread to other Protestant countries and areas in Europe. In the 1850s, Florence Nightingale began to pull together the threads of what she had learnt from the nursing traditions of Catholic sisters and Protestant deaconesses, after having worked alongside both. With this as her framework, she pioneered a secular (albeit religious in origin) nursing training programme at St Thomas’ Hospital in London in 1860, a programme that would rapidly spread across the world. It is important, however, that the contribution made by the Daughters of Charity not be forgotten: they were an important source of inspiration for Florence Nightingale when she articulated her vision of nursing as a profession and set out the key elements essential to any training programme for nurses (Nelson 2001, Malchau 2008).

Epilogue: Catholic Nursing Congregations in Denmark

Establishment and Active Ministry

In the nineteenth century, Catholic nursing congregations began to proliferate across the globe with the dual purpose of ministering to the poorest in society (nursing and teaching) and evangelizing for the Catholic Church.

When Denmark saw the introduction of constitutionally protected freedom of religion in 1849, the way lay open for Catholic sister congregations to extend their ministry to Danish shores. The first congregation – the nursing congregation of the Sisters of St Joseph of Cambéry in the Savoy – arrived in the country in 1856. In the period to 1935, ten further Catholic nursing congregations established themselves on Danish soil. For these congregations, hospital nursing and administration was the overriding focus area. Seven of them were responsible for the founding and
St Joseph Hospital in Copenhagen 1905. (The Copenhagen CSJ Archives)

The operating theatre at St Joseph Hospital in Copenhagen 1905. (The Copenhagen CSJ Archives)
management of 17 hospitals in Denmark, jointly accounting for 10 per cent of the country’s hospital beds.

**The Sisters of St Joseph**

The Sisters of St Joseph was the leading religious congregation in Denmark. They owned eight hospitals, a string of clinics and several large schools. In 1940, when the congregation’s activities were at their peak, there were 524 sisters in the country, accounting for two thirds of the sisters in active congregations in Denmark (Dietz 2009). The hospitals owned and run by the Sisters of St Joseph continued to be an important component of the Danish health system until the 1960s. The expansion of public sector hospitals and the decline in sister numbers led to their closure – the last closing in 1990. Today there are roughly 60 sisters in Denmark, whose activities are targeted towards responding to the ‘spiritual poverty’ of contemporary society. In 1985, there were approximately 25,000 St Joseph Sisters in different congregations across the world.

Today (2016) there are 30 sisters in Denmark, whose activities are targeted towards responding to the ‘spiritual poverty’ of contemporary society. In 1985, there were approximately 25,000 St Joseph Sisters in different congregations across the world. Today, the number of sisters is still considerable: roughly 14,000 sisters are active in the USA, France and 50 other countries. However, numbers are in decline since far fewer women in modern Western society choose this vocation (Malchau 1998 og 2004, Malchau & Nilsen 2004, Nielsen 2015, Wikipedia 2016).

![Image](image_url)

*The Prioress Provincial of the St Joseph Sisters in Denmark, sister Marianne Bode and the author of this book, Susanne Malchau Dietz, May 2013.*
The St Vincent Sisters

In 1904, the Daughters of Charity opened a house in Denmark, referring to themselves as the “St Vincent Sisters”. For the St Vincent Sisters, in contrast to the Sisters of St Joseph, Denmark was never a major focus area.

The St Vincent Sisters came to Denmark through the intervention of the widowed countess Marie-Louise Moltke Huitfeldt. The countess became acquainted with sisters in Paris in 1900 and was prompted to apply to their superior general to send sisters to Denmark. The request was initially declined but when, in 1903, French law forbade the teaching of children by religious, it meant that there were sisters who were surplus to requirements. In 1904, four sisters – having completed courses in nursing and Danish – were sent to Denmark. They settled in Elsinore (Helsingør), as did certain Lazarist priests in the same year who came to be known in Denmark as St Vincent priests. The sisters contacted the town’s doctors and, to general surprise, began to offer home nursing care without charge in people’s homes. Visiting the sick and the poor in their attractive habits, the sisters soon became familiar figures in the townscape. In the decades that followed, the sisters opened a Catholic school, a children’s home and a nursing home. From the 1980s onward, the sisters devoted themselves primarily to pastoral work both within the local Catholic community and beyond (Andersen et al. 2004, Nordisk Ugeblad 1904, Katolsk Ugeblad 1964b).

After more than a century’s work in the country, the last remaining three sisters...
belonging to the congregation left Denmark in May 2006. Internationally, the Daughters of Charity are still an active presence. In the 1950s there were 40,000 sisters distributed across various congregations the world over. Today the number is still considerable – roughly 20,000 across some 91 countries – but their numbers are in decline for the same reasons as in the case of the Sisters of St Joseph (Dinan 2006, Daughters of Charity 2009).
Notes

1. The Renaissance (French: rebirth) is the term used to describe a cultural period that began in fourteenth century Italy. It should be borne in mind, however, that it is an elusive and contested concept. It is sometimes used in a broad sense to designate the transition from the Middle Ages to the modern period (Pade and Jensen 2004). In the history of medicine it tends to be defined (as in Porter 1997) as the period spanning the fifteenth and sixteenth centuries, a period during which artists and philosophers were much preoccupied with the beauty of the human body and the nobility of the human spirit. Their insatiable curiosity about the body rubbed off on the learned physicians of the time, who followed the artists in re-appropriating the classics, which, for them, were the iconic medical names of antiquity.

2. The Reformation is the term used to designate the transition from Catholicism to Protestantism in Northern Europe. It began in Wittenberg, Germany where, in 1517, the monk Martin Luther (1483-1546) wrote 95 theses attacking the Roman Catholic practice of indulgences. He rejected the whole idea of justification by works, and not least the notion that salvation could be gained through the purchase of indulgences. Salvation depended on grace alone, and the rewards attendant upon diligence were signs of divine grace. The Reformation took hold in Denmark in 1536. With Roman Catholicism outlawed, the Evangelical Lutheran Church became the established church and Lutheranism the only permitted religion. The Counter-Reformation, which began with the Council of Trent in 1545, marked a period of revival in the Catholic Church, in part in reaction to the Reformation (Lausten 1997).

3. Clausura designates both the practice of enclosure and the portion of a monastery or convent from which egress for the religious is regulated by a set of precepts or rules and ingress by outsiders is not permitted (Clausen 1994). As noted in the text, the rules of enclosure were very strict in the sixteenth century as a result of certain Tridentine decrees.

4. The section on the Council of Trent draws on my article “Nonneliv på San Cataldo i renæssancen” [Convent Life at San Cataldo during the Renaissance] (Malchau 2006), where the conditions described were those that obtained in Italy, more specifically, in the kingdom of Naples and the city state of Venice. The following sources were consulted: Laven 2003, Black 2004, Hill 2004 and the Catholic Encyclopedia 1986.

5. In sixteenth and seventeenth century France, Huguenot was the term applied to a member of the (Protestant) Reformed Church of France. A precursor of certain Huguenot ideas was the pro-reform Roman Catholic Jacques Lefevre (c. 1455-1536). The Huguenots were essentially Calvinists (Wikipedia 2010).

6. While the Edict of Nantes of 1598 established Roman Catholicism as the state religion in France, it also granted (with certain restrictions) Protestants (Huguenots) free exercise of their religion, their own churches and pastors, as well
as the same civil rights as Catholics (Lausten 1997).

7. In the text, the term the Ladies of Charity is used of both the Confréries de la Charité (the Confraternities of Charity) and the Association des Dames de la Charité (the Association / Company of Ladies of Charity). It needs to be pointed out that these are in fact two distinct associations. The first Confrérie de la Charité was founded in 1617 and was an association of well-to-do ladies who aided the sick poor. The Association des Dames de la Charité was founded in 1634 and was an association of noblewomen who took it upon themselves to give spiritual guidance to patients at the Hôtel-Dieu hospital in Paris. Together with the Lazarists, the Ladies of Charity played a key role in the organization, supervision and expansion of the Company of the Daughters of Charity, both in its founding phase and beyond (LaFleur 1996, Jones 1989a).

8. The Capuchins were founded in 1525 as a reformed offshoot of the Franciscan Order. The name is a reference to the pointed cowl, the “capuche”, worn by its members. The austerity of their rule led to their playing a prominent role in the Counter-Reformation. The order of Capuchin nuns, the Capuchines, was founded in 1538 (Wikipedia 2009).

9. In Roman Catholic terminology, the term ‘sister’ is used of women in religious congregations with an apostolic ministry, as for example, a nursing congregation like the Daughters of Charity. The designation ‘nun’ is reserved to members of enclosed or contemplative orders (Carey 1997). Consequently, I refer to the Daughters of Charity as sisters throughout.

10. I refer throughout to the La Compagnie des Filles de la Charité (which has the status of a confraternity) as the Daughters of Charity. However, in the Danish literature they are also referred to as ‘De Barmhjertige Søstre’ [the Sisters of Mercy]. The Daughters of Charity working in Denmark, who first came to the country in 1904, are known as the Sankt Vincent Søstrene [the St Vincent Sisters] (De kvindelige ordenssamfund i Danmark [Women Religious in Denmark] 2001).

11. The entire section entitled “Ecclesiastical Approbation” is based on Dinan 2006 and Jones 1989a.

12. The entire section entitled “Leadership and Organization” is based on Dinan 2006 and Jones 1989b.


14. Hippocrates (c. 460 – c. 370 BC) was a physician living in the Mediterranean Greek island of Kos. He founded the Hippocratic school of medicine and revolutionized Greek medicine by establishing it as a distinct discipline (and profession), separate from philosophy and theology (Porter 1997).

15. Galen /Aelius Galenus or Claudius Galen (129 – c. 370 AD) was a prominent physician in antiquity. He was one of the most celebrated biologists and doc-
tors of his era and penned one of antiquity’s most renowned scientific works. Notably, he contributed to and extended Hippocrates’ medical system. Moreover, his studies involved the dissection of animals (apes and pigs), which resulted in his extrapolating (sometimes erroneously) to human anatomy and physiology. The dissection of humans was forbidden at that time (Porter 1997, Wikipedia 2009).

16. My thanks are due to Professor Ib Friis, University of Copenhagen, Denmark, for valuable information on botany in the Renaissance.

17. The entire section entitled “Nursing Training” is based on Jones 1989a and 1989b.

18. The Hôtels-Dieu, the principal hospitals in the towns, were established in the Middle Ages. In the course of the seventeenth century – the period which saw the founding and expansion of the Company of the Daughters of Charity – these hospitals shifted their focus from being care institutions for the sick poor to offering treatment to the sick, wounded and dying. In this same period, the hospitals began setting up contracts with doctors and surgeons in order to ensure that patients were seen and treated. It was only in the eighteenth century, however, that hospitals generally could count on the presence of doctors. In the same period, religious nursing congregations assumed responsibility, to a very considerable extent, for the care of patients in these hospitals (Hickey 1997).

19. The findings of recent research strongly suggest that sisters were conversant with current medicine. This familiarity is evidenced in the care and treatment they provided, as reflected in particular in the links between diet and treatment, pharmaceutical practice and operations (Jones 1989b).

20. The congregation of the Sisters of St Joseph was founded in the seventeenth century and emerged from the same set of motivations as led to the setting up of the Daughters of Charity. Indeed, there are many similarities between their founding histories. The congregation, which took its name from St Joseph, who selflessly cared for Mary and Jesus, was founded in 1646 in Le Puy in southern France by the Jesuit Jean-Pierre Médaille (1610-1669), and received the Church’s official approbation in 1650. The sisters’ habit was modelled on the widow’s costume of the time: this allowed sisters to circulate in the public realm without a male escort. The sisters lived in small communities located among those whom they sought to help. They made vows annually and strove to live in imitation of Christ by helping society’s poor and needy. By 1700, the congregation had houses across the whole of France (Byrne 1985, Malchau 1998). The congregation’s earliest constitutions, of 1646, indicate that nursing was from the outset an important field of activity. They will devote themselves, as far as leisure permits, to all the works of corporal mercy for which they will have particular instructions, and to all the spiritual needs of the dear neighbour, the sick, the poor and others, for which they will also have a directory (Original Documents translated 1975).
Literature


Hill, Helen (2004): Invisible City. The architecture of devotion in seventeenth-cen-


Katolsk Ugeblad (1964a): “I september udskifter 45.000 Vincentsøstre deres hidtidige dragt […]”. 38: 3.


Nielsen, Lasse Ryum. “Hjælp vor kommende generationer til at tjene dig og kirken”. Kristeligt Dagblad, 9.2.2015


Practice in Malta”. Medical History, 39:18-34.

Proceedings – First Danish History of Nursing Conference. Aarhus: Department of Nursing Science, Aarhus University, s. 137-150.


St Vincent Chruch in Helsingør, Denmark.


Danish Museum of Nursing History
Sankt Annæ Plads 30, 1250 Copenhagen K
Phone +45 76 32 76 76
Mail: museum@dshm.dk