2

Medicine and religion

Joris Vandendriessche and Tine Van Osselaer

On 1 October 1928, a community of women religious arrived in Leuven to run the newly built Institute of Cancer, the first of a series of institutes that made up the St Raphael Hospital of the Catholic University of Leuven. Like all monastic communities of the Sisters of Charity of Jesus and Mary, it kept a memorial book to chronicle exceptional events: the consecration of a baptismal font in the maternity ward, the thousandth patient of the Institute of Cancer, the visits from royalty and bishops to inaugurate new hospital buildings, the anniversaries of sisters' vows, etc. The book evokes a community drawing strength from faith to offer medical care as a form of missionary work. 'The shrine [in the chapel]', Mother Superior wrote in 1934, 'infuses life and generates energy for divine Charity to rule and spread'. The book is a telling record of the interwoven histories of Belgian medicine and Catholicism. Entries from the 1930s adopt a militant and expansionist rhetoric at a time of Catholic Action, the movement to re-Christianise society in the face of secularisation: 'Charity is victorious and St Raphael dreams of an ever-growing place under the blue sky.' Later entries point to public practices of devotion in healthcare. In 1955, a statue of Mary with child was placed on the monastery's facade, 'which one can see from a long way and seems to reassure the ill who are on their way to the clinic.' In 1958, a procession of doctors, patients, nurses and sisters – together more than 450 people – made its way across the hospital buildings and inner courts, praying and carrying candles to celebrate the beginning of May, the month of Mary.[1]

The women religious' memorial book hints at the importance of religious beliefs and practices in Belgian medicine and healthcare.[2] Such importance should hardly come as a surprise: up until the 1960s, when the speed of secularisation increased, Belgium was a

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profoundly Catholic country. For most Belgians, the experience of illness and medical care was closely connected to their (Catholic) faith. For many doctors and caregivers as well, religion occupied an important position in the way they conducted their professional lives. Recent historical analyses have gradually come to acknowledge this relation between medicine and religion. These histories follow an international trend in moving from a representation of both domains as 'opposites' to narratives of interaction and collaboration. In that sense, they break with older representations of the physician as a modern substitute for the priest, or of the lay nurse as a replacement for sisters and friars – representations that imply an understanding of medicalisation and secularisation as mutually reinforcing processes.[3] Historians have also started to paint a broad picture of the place of ideology in medicine that goes beyond the political conflicts between liberals, socialists and Catholics over the provision of medical care.[4] Within an older historiography, attention to the imagery that was used in political strife (i.e. of the rise of modern medicine going hand in hand with the secularisation of medical institutions, e.g. of lay nurses replacing nuns), had precisely underpinned an oppositional reading of the relation between medicine and religion.

Recent historical scholarship has started exploring the variety of interactions between the medical and religious fields. These could lead to conflict, but also to productive exchange.[5] Entries from the memorial book of the Sisters of Love reveal women religious' pride in working within 'modern' equipment and in 'up-to-date' hospitals. In 1932, the order took over the St Elizabeth School for Nursing, founded in 1922 in Leuven. In 1939, it opened a college for 'nursing instructors'. Both were spaces where a Christian tradition of care, morality and responsibility was integrated into the professional training of (lay) nurses. While the order faced the effects of secularisation, with diminishing callings and with the resulting decision in 1966 to leave the Leuven hospitals, the development of Catholic nursing education gained traction. At the college's twenty-fifth anniversary in 1964, 'the formation of a Christian senior staff of nursing, who devote themselves to mankind and the Holy Church' was seen as its major achievement. A narrative of lay nurses merely replacing women religious as care providers does not fully do justice to this trajectory. As Barbra Mann Wall has shown for American

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religious congregations, women religious acted as 'entrepreneurs' over the past two centuries in developing modern healthcare.[6]

In taking stock of this historiography, this chapter attempts a varied overview of the historical relation between medicine and religion in Belgium. To an extent, this is an exercise in balancing out a too strong political reading of the history of healthcare, which has focused on strive or compromise between oppositional forces, with more attention to 'productive' intellectual encounters. To develop the latter perspective, the chapter draws on recent scholarship from the history of science and medicine, sexuality and religion that has turned to venues of debate and identity formation such as scientific academies (e.g. the Belgian Academy of Medicine) and professional societies (e.g. the Belgian Society of Saint-Luc, a society of Catholic doctors). In these spaces, the encounter between medicine and religion took on a less polemical style and inspired new approaches on both sides. Only limited attention within Belgian historiography has gone to studying archival (patient) records, looking for the space of rituals or devotion in medical practice (see Chapter 7, pp. 261–3). As such, the chapter brings a particular set of Catholic historical actors into the limelight: Catholic doctors, missionaries, women religious, theologians, etc. Their integration into medical history, however, does not mean that moments of conflict are left out. It is key to acknowledge that ideological tensions had a clear impact on the Belgian medical field, shaping its institutional outlook since the second half of the nineteenth century and still resurfacing in debates on medical ethics in the late twentieth and twenty-first centuries.

The chapter distinguishes three levels of interaction between the medical and religious spheres, each treated in a separate section. First, we sketch the evolution of Catholic organisations and institutions in Belgian healthcare, most notably the changing role of religious orders, which in Belgium have held a firm grip on the medical field. We describe evolving Catholic views on 'care' along with political conflicts over an expanding welfare state and changing views on the growing role of lay medical personnel. Second, we turn to religious practices, rituals and exceptional phenomena such as miracles, and the medical debates these inspired. From a medical perspective, and in some cases depending on one's personal religious convictions, religion could be a source of health (e.g. 'moral therapy' to treat

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mental illness) or disease (e.g. 'Christomanie', a nervous disease said to result from excessive religious behavior). Third, we discuss how Catholic doctors and caregivers gave their religious views a place in their professional work and identities. Here we turn to medical ethics and professional codes of conduct, and the ways in which these have been inspired by Catholic thinking. We pay particular attention to questions related to reproductive medicine and the end of life. The presence of the Catholic University of Leuven, the largest Catholic university in the world, ensured that these debates were followed closely far beyond Belgium, most notably in the Vatican.

Traditions of *Caritas*

Caritas, the care for the sick and the poor, has been central to Catholic teachings for centuries and has stimulated Catholic involvement in this field.[7] Since the *Ancien Régime* (and even long before that) religious orders have been actively engaged in social and healthcare provision in the Southern Netherlands.[8] The French regime incited a structural change as public health became the responsibility of the public authorities (localities and departments). As a result, many of the independent institutions became public institutions, ruled by a municipal commission (see Chapter 6, pp. 208–9). In a second phase, the religious orders that had hitherto been involved in caretaking (like the hospital sisters) were expelled and replaced by lay personnel.[9] There was, however, never a complete expulsion as the hospital sisters could count on the sympathy of the population and their replacements soon proved costly and inexperienced.[10] Older orders like the hospital sisters resumed their activities after their initial (yet only partial) suppression under French rule. Most of them were active again by 1810. In nineteenth-century Belgium, as in France, most public medical institutions were thus run by religious congregations at the request of the authorities.[11] Many of these were new congregations: the Sisters of Charity of Jesus and Mary were founded in 1803; the Hospital Brothers of St Vincent in 1807, who were later called the Brothers of Charity; and the Sisters of St Vincent de Paul in 1818.[12] In 1846, approximately 5,298 of the 11,968 religious orders (45 per cent) were involved in the provision of medical care.[13]

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The growth of these new religious orders occurred against the background of a young nation state with a profoundly liberal constitution. These liberal freedoms allowed congregations to expand without being opposed by the state, laying the basis of the Catholic dominance in the provision of medical care. In the field of psychiatry, the activities of the mentioned Sisters and Brothers of Charity, founded by Canon Petrus-Joseph Triest, form a telling example. Both orders started their work in Ghent, taking care of the city's mentally ill, but soon developed activities across the country and abroad. The Sisters of Charity were asked to run an asylum in Tournai in 1818 as well as the state-owned psychiatric institution of Mons in 1866. They also founded private institutions in Sint-Truiden in 1838, in Melle in 1911, in Beau-Vallon in 1914 and in Lovenjoel in 1926.[14] The Brothers of Charity followed a similar trajectory. By 1924, they ran ten institutions in Belgium and were responsible for the medical care of nearly five thousand patients.[15] The governance of such networks of hospitals required considerable financial and administrative expertise. Religious orders developed an almost 'entrepreneurial' spirit.[16] Both orders merged the ideal of *caritas* with the values of social engagement and of leading a moral life that were central to a developing civil society. *Caritas*, embodied by the zealous work of the religious, became in this way a means by which the Catholic Church expanded its influence on Belgian society.[17]

The strong rise of female religious orders in the nineteenth century, the 'century of the nun',[18] has been well documented. Already in 1976, André Tihon made an in-depth study of the Belgian 'feminisation' of the religious profession. He concluded that the largest number of these religious women were working in the field of education, but the orders involved in hospitals came in second place (Figure 2.1). Tihon's extensive study includes convincing statistics: in 1846 these nuns formed 28.19 per cent of the female religious; in 1900 this dropped to 18.30 per cent, in 1947 their number rose again to 20.46 per cent of the total of female religious. Still, even though their relative importance diminished, their numbers rose in those years: in 1846 they counted 2,359 members, in 1900 there were 5,738 and in 1947 10,155.[19] In comparison with lay staff of the hospitals, in 1910, 1,644 laywomen were active as caretakers, nurses and helpers in all medical establishments,

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Figure 2.1 A woman religious operating sterilisation equipment in the Leuven academic hospitals, n.d. (mid twentieth century).

hospices and poor relief services. Apart from these institutions, 3,328 women worked as birth helpers, masseuses, pedicurists and carers. In total their number rose to 4,972, whereas there were 8,121 members of female orders that were exclusively focused on hospitals.[20] Just like in other European countries such as Germany and France, ecclesiastical *caritas* carried a 'female face'.[21] A similar trend might be detected in the lay charity movements that developed in the second half of the nineteenth century. These were a means for Catholic men and women from the bourgeoisie and upper classes, conducting home visits, to alleviate the needs of the poor and by doing so diminish social tensions.[22] Nursing and caring seem to have been central to women's movements.

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Described as a continuation of their 'feminine' task of caring for others (see Chapter 1, pp. 34–5), an extension of their motherly duties, these movements provided women with a space of action beyond their homes. Tellingly, of the 144 charity works that were initiated by *dames d'œuvres* (charitable ladies from the aristocracy and bourgeoisie), 111 focused on healthcare at home, one took care of pilgrims, 23 worked in the colonies of sick children and 9 were part of Work of the Calvary (who helped cancer patients in the homes that they had created).[23]

While the competence of these voluntary laywomen as care providers was rarely questioned, the capabilities of women religious as nurses were subject to considerable debate, certainly from the late nineteenth century onwards. Such debates paralleled the introduction of new technologies into the hospital (e.g. for radiotherapy) and, more generally, the rise of the 'general hospital' as a space for medical treatment (in particular surgery) rather than of social care. The medical training of women religious is one of those topics for which ideological conflict has formed the dominant framework in historiography. Even if not to the same degree as in France, where the image of the unqualified nun featured prominently in the politicised debates over healthcare in the late nineteenth century,[24] Belgian politicians and physicians – mostly liberals – did criticise the competence of the religious as care providers. The most telling example is perhaps the attacks by the socialist doctor-politician Modeste Terwagne, which earned him the nickname of *nonnenvreter* ('nun-eater').[25] It is also clear that the setting up of training programmes for (lay) nurses started in the liberal settings of Liège and Brussels in the 1880s. The first Catholic initiatives for the schooling of nurses date from the early twentieth century; these included the St Camille School in Brussels in 1907 and the aforementioned St Elizabeth Institute in Leuven in 1922.[26] But within congregations as well, formal training courses were organised for new brothers and sisters in addition to the informal ways in which hands-on knowledge was passed on. Luc De Munck's ongoing research engages with these Catholic educational initiatives to improve patient care. The many journals that were developed to this end since the early twentieth century, such as *Catholic Nursing* (*De katholieke ziekenverpleging*), *Caritas* and *Caring for the Ill* (*Ziekenverpleging*), offer a wealth of source materials.

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After the First World War, the Catholic Church strongly emphasised the religious nature of healthcare institutions operated by religious orders. At a moment when coalition governments with socialists and liberals replaced the hegemony of the Catholic party, which had held the majority in the Belgian parliament between 1884 and 1914, the dominance of religious orders in the provision of medical care seemed threatened. New medical institutions of a different nature appeared, such as socialist outpatients' clinics and the institutes of the ideologically neutral Red Cross. As the Catholic world felt forced on to the defensive, stronger organisational structures were developed. In 1922, the Belgian Society of Saint-Luc, a professional organisation for Catholic physicians, was founded. In 1932, the Catholic Service for Hygiene and Aid, soon renamed Caritas Catholica following international trends, was established to group all Catholic initiatives in healthcare. In 1938, the League of Health Care Institutions was created as a subdivision of Caritas Catholica to assist Christian hospitals and defend their interests.[27] The organisation seems comparable to the Catholic Hospital Association, established in 1915 in the United States to help institutions keep up with the pace of hospital modernisation and nursing education.[28] At a time when state initiatives were regarded as too 'materialist', these professional organisations took up the challenge of reconciling medical care in a Christian tradition with developments in modern medicine, without losing sight of its moral grounding. This increasing emphasis on Catholic identity in healthcare initiatives can be illustrated via the histories of seaside vacation colonies for children. Every ideological pillar had its own homes, but the Catholic initiatives developed slightly more slowly (even though the Sisters of Charity of Jesus and Mary had been involved in the first seaside hospital in Wenduine that was created in 1881). Catholic involvement increased especially since the last year of the First World War with creation of 'Mont Thabor' (Berg Thabor) that helped children who were suffering from consumption. It had homes in Koksijde, Ostend and Middelkerke and employed religious women (Sisters of St Vincent de Paul and Dominican Sisters) alongside Catholic physicians.[29]

As for the Catholic involvement in healthcare in the colonies, that took a slow start too (see Chapter 3, pp. 113–6). Initially King Leopold II had little success in persuading Belgian Catholic orders to

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found missions in the Congo. They only started to arrive in the last decade of the nineteenth century (Scheutists in 1887 and Jesuits in 1893, other orders followed). From the 1920s onwards the numbers of religious and missionaries involved in Congo was on the rise. In 1908 there were still very few: 'only' 233 priest-missionaries and 102 religious, while between 1920 and the 1940s the numbers quadrupled from 895 in 1924 to 4,607 in 1959. This coincided with the feminisation of missionaries. In 1908, nuns made up one-third of the total of the missionary staff (102), in 1959 they were more or less half of the staff (2,130 out of 4,607).[30] So while the men saw the numbers rise primarily between 1908 and 1924, the women peaked a little later (278 per cent growth between 1924 and 1935).[31] Besides this feminisation of colonial healthcare, and similar to evolutions in the home country, a professionalisation took place. By the 1920s, nurses were required to follow a brief course at the School of Tropical Medicine (École de Médecine Tropicale) in Brussels. As in Belgium, the trend of replacing nuns with accredited nurses can be traced to the interwar period in the state hospitals in the colonies. There were, however, as Sokhieng Au has pointed out, exceptions: nuns remained active in certain types of palliative care (especially for leprosy) because of its close links to Christian theology and missionary work.[32]

After the Second World War, the challenge for religious orders to maintain their role in healthcare became ever more difficult, both in Belgium and the colonies. As the pace of secularisation increased since the 1960s, the number of (missionary) vocations declined and religious practice in Belgium diminished. In 1981, 72 per cent of Belgians declared themselves Catholics (a number that soon diminished: 65 per cent in 1990, 57 per cent in 1999 and 50 per cent in 2009). However, such a declaration of 'belonging' sometimes merely referred to the fact that they were baptised. At the same time, the development of the welfare state put pressure on the Christian ideal of *caritas*. With the introduction of mandatory health insurance in 1944, and the subsidising of new hospitals (public ones from 1949, and since 1953 also private – mostly Catholic – institutions), medical care was turned from a form of charity into a social right.[33] This policy of state support resulted in a rapid expansion of the number of hospital beds in Belgium, which reached a peak in the early 1980s. With such a rise in scale, in a society that was secularising at a rapid pace, the question of how to preserve the Christian identity

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of Catholic hospitals arose. As the community of women and men religious was aging and the participation of lay personnel grew – certainly after the Second Vatican Council, during which a more important role for laity in the church was discussed – the Christian nature of these institutions had to be rethought. Archbishop Leo Suenens and the League of Health Care Institutions took initiatives for the development of pastoral work in hospitals and for the creation of a 'humane approach' to healthcare.[34] During a conference organised by the League in 1972, the latter approach was regarded a counterweight to the growing technicality and bureaucratisation of healthcare. Four years later, a report on the role of religious personnel stated that their presence should act as 'yeast in the dough', reminding their colleagues of the Christian inspiration that lay at the basis of their medical work.[35] In 1976, when Suenens was succeeded by Godfried Danneels as archbishop of Mechelen, a letter by Jos De Saeger, president of Caritas Catholica at that time, captured the reform of Christian healthcare well:

> [Our hospitals] have made such efforts to humanize, for a humane welcoming, for the care of the dying … the training of our staff, the renewal of our pastoral work … ; in order for this last work not to form a separate 'service', left to the priest alone, but would integrate all those aspects in this so humane approach to man, as being ONE, in relation to what is beyond description … to avoid all misunderstanding: I do not intend all of this as the obtrusiveness of the missionary work of half a century ago. We should make no pretensions to replace [God's] mercy, but we should be willing and prepared to assist when it calls upon us.[36]

In the last quarter of the twentieth century, a Christian tradition of medical care was thus recast in line with contemporary demands for the improvement of patient care. Religiously inspired caring, De Saeger believed, still had a role to play in easing the excesses of an all too radical medicalisation of society. As Liliane Voyé and Karel Dobbelaere have noted, in the last decades the importance of pastoral care has diminished. Yet, pastoral service is provided in all Catholic institutions (with the exception of some smaller houses) even if the priests and religious have been replaced by laymen with pastoral training. In fact, in all Belgian hospitals the sick can call upon the services of representatives of different religions or the Union of the Associations of Freethinkers.[37]

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In spite of these evolutions, religious orders and the Christian Health Funds maintained their dominance: they still owned about 50 per cent of the general hospitals and 80 per cent of the psychiatric institutions in 1980.[38] Today, Catholic hospitals exist alongside the public system and other private initiatives. The League was split into two federations: the Fédération des Institutions Hospitalières (FIH, francophone) and the Verbond van Verzorgsinstellingen (VVI, Dutch-speaking), called Zorgnet since 2009[39] – both belong to Caritas Catholica. In 2007, 63 per cent of the beds of general hospitals in Flanders were in Catholic hospitals, in Wallonia the Catholic hospitals had 42 per cent of the beds. In psychiatric hospitals, they hold no less than 85 per cent of the beds in Flanders and 43 per cent in Wallonia. Caritas Catholica also comprises the federation 'Welzijnsverbond' that groups services that were initiated by the parents of the patients rather than religious orders and thus have a very pluralistic character (e.g. children with impairments or educational issues). The federation has its own ethical and pastoral service.[40]

Medical meanings of religious practice

A second level on which the fields of medicine and religion have interacted concerns therapeutic practices and the debates surrounding them. We focus more specifically on the use of religious rituals in relation to the (diseased) body. Rituals, religious phenomena and medical practices have historically been interconnected in different ways. Their use has inspired considerable debate in the Belgian medical community, triggering doctors to formulate an opinion and sometimes laying bare ideological divides between Catholic and liberal experts. In some cases, they have been considered sources of healing, and therefore as inspiring examples (e.g. in mental healthcare). In other cases, religious practice has been regarded as pathological of itself, that is causing or spreading illness rather than having a therapeutic effect.

The nineteenth-century belief in 'moral therapy' for psychiatric patients forms a telling example of the belief in the healing power of faith. This theory, attributed to the French physicians Philippe Pinel and Étienne Esquirol, was promoted in Belgium by the Ghent physician Joseph Guislain. It rested on a conception of mental illness as a lack of order, morality and self-discipline, which could be

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corrected through psychological influencing and the enforcement of a strict daily regime, similar to the structured lifestyle of men and women religious.[41] Guislain attributed many therapeutic benefits to religious influence. The stern appearance and solemn clothing of religious personnel, he argued, gave them an authority that was essential to the success of moral therapy. He also considered their soothing role as a form of treatment, an idea that matched well with a long-standing tradition of spiritual aid. By engaging in religious practices, patients could find a form of comfort, which could act therapeutically in particular when their mental illness was caused by feelings of sadness.[42] Patients, for example, participated in reading sessions of devotional texts, a religious practice that again resembled monastic life. Up until the 1960s, religious rituals (such as attending mass) constituted an obvious component of living in an asylum. Many institutions possessed their own chapel or cemetery, or even – as was the case at the asylum of Beau-Vallon – a grotto for the devotion of Our Lady of Lourdes.[43] At the Salve Mater Institute in Lovenjoel (1926), annual pilgrimages were organised at least up until the 1950s with different destinations according to patients' social class and medical condition (e.g. to the sites of Banneux, Beauraing or Koekelberg).[44]

Figure 2.2 Postcard of Belgian pilgrims holding mass in a train.

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Yet, religious practices have also been contested for medical reasons and these contestations were sometimes inspired by ideological motives. During the nineteenth-century cholera epidemics, public health specialists considered attending mass or holding a religious procession to be dangerous to spread the epidemic. On their advice, local authorities prohibited these events. For the Catholic population, however, the performance of religion (e.g. calling to a saint for help by holding procession) was a way to cope with the disease and the fears it generated. Here a medical and religious way of understanding disease clashed.[45] Similar tensions emerged surrounding the treatment of the deceased body. As the 'culture wars' between liberals and Catholics flared up in the late nineteenth century, funeral and burial rites became objects of intense conflict. The practice of cremation, which was promoted for being more sanitary, was opposed by Catholics who clung to the traditional burial out of respect for integrity of the body. Freethinkers embraced the civil burial – a burial without the interference of priests on newly founded civil, non-Catholic cemeteries. While such debates were of a wider ideological nature, they also impacted the medical field. Tinne Claes' and Jolien Gijbels' research on the use of the bodies of the poor for medical research and anatomical dissection has revealed the waning influence of the Catholic Church in Belgian public hospitals in the late nineteenth century. The unsanitary and disrespectful way in which the bodies of paupers were disposed, whose families could not afford to pay for a funeral and claim these bodies, led to the creation of both anticlerical and Catholic burial societies who took over these costs. As a result, not only did the (already existing) body shortage for dissections increase in the Brussels hospitals, but funeral rooms were also constructed, in addition to the existing chapels in hospitals, as spaces where non-Catholic funeral rites could be held.[46]

The relationship between devotion and medical expertise also worked the other way around and medical experts were summoned to make some religious activities run more smoothly. Devotional practices like the yearly Lourdes pilgrimage involved sick and invalid faithful and often required medical support. The number of sick pilgrims participating in the Lourdes trip grew steadily: in 1881, there were 60 of them; in 1895, 100 joined the pilgrimage (out of the more than 1,000 participants); and the following year they numbered 250 (out of 2,500 pilgrims).[47] To provide the

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pilgrimage participants with the care they needed, the organisers called upon the help of Catholic doctors. In 1895, a movement for the healthcare workers and the stretcher-bearers developed, called the Hospital Service of Our Lady of the Cross. They tried to have the necessary medical equipment at their disposal and used hospital wagons for their trip to Lourdes. Tellingly, the wagons had a double purpose for the Pope had granted a special permission to say Mass in these wagons and the organisers used every opportunity to stop in small villages, open the doors and allow everyone to participate in the Eucharist (Figure 2.2). The Belgian national pilgrimage seems to have been a forerunner in this perspective: the article of the movement's periodical introducing the wagon noted that if it was not needed by the Belgian pilgrims, the pilgrims from neighbouring countries could use it.[48]

The pilgrims of Lourdes also stimulated another type of medical involvement in the religious sphere. In particular, the 'miraculous' cures of sick pilgrims were carefully examined by a new office of the Catholic Church, the Bureau of Medical Verifications (1883). This 'medicalisation of the miracle', the call upon medical experts to examine exceptional cures,[49] can be traced in the Belgian context as well. The most well-known case is that of Pieter de Rudder whose injured leg healed suddenly at the replica Lourdes grotto of Oostakker in April 1875.[50] His cure, an 'organic' case of healing (devoid of the slightest hint of hysteria or suggestion) was the object of at least four medical examinations (some conducted after his death from pneumonia in 1898).[51] The church called for such thorough examinations since it was well aware that a well-examined case would be more difficult for its enemies to reject.[52] Not only world-famous Lourdes inspired medical interest; more local or national cases show a similar involvement. In Beauraing and Banneux, two Belgian apparition sites of the 1930s, miraculous cures were examined closely (and two of them were eventually used as proof for the official recognition of the Beauraing apparitions). However, medical experts were also present at these sites (and others) while the series of apparitions took place – studying and testing the ecstasy of the visionaries. In Beauraing, horror stories about those examinations (admittedly involving knives and candles) resulted in the visionaries' refusal to be tested again and the subsequent shift of focus of the medical experts from studying their bodies during the

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apparitions to their questioning after each episode (adopting interrogation techniques from criminal anthropology).[53]

Not all examinations reached the same conclusion however, and in Belgium, as in other countries, this difference in opinion was linked to anti-Catholic discourse. The most notorious case was that of the stigmatic from Bois-d'Haine, Louise Lateau. In the same year that she first displayed the (visible) wounds of Christ (1868) her bishop created a commission to examine her case and asked Dr Ferdinand Lefèbvre, professor of general pathology and therapeutics at the Catholic University of Leuven, to study her more closely. He concluded that no physical cause for her wounds could be detected and deemed a supernatural intervention at least possible.[54] It is unnecessary to state that his conclusion earned him not much more than mockery from his anticlerical colleagues. Hubert Boëns, a physician from Charleroi, presented his evaluation of Louise's case before the Royal Academy of Science in October 1874. He called her 'sick' and suffering under 'Christomanie' or 'stigmatic ecstasy' that had affected her nervous system and blood.[55] Still, Sofie Lachapelle notes, the Belgian setting of the discussion was quite different from

Figure 2.3 Louise in ecstasy (photograph by Lorleberg, October 1877).

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that of polarised France where the 'pathologisation' of religious phenomena like stigmata and ecstasy and the redefinition of hysteria were a powerful weapon in the anti-Catholic struggle.[56] In Belgium, the 'collaboration between scientific and religious authorities was perhaps more amicable … than elsewhere'. In France, Catholic universities were only allowed after 1875 'and never attained much recognition for their faculties of sciences' whereas the Belgian universities of Leuven and Liège were 'prestigious institutions'.[57] On the evaluation of such 'religious' phenomena by medical experts and the tensions and collaborations between the two knowledge systems, much work remains to be done. Scholars might take their cue from, for example, the work that has been done on German and Austrian asylums and its focus on religious mania, melancholia and the differentiation between, in the words of Ann Goldberg, excessive and rationalist religion.[58]

It is important to note that the faithful kept track of medical evolutions such as the redefinition of 'hysteria' and these also permeated Catholic discourses and images. In Lateau's case, for instance, the accusation of her being an 'hysteric' seems to have had an impact on her visual representation. Her supporters seem to have been well aware of her problematic reputation and the use of her case as exemplary for certain stages (e.g. 'passion', 'crucifixion') of hysteria. When it came to choosing photographs for her 'promotion', they selected what they called a 'saintly' image of Lateau in her 'natural state', rather than one of her ecstasy (that they also had at their disposal) (Figure 2.3).[59]

Catholic medical expertise and ethics

A third level on which we may gain new insights about the historical relation between medicine and religion is the level of Catholic views about reproduction and sexuality. The Italian historian Emmanuel Betta situates the emergence of 'Catholic biopolitics' between the mid nineteenth century and 1930, when the encyclical letter *Casti Connubii* was published, in which the Vatican definitely dismissed all kinds of birth control practices. According to Betta, the Vatican outlined its views on the reproductive body in this period not only as a reaction to an expanding medical discourse on the reproductive

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body in society, but also as an attempt to produce its own modern norms.[60] While the construction of Catholic biopolitical thinking was clearly a transnational process, to which Belgian Catholic doctors contributed, on the Belgian level as well bodily norms were debated. These debates, moreover, shaped the ways in which Catholic caregivers acted as professionals. Deontology, professional codes of conduct and guidelines for ethical decision making on medical interventions (e.g. abortion) were essential for the way they identified individually and collectively as Catholic practitioners. These norms allowed them to determine whether or not they performed medicine in ways that conformed to their religious beliefs. Recent research – discussed in this section – has turned to the ways in which Catholic medical views were debated and spread, with a particular focus on venues of sociability where Catholic doctors met with like-minded or ideologically opposed colleagues, or with religious actors such as priests and theologians.

During the nineteenth century, the Royal Academy of Medicine of Belgium (1841) acted as an important intellectual meeting place for outspoken Catholic professors of the Catholic University of Leuven, and their liberal counterparts of the Free University of Brussels. Jolien Gijbels has shown how questions surrounding medical interventions during difficult childbirths and the desire to baptise unborn foetuses (to save their souls) led to the weighing of religious and medical arguments in the academy, dividing members along ideological lines. Such debates treated the desirability of *in utero* baptism (1845), of medical abortion (and embryotomy) before and during difficult deliveries to save the lives of mothers with a small pelvis (1852) and of priests performing post-mortem caesarean sections (after the assumed death of the mother) to baptise foetuses (1845). Gijbels revealed a willingness to integrate religious concerns in medical debate, as long as such concerns were in line with physicians' codes of conduct.[61] Hence the widely spread custom of intrauterine baptisms in Belgium by means of a syringe filled with holy water – a practice, however, that was never fully approved by theologians who were uncertain about whether or not the water effectively reached the foetus's head. In general, academy members preferred to treat contentious matters as purely 'scientific questions' – a strategy that allowed them to avoid politicised debates and maintain professional unity. Only on rare occasions

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did Catholic physicians explicitly defend their religious beliefs in opposition to their professional viewpoints. When the Catholic professor of obstetrics Eugène Hubert stated in 1869 that priests had medical expertise (to recognise signs of death) and saved lives in their attempts to baptise foetuses by performing post-mortem caesarean sections, he took a rather exceptional position. His remarkable claim may also be explained by the political circumstances the time. In the late 1860s, the ideological conflict between Catholic and liberals reached a peak in Belgium. It seems no coincidence that in those same years a topic such as the post-mortem caesarean section caused a heated public debate.[62]

In the first decades of the twentieth century, the falling birth rate proved an important context to understand a growing Catholic influence in Belgium's biopolitical discourse.[63] Unlike in France, as Wannes Dupont has shown, the response to these changing demographics in Belgium was pervaded by Catholic reasoning and moral arguments. As elsewhere in Europe, Belgian intellectuals connected the country's declining natality to social problems and feared for a 'degeneration' and loss of national vitality. Yet, they also tied it to the rise of 'materialism' in Belgian society and the need for moral regeneration.[64] Such thinking played a crucial role in the development of a stricter general Catholic policy towards birth control. Joseph-Désiré Mercier, a Leuven professor who became archbishop of Mechelen and head of the Belgian church in 1906, took many initiatives in this regard, including a pastoral letter on the duties of conjugal life and stricter directions for priests on how to approach the matter of contraception during confession in 1909.[65] Mercier was also open to cooperation with Catholic physicians – gynaecologists in particular – to develop this new Catholic stance towards reproduction. In 1910, he initiated a meeting of Belgian Catholic physicians that led to the creation of the National League Against Depopulation.[66] Its president was the Leuven professor of obstetrics Rufin Schockaert (see Chapter 1, pp. 46–7). In his gynaecological clinic, Schockaert taught medical students about the social role of the gynaecologist. The latter had a moral role to play in fighting practices of birth control such as coitus interruptus, which Schockaert regarded as 'unhealthy' for women.[67] In the following decades, this reproductive message was spelled out for the Catholic laity in books like *The Christian Marriage*

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(1918, by Canon Aloïs De Smet[68]) and mass gatherings like the Catholic congresses (the 1936 meeting featured a special section on the family).[69]

In addition to questions of sexual morality and birth control, the Catholic Action movement also exerted a strong influence on the Belgian medical profession. First coined by Pope Pius X, but narrowed down by his successor Pius XI in 1922 to a movement of Catholic laity designed to restore the Catholic grip on state and society, Catholic Action called upon Catholic physicians to take up a more visible social role. While new forms of Catholic medical sociability had emerged across Europe and the United States, for which the model of the first French Society of St Luc, St Cosmas and St Damian (1884) had acted as a source of inspiration, Reinout Vander Hulst and Joris Vandendriessche have shown how the Belgian Society of Saint-Luc (1922) was marked by a particular Catholic Action imprint. The society outlined a 'medical apostolate' for Catholic physicians in the form of a strict deontological code that was constructed at society meetings, at which Jesuit fathers acted as theological advisers, and that was spread through its journal *Saint-Luc Médical*.[70] Maarten Langhendries and Kaat Wils identified a similar notion of a 'lay apostolate' in the self-representations of Belgian doctors who were recruited by the Medical Missionary Aid Society (1925) to work in the Belgian Congo. In the latter society as well, both doctors and clergy were involved. Yet, they also conclude that this apostolate was above all a propagated ideal that was difficult to put into practice in the colonial context itself.[71]

In the 1930s, these new spaces of sociability testified of intense interactions between clergy and doctors, both on the national and the international level. Mercier's close colleague Arthur Vermeersch, for example, who became a professor at the Gregorian University in Rome, strongly influenced Pope Pius XI's encyclical letter *Casti Connubii* of 1930.[72] The Belgian bishops applauded the encyclical in a letter of 2 February 1931.[73] That same year, they discussed the usefulness of a medical examination of fiancées before their marriage. The moral theologian Arthur Janssen suggested in 1932 that the Catholic Action movement should propagate such premarital examinations to minimise the tensions and frustrations in marriage and diminish the number of divorces.[74] Both among clergy and doctors, there was less consensus about the desirability

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of periodic abstinence. In Janssen's opinion (and that of Pius XII), it was never acceptable when done out of selfish motives (e.g. material or physical concerns). However, it might be permitted when a couple already had some children and the physical and psychological strength of the mother (or both parents) were tested. Others, like Jean Dermine, the later chaplain ('proost') of the People's Movement for Families (Mouvement Populaire des Familles), were less open-minded.[75] In the Society of Saint-Luc as well, the question of whether physicians could recommend the method of periodic abstinence, and whether or not such information could be spread to the wider public was intensely debated.[76]

After the Second World War, the University of Leuven continued its role as a mediator between Catholic doctrine and new developments in the medical field. The 1950s formed a period of remarkable openness in this regard. Archbishop Leo Suenens played an important role in the redefinition of Catholic views on sexuality as part of the shaping of an 'intimate community of life and love' in marriage.[77] In 1958, at an international conference for Catholic physicians in Brussels, he pleaded for a closer collaboration between the medical world and the Catholic clergy – a message he repeated at an International Colloquium for Sexuality in Leuven a year later. Suenens acted as one of the strongest advocates of a more lenient position of the Catholic Church at the Second Vatican Council, where a committee was set up on the matter in which many Belgians participated.[78] In the same spirit of reform and collaboration, an Institute for Family and Sexuality Studies was opened at the University of Leuven in 1961. With the support of Suenens, the Institute was devoted to the scientific study of human sexuality. It focused on the use of contraceptive pills, and later also on questions of infertility, sterilisation and divorce, and hence fit in with wider attempts among Belgian Catholics in the post-war years to overcome the strict clerical guidelines regarding birth control.[79]

When Paul VI succeeded John XXIII in 1963, however, the Vatican again took a hard line concerning sexuality and family planning. The encyclical letter *Humanae Vitae* of 1968 strongly condemned 'artificial' forms of birth control.[80] The Belgian clergy were soon worried about those medical practices in Catholic hospitals that were at odds with the papal stance on the matter. In the Leuven academic hospitals, artificial insemination, sterilisation and

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abortion were effectively practised in strictly defined circumstances. Abortion, for example, was conducted in case of severe genetic defects.[81] In 1975, these medical practices were explained to the bishops on their request. To meet their objections, a Commission of Medical Ethics was established. The gynaecologist Marcel Renaer became its first president. Since the 1950s, Renaer had taught medical ethics to students and supported the use of contraceptive pills and the practice of sterilisation in certain cases, articulating the views of many Catholics who disagreed with the condemnation of such practices in *Humanae Vitae*. Together with the new commission, a chair of medical ethics was installed.[82] A need to rethink the relation between Catholic doctrine and medical practice thus led to a professionalisation of the field of medical ethics. In 1986, the Centre for Bioethics was founded, which was modelled after similar centres in the United States. Paul Schotsmans became its first director. Like Renaer, he was influenced by the personalist theories of the Leuven professor, priest and theologian Louis Janssens.[83]

Since the 1980s, ethical debates have sprung up from the field of human genetics. Liesbet Nys and Tinne Claes have shown that the technique of *in vitro* fertilisation (IVF) caused tensions within the Catholic medical world and the Leuven Faculty of Medicine. The conservative Catholic leadership of the faculty preferred keeping the birth of Belgium's first test-tube baby at the university hospital in 1983 quiet to avoid offending ecclesiastic authorities.[84] In particular, the fact that 'superfluous' fertilised egg cells were created during IVF raised questions about the start of human life. Prenatal genetic tests, which had been conducted for some time at the Leuven Centre for Human Genetics, similarly evoked ethical objections by the Belgian clergy. The rising number of these tests (e.g. amniocenteses during follow-up consultations of pregnancies) in the 1980s was feared to augment the number of abortions. After the publication of the encyclical letter *Donum Vitae* in 1987, Catholic ethicists such as Guido Maertens invested energy in the creation of an ethical framework for genetic counselling. *Donum Vitae* had stipulated that prenatal diagnoses could only be conducted if they were oriented towards healing and with respect to the 'integrity of the human foetus'. They were 'in opposition to moral laws' if they provoked abortions. In 1988, Roger Dillemans, rector of the

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University of Leuven, and Maertens visited the Vatican as part of a delegation of Catholic universities to explain the medical procedures in Catholic academic hospitals. No conviction by the church followed.[85] Since 1994, every Belgian hospital is legally obliged to have an ethical commission; a national committee on bioethics was created in 1993 (as in other European countries). The committee has a double task: it advises on problems arising from biology and medicine and communicates these to the public and the authorities.[86]

In the last decades, debates on medical ethics have centred on questions of human suffering, particularly in regard to euthanasia. The death of the Flemish author Hugo Claus in 2008 from euthanasia brought the whole debate on the meaning of suffering in contemporary society to the fore again. Especially after Archbishop Danneels addressed the issue in his sermon on Holy Saturday:

> To leave one's life this way did not answer the problems of suffering and death. This way one only bypasses them. And to skirt around them is not an act of heroism and does not merit the front page of the newspapers … Our society apparently does not know how to handle death and suffering. According to its own words, many taboos have been set aside. However, doing so, society has created new taboos, including one according to which death has no meaning and all suffering is absurd.[87]

The meaning of suffering is essential for understanding the different positions taken in this debate. As Voyé and Dobbelaere described in their article about the Catholic responses to the euthanasia debate in Belgium, 'suffering' can mean two things. For some, 'suffering is inhumane, useless, has no sense and it is immoral to let people suffer. For others, conversely, suffering may help to deepen the sense of one's own life … suffering may also be of use to invite others to reflect on the sense of life.'[88] It is important to pause a moment to reflect on the meaning and history of 'suffering' from a religious point of view. In the previous centuries, for the religious, who were involved in healthcare and for the wealthy Catholic laymen who supported them (financially), illness and suffering were a 'gift' from God. They were meaningful and functioned either as a punishment or as a means to put the afflicted on the right track again.[89] This 'productive' view of pain (with its own salutary end) was criticised more and more in the nineteenth century as pain

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came to be regarded as something that needed to be controlled, eased (e.g. by anaesthetics) and treated.[90] Yet, one should be wary of presenting this story as a 'secularisation' of pain in the nineteenth century as this implies a rather oppositional view of the relationship between medicine and religion. Whereas 'philopassionism' was indeed a Catholic tradition and there was a revitalisation of this medieval idealisation of Christ's pain in the nineteenth century, this was certainly not the only Catholic view on pain of that time. As scholars as Richard Burton have emphasised, the idealised, voluntary, suffering was a minority calling and many Catholic women dedicated their lives to relieving suffering rather than seeking it out.[91] There is still much work that needs to be done on the interaction and coexistence of the two perspectives in the nineteenth and twentieth century (for the Catholic view on the beneficial effects of suffering continued up until the Second Vatican Council).[92] Studying the interaction between the views described above will at least better our understanding of the day-to-day interaction of the religious orders and the medical professionals in the hospital setting. In the euthanasia debate, for instance, religion was, according to Voyé and Dobbelaere, an important determinant for a negative attitude on the part of the nurses. The more religiously inspired they were (especially Catholics), the more they opposed euthanasia.[93]

As Voyé and Dobbelaere have amply illustrated, Belgium was one of the first Western European countries 'to introduce new legislation clashing head on with the prescriptions of the Catholic Church in these matters. In 1990, a law was passed de-penalising abortion, in 2002 a law authorising euthanasia and, in 2003, one legalising same-sex marriages.'[94] It is primarily on these occasions, when ethical questions arise, that we see the impact of Christian ideas on the debates (and voting behaviour of e.g. Christian Democrats). The aforementioned Law on Abortion stipulated that a pregnancy could henceforth be terminated within the first twelve weeks after conception. It was a piece of fairly liberal legislation, which neither the Christian Democrats nor the Belgian King Baudouin, a devoted Christian, supported. The latter would not sign the law and declared himself 'unfit to govern' for a single night, during which the law was signed by all ministers – a creative legislative solution.[95] As the country's politicians, following public opinion, further

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distanced themselves from a strict application of Catholic morality, the Catholic University of Leuven continued to struggle with the ethical implications of medical procedures. In forums such as the Platform for Christian Ethics (Overlegplatform Christelijke Ethiek) and in the organisation's journal *Ethical Perspectives* (*Ethische Perspectieven*), the technique of pre-implantation genetic diagnosis (PGD), which allowed genetic testing of embryos prior to implantation, was debated in the 1990s.[96] Research on stem cells generated a similar debate in the 2000s. In 2006, Archbishop Danneels and the rectors of the universities of Leuven and Louvain-la-Neuve again travelled to the Vatican to explain (with little success) the medical procedures in their academic hospitals.

Conclusions

Through the lens of Catholic thinkers and men and women religious, the historical relation between medicine and religion becomes a story of interaction, adaptation and mutual influencing. That is not to say of course that there were no conflicts. Debates over ethically contentious issues such as abortion, at least since the middle of the nineteenth century, were often fierce. But when we bypass the politicised representations of the downfall of religion in medical care in favour of scientific progress, we may better understand what was at stake in these intellectual debates and reveal more broadly how issues of sickness and health were tied to questions of identity and ideology. Here lies an agenda for future research, which may explore the history of the reception of medical technologies and techniques in the Catholic clerical and intellectual world, the everyday practices and rituals in Catholic hospitals and the often strikingly 'modern' responses of religious orders to the challenges of healthcare.

When it comes to the influence of religion on the medical field, the Belgian experience was quite particular. Religion was very much part of the 'politics' of Belgian medicine, meaning that shifts in the political power of the Catholic party shaped healthcare profoundly. The relative absence of the state in the organisation of healthcare in the nineteenth century, and the resulting dominance of religious orders, was a product of clerical–liberal compromises. The Catholic

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profiling of the interwar years was a reaction to the limited power of Catholic politicians in those days. In general, however, it seems fair to say that the relative comfort of Catholic healthcare, given its overall strong political support, allowed the sector to adapt itself to modern medicine without continuously being on the defensive. Future studies may find out whether or not this holds true for different aspects of the medical field. For a historiography seeking to balance collaborations and conflicts, the Belgian experience offers a fruitful test case.

Notes

1 Ghent, Archive of the Sisters of Charity of Jesus and Mary, 'Leuven: Spes Nostra', no. 3#1, *Memorial Book, 1928–71*. On the role of women religious in the Leuven academic hospitals, see J. Vandendriessche, *Zorg en wetenschap. Een geschiedenis van de Leuvense academische ziekenhuizen in de twintigste eeuw* (Leuven: Leuven University Press, 2019), 71–95.

2 On this topic, see H. Guillemain, *Diriger les consciences, guérir les âmes: une histoire comparée des pratiques thérapeutiques et religieuses (1830–1939)* (Paris: La Découverte, 2006).

3 K. Velle, *De nieuwe biechtvaders. De sociale geschiedenis van de arts in België* (Leuven: Kritak, 1991); K. Velle, 'De geneeskunde en de R.K. Kerk (1830–1940): een moeilijke verhouding?', *Trajecta: Tijdschrift voor de geschiedenis van het Katholiek leven in de Nederlanden*, 1:4 (1995), 1–21; K. Velle, 'Kerk, geneeskunde en gezondheidszorg in de 19de en het begin van de 20e eeuw', in *Het Verbond der Verzorgingsinstellingen 1938–1988. Vijftig jaar ten dienste van de Caritas-Verzorgingsinstellingen*, ed. J. Depuydt, L. Dhaene, K. Schutyser and K. Velle (Leuven: VVI/Kadoc, 1988), 35–59.

4 See, for example, J. Goldstein, 'The hysteria diagnosis and the politics of anticlericalism in late nineteenth-century France', *Journal of Modern History*, 54:2 (1982), 209–39.

5 See, for example, M. Pia Donato (ed.), *Médecine et religion: compétitions, collaborations, conflits (XIIe–XXe Siècles)* (Rome: École française de Rome, 2013); G. B. Ferngren, *Medicine and Religion: A Historical Introduction* (Baltimore, MD: Johns Hopkins University Press, 2014).

6 B. Mann Wall, *Unlikely Entrepreneurs: Catholic Sisters and the Hospital Marketplace, 1865–1925* (Columbus: Ohio State University

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Press, 2005); K. Suenens, *Humble Women, Powerful Nuns: A Female Struggle for Autonomy in a Men's Church*. (Leuven: Leuven University Press, 2020).

7 The love for suffering fellow men is at the core of Christian teachings. According to Paul (1 Corinthians 13:13) it is the greatest of the Christian virtues. See C. Stiegemann, *Caritas: Nächstenliebe von den frühen Christen bis zur Gegenwart* (Petersberg: Michael Imhof Verlag, 2015); E. Baldas, 'Caritas', in *Lexikon für Theologie und Kirche*, vol. 2 (Freiburg: Herder, 1994), 947–51.

8 For a history of this first involvement of, for example, the Knights Hospitaller, see R. Stockman, *Pro Deo. De geschiedenis van de christelijke gezondheidszorg* (Leuven: Davidsfonds, 2008), 48–68.

9 The hospital sisters dated back to the twelfth and thirteenth centuries. See Stockman, *Pro Deo*, 94.

10 Velle, 'Kerk, geneeskunde en gezondheidszorg', 37–40.

11 For a brief discussion of the organisation of hospital care in France up until the early twentieth century, see B. M. Doyle, 'Healthcare before welfare states: hospitals in early twentieth-century England and France', *Canadian Bulletin of the History of Medicine*, 1:33 (2016), 174–204.

12 For an extensive overview, see Stockman, *Pro Deo*, 94–103; Ch. Vloeberghs, *Belgique Charitable* (Brussels: Librairie Nationale, 1904), 4.

13 Velle, 'Kerk, geneeskunde en gezondheidszorg', 48, 50.

14 Several institutional histories of medical institutes ran by the Sisters of Charity of Jesus and Mary have been published, but there is no synthesis of the congregation's work. See K. Leeman, F. Marysse and J. Demets, *Terug naar de toekomst: 1808–1908–2008: 100 jaar psychiatrisch centrum Caritas: 200 jaar psychiatrische zorg door de Zusters van Liefde* (Melle: Psychiatrisch centrum Caritas, 2008); A.-J. Billekens, *100 jaar psychiatrie in Venray: geschiedenis van de psychiatrische instellingen Sint Anna en Sint Servatius* (Zutphen: Walburg Pers, 2005); *150 Jaar Zusters van Liefde te Sint-Truiden* (Sint-Truiden: Psychiatrisch Ziekenhuis Sancta Maria, 1991); G. Deneckere, *Het Gentse Sint-Vincentiusziekenhuis: de zusters van liefde J.M. en de ziekenzorg te Gent, 1805 tot heden* (Ghent: Zusters van Liefde van Jezus en Maria, 1997); A. Roekens (ed.), *Des murs et des femmes: cent ans de psychiatrie et d'espoir au Beau-Vallon* (Namur: Presses Universitaires de Namur, 2014).

15 R. Stockman, 'De broeders van Liefde', in *Geen rede mee te rijmen*, ed. R. Stockman and P. Allegaert (Sint-Martens-Latem: Aurelia Books, 1989), 157.

16 Barbra Mann Wall has highlighted this feature of religious orders' involvement in American healthcare, see Wall, *Unlikely Entrepreneurs*.

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17 J. Godderis, ‘De geesteszieken: nieuwe inzichten en instellingszorg’, in *Er is leven voor de dood: tweehonderd jaar gezondheidszorg in Vlaanderen*, ed. J. De Maeyer, L. Dhaene, G. Hertecant and K. Velle (Kapellen: Pelckmans, 1998), 65.
18 H. McLeod, ‘New perspectives on the religious history of western and northern Europe 1815–1960’, *Kyrkhistorisk Arsskrift*, 1:100 (2000), 135–45, at 137, 141. On the ‘feminisation’ of religion in this period and the role of female religious orders (disparate growth in comparison to male religious orders), see C. Langlois, ‘Le Catholicisme au féminin’, *Archives des Sciences Sociales des Religions*, 57:1 (1984), 29–53.
19 There were of course also orders combining activities in education and healthcare, these counted for 17.07 per cent in 1846, 20.48 per cent in 1900 and 16.47 per cent in 1947.
20 A. Tihon, ‘Les religieuses en Belgique du XVIIIe au XXe siècle. Approche statistique’, *Belgisch Tijdschrift voor Nieuwste Geschiedenis*, 1–2 (1976): 1–54, at 40–1 and fn 114. The French and Dutch periods of control over the Belgian territories had resulted in the high number of religious houses dedicated to healthcare (as these active congregations had often been deemed more useful than the contemplative orders that were suppressed).
21 ‘Die kirchliche Caritas trug ein weibliches Gesicht’; B. Schneider, ‘Feminisierung der Religion im 19. Jahrhundert. Perspektiven einer These im Kontext des deutschen Katholizismus’, *Trierer Theologische Zeitschrift*, 111 (2002), 126, 129.
22 The bourgeois laymen who joined the St Vincent de Paul movement, not only offered material support to the families they visited, but also advised them in matters of hygiene (well aware of its link with physical health). See S. Baré, *Het Wit-Gele Kruis, 1937–2007: 70 jaar thuis in verpleging aan huis* (Leuven: Kadoc, 2007), 21; J. Lory and J.-L. Soete, ‘Implantation et affirmation (1845–1914)’, in *Les Vincentiens en Belgique, 1842–1992*, ed. J. De Maeyer and P. Wynants (Leuven: Leuven University Press, 1992), 45–84.
23 J. De Maeyer, ‘ “Les dames d’œuvres”. 19de-eeuwse vrouwen van stand en hun zoektocht naar maatschappelijk engagement’, in *Vrouwenzaken/Zakenvrouwen. Facetten van vrouwelijk zelfstandig ondernemerschap in Vlaanderen, 1800–2000*, ed. L. van Molle and P. Heyrman (Ghent: Provinciebestuur Oost-Vlaanderen, 2001), 108–27, references to Vloeberghs, *Belgique Charitable*.
24 K. Schultheiss, *Bodies and Souls: Politics and the Professionalization of Nursing in France, 1880–1922* (Cambridge, MA: Harvard University Press, 2001).
25 E. De Schampeleire, ‘De socialist-geneesheer-vrijmetselaar Modeste Terwagne en zijn tijd’ (Vrije Universiteit Brussel, unpublished licentiate

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