Chapter 1: Florence Nightingale: The Challenge, the Impact

It is Nature that cures, not the physician or nurse.

—Nightingale (1883, p. 1043)

WHY A NEW BOOK NOW

Why a new book now on Florence Nightingale's nursing? Her active career ran roughly from 1850 to 1900, and the bicentenary of her birth is 2020. She is recognized worldwide as the major founder of nursing, and International Nurses' Day is celebrated on her birthday, May 12. She still arouses controversy and probably will continue to, the consequence of the power and originality of her ideas and the concerted campaigns she waged to see serious system changes effected. In any event, few nurses are interested in the history of their profession. Nursing history courses or modules, which previously were common in nursing education, have largely been dropped from the curriculum.

The contention here is that many of Nightingale's key principles are still valid and that not only nurses but also health care decision makers would benefit by paying attention to them. Her insistence on high ethical standards, the centrality of the patient's needs, cautions about innovations—she advocated starting small and evaluating before wider application—are all good advice today. Medical science, technology, and hospital buildings have changed greatly since her day, but the new challenges of antibiotic-resistant disease germs call for new thinking and possibly a revisiting of old techniques. Her pioneering "evidence-based" approach to nursing and health care still holds (McDonald, 2001).

Nursing is not as old as medicine—Nightingale's school opened in 1860, a convenient date to mark the birth of the new profession. Earlier,

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there were nuns who gave devoted care, but no regular, trained professionals. Medicine, by contrast, dates back to the fifth century BCE in the West. Nightingale and her influence, in other words, do not date back to time immemorial, but to a period not all that different from the present.

The creation of the new profession was a key goal, but nursing itself was always a means to an end: quality health care. Hospital reform and broader social reforms thus must always be kept in mind in pursuing Nightingale's vision and work.

She was exceptionally well educated for her time, able to produce professional level reports and articles in all these areas, some with pioneering charts to present the data. She was an effective writer, good at one-liners and the equivalent of sound bites. Some of her ideas have yet to be implemented.

Eight key components of Nightingale's work and vision, it is argued, are still pertinent to nursing and health care today; however, much of the details have changed.

1. The prime purpose of nursing is to give high-quality, compassionate, patient care, which can be ensured only with adequate training and administration.

2. Best practice must evolve with advances in medical science, surgery, and related health sciences. Nightingale herself saw great progress made in reducing death rates by bringing in improved sanitary measures in the Crimean War of 1854–1856. She practiced this precept for the rest of her life. Best practice gets lip service routinely now, but serious implementation is more problematic.

3. When changes are made in care, they must be carefully monitored for both positive and negative results. Nightingale was herself a pioneer of what came to be called "evidence-based health care." It is acknowledged as essential now, although there is much resistance in practice.

4. Her goal in health care was quality care for all, including those unable to pay. Such a goal assumes a strong component of public provision for services, or "universal health coverage." It has been legislated in many countries, notably those with a social democratic ethos. The Germans pioneered coverage early via social insurance. It was first legislated, as a direct service, in Britain in 1946, in the National Health Act, and came into force through the National Health Service in 1948. It is perhaps no coincidence that the first instance of universal health care should have occurred in the country where the goal was first articulated—by Nightingale.

Canada's national Medicare shares this commitment, but with threats of privatization. The American Affordable Care Act, known as

"Obamacare," extended coverage to millions more uninsured Americans, but still without reaching Nightingale's objective of quality care for all. Abolition of this limited measure was a promise of Donald Trump in his successful presidential election campaign of 2016. However, even with a Republican Congress, he has failed so far to get his substitute American Health Care Act adopted, or to repeal Obamacare. Extensive privatization in the British National Health Service has turned its health care coverage into a two-tier (or more) system, depending on ability to pay. In short, Nightingale's goal of quality care for the poorest as well as the rich is still far from realization. The increased coverage achieved in the United States with Obamacare may be reversed

5. Health status is greatly affected by surrounding environmental conditions, which are themselves influenced by income, status, and other factors, now termed the "social determinants of health." To promote good health thus requires attention to the quality, or not, of housing, nutrition, air, and water. As the gap in income and wealth increases in many countries, people at the bottom are at increased risk of illness and premature death.

As nurses today increasingly take on health care policy issues, Nightingale's example becomes ever more germane.

6. Quality care requires teamwork from many professionals. Nightingale herself led a team of medical doctors, statisticians, engineers, and architects in implementing change post-Crimea. All these professional men deferred to her for her vision, research ability, and effectiveness in implementation. She deferred to them in their areas of expertise.
7. Adequate health and safety measures must be put in place to protect nurses' health. During the 19th century, most nurses lived in hospital or district residences, so this meant measures for comfortable living conditions as well as health and safety on the job itself. Since living accommodation is no longer an issue in most jurisdictions, and unions now attend to working conditions, Nightingale's principles serve here only as a guide for comparison.
8. Priorities for action on health care matters should be based on extent of need and feasibility of achievement. Nightingale took on the highest death rates and worst social conditions of her day, and, with her team, made progress on both. Applying this principle today, the priorities that appear are the threats of climate change, hospital-acquired infections, prescription errors and accidents, lack of access to health care, and the continuing toll of tobacco-related deaths: quite different matters each. Nurses in many jurisdictions are actively involved in variations of these challenges, as policy advocates and experts as well as clinicians.

How far ahead of her time Nightingale was is seen as the developments a century later began to catch up with her eight components of practice. The definition of health, as "a state of complete physical, mental, and social well-being and not merely the absence of disease," adopted by the World Health Organization (WHO, 2017) on its formation in 1948, is an example, discussed further in Chapter 3. The WHO's Alma Ata Declaration of 1978 goes yet further, making "the highest attainable standard of health" to be "a fundamental right of every human being," a statement unanimously agreed to by 113 countries (WHO, 1978). The declaration then specified primary health care to be the chief means to this end. Nightingale did not use rights language herself, but her espousal of access to quality care for the very poorest members of society was an early step toward this understanding.

WHO WAS NIGHTINGALE AND WHAT WAS HER NURSING?

Florence Nightingale (1820–1910) is recognized as the major founder of the modern profession of nursing. Her training school, which opened at St. Thomas' Hospital, London, in 1860, was the first secular nurse training school in the world. That is, while limited training was given to Roman Catholic nuns and Anglican sisters before Nightingale's time, her school accepted pupils (all women at that time) of any faith and no faith. It trained nurses for full-time paid work, with a hierarchy of positions of increasing responsibility and salary to top administration.

The women called "nurses" before her reforms, apart from those in religious orders, were low paid, disreputable, and often drunk. They were mainly used as hospital cleaners. Their "cardinal sin," according to Nightingale, was demanding bribes for their services. Nuns, she readily acknowledged, were an exception to this charge, but not their servants. To establish high ethical standards was a decided challenge for the time (Sellman, 1997), which explains why Nightingale so often said that a "good nurse" had to be a "good woman."

Nightingale chose St. Thomas' for her school as the process of reforming nursing had already started there, with the appointment of Sarah E. Wardroper (1813–1892) as "matron," or nursing director, early in 1854. Wardroper was an army doctor's widow who had never nursed, but she had to earn a living for herself and her children. She raised the standards at St. Thomas', improved the pay and working conditions, and attracted better applicants. Nightingale met her before she left for the Crimea.

When Nightingale began the task of establishing her school post-Crimea, the need for trained nurses had gained wide acceptance. The failings of the old-style "Sairey Gamps" Charles Dickens ridiculed in his novel

Martin Chuzzlewit were well understood. There were serious analyses of the inadequacies as well, which soberly point out that the medical attendant at a hospital had to go his rounds at night to see that the wine or beer ordered for the patients was "not abstracted by the nurses" ("Hospital nurses," 1848, p. 540). But there were still many doctors content with the status quo. An eminent doctor at St. Thomas', Dr. John Flint Snow, published a pamphlet opposing nurse training in 1857, although he did not oppose Nightingale when the school opened.

Medical science, when Nightingale set to work, was at a rudimentary level. Anesthetics were new and experimental. Nightingale promoted their use during the Crimean War, although the principal medical officer, her superior, opposed them. Antiseptic surgery was yet another decade in coming, with Joseph Lister's great breakthrough publication in 1867 (Lister, 1867). Bloodletting, blistering, and violent purging of the bowels were standard treatments. Doctors were frustrated by their inability to treat the great epidemic fevers (typhoid and typhus, cholera, smallpox, measles, dysentery, and diarrhea). They used toxic substances like lead, mercury, arsenic, bismuth, and turpentine. Articles in medical journals, "materia medica," and medical textbooks show how widely accepted use of these substances was. Nightingale preferred cautious doctors and urged caution, which is discussed in Chapter 2 in the section "Heroic Medicine," "Bad Medicine."

Nightingale's "restorative" approach entailed a firm rejection of the prevailing "humors" theory of Galen and other ancients that the world was made up of four elements: air, fire, water, and earth. Human beings and animals, similarly, were thought to be composed of four elements: yellow bile, blood, phlegm, and black bile. Disease was the result of an imbalance in the humors, and so treatment required applying the contrary to redress it. Bloodletting, which continued to be used into the 20th century, was the cure for diseases of the blood, sweating and expectoration for diseases of excessive phlegm (Arikha, 2008, p. 4).

Nightingale nurses had to act on medical orders, and accordingly were trained on the application of leeches, but it seems they never had to participate in the more dire forms of bloodletting, such as by the lancet (the medical journal, *The Lancet*, takes its name from this widely practiced "treatment").

Referencing Nightingale's Work

Great care has been taken in referencing Nightingale's multitudinous writing. For her correspondence and hard-to-find printed works, reference is made to their publication in the *Collected Works of Florence Nightingale*, a sixteen-volume work, in print and ebook (McDonald, 2001–2012), for which there is an associated website that gives transcribed sources, in a searchable database,

with biographical data on her correspondents, visitors, and authors she cited (www.uoguelph.ca/~cwfn/archival/index.htm). Manuscript sources cited here, the great number at the British Library, are given only when the item was not published in the *Collected Works* or another printed source.

Nightingale's writings include scholarly journal articles, letters to the editor, pamphlets, and thousands of letters in addition to her well-known full books. Large numbers of letters to and from nurses serve to flesh out what is known of Nightingale from the limited amount of her nursing work available in print. Seven of the volumes in the *Collected Works* have significant amounts of material on nursing. A short book, *Florence Nightingale at First Hand*, gives highlights selected from the whole collection (McDonald, 2010).

Part II of this book provides selections of her most important writing from 1858 to 1893, thus facilitating the tracing of her ideas as they evolved. Quotations in Part I are cross-referenced to those selections.

Because the titles of nursing positions have changed so much over the years, this text uses current terms. Thus, *matrons* and *superintendents*, even *lady superintendents*, have become *directors of nursing* here, except in direct quotations.

THE NEW PROFESSION OF PATIENT CARE

Nightingale's goal was a new, distinctive, profession of patient care. Given the poor educational level of nurses, medical orders would necessarily be the province of the physician or surgeon to determine. However, Nightingale was insistent that all decisions on hiring, promotion, discipline, and dismissal be made by senior nurse administrators, not doctors. A doctor who was dissatisfied with a nurse's performance would take that complaint to the nursing director, who reported to the senior hospital manager, as did the medical director. This manager would desirably not be a doctor—doctors made poor administrators, Nightingale thought. She also thought that they might prefer to practice their profession. To her friend, Sidney Herbert, she joked that there "must be something in the smell of the medicines which induces absolute administrative incapacity" (letter, May 25, 1859, in McDonald, 2009b, p. 123).

There is great misunderstanding in the secondary literature on Nightingale's use of the terms *profession*, *calling*, *art*, and *science* in relation to nursing. When it was crucial to demarcate the new trained nurses from the old-style nurses who drank and demanded bribes, Nightingale emphasized "calling." She stressed that it was the training, not the payment, that made someone a nurse, as it did a doctor. However, the profession was always to be paid work, and well paid, with good working conditions and opportunities

for career advancement. She particularly regretted the low pay of workhouse nurses when the workhouse infirmaries began to employ trained nurses.

Nightingale had herself experienced a "calling," if not by an audible voice, a clear message she understood to be from God. However, nursing was always to be open to people of any faith or no faith, a secular profession, not a religious order. Its standards included moral qualities as well as technical knowledge and, most importantly, bedside skills, which could be learned only through apprenticeship-type training. Science was always part of the mix, to be introduced gradually—a reasonable strategy at the time, given the lack of education of the first nursing students.

Nightingale also linked "calling" with "enthusiasm":

> What is it to feel a *calling* for anything? Is it not to do our work in it to satisfy the high idea of what is the *right*, the *best* . . . ? This is the "enthusiasm" which everyone . . . must have in order to follow his "calling" properly. Now the nurse has to do . . . with living human beings. (Nightingale, 1893, p. 193, in McDonald, 2004, p. 213, in Part II, Chapter 12)

In her article on nursing practice in Quain's *Dictionary*, she described nursing as "an art, and an art requiring an organized practical and scientific training" (Nightingale, 1883, p. 1043, in McDonald, 2009b, p. 736). In places, Nightingale exaggerated the "calling" aspect over the paid professional aspect. However, she strongly opposed unpaid nursing by "ladies" whose families did not want the indignity of their accepting a salary. Most nurses had to earn their living—some were supporting children or an aged parent. Unpaid nursing would depress wages, a decided wrong. A lady who did not need the salary should take it and donate it, Nightingale advised. Agnes Jones (1832–1868), the first professional nursing director of the Liverpool Workhouse Infirmary, who came from a well-off family, did precisely that.

When combating the state registration scheme proposed by the British Nursing Association, Nightingale argued that written examinations could not ascertain moral qualities. An experienced manager seeing the student's work in the ward could. Correspondence with Dr. Henry Acland, regius professor of medicine at Oxford, shows her stressing "calling" and deemphasizing "book learning." Nurse training was more about building character than technical knowledge, and she even said that nursing was not "a profession, but a calling" (letter, April 28, 1893, in McDonald, 2009b, p. 554).

In her 1893 paper, the last discussed in this book, Nightingale conveniently brought together the elements of art, science, profession, and calling. She began by announcing the creation, in the last 40 years of her career, of "a new art and a new science." She referred to a "threefold interest" in a nurse's

work: "an intellectual interest in the case, a (much higher) hearty interest in the patient, a technical (practical) interest in the patient's care and cure" (in McDonald, 2004, p. 215, in Part II, Chapter 12). In the 1894 revision to her Quain's *Dictionary* practice article, Nightingale brought calling and technical aspects together. Nursing was "above all, a progressive calling," so that year by year, nurses had to learn "new and improved methods, as medicine and surgery and hygiene improve." Yet "year by year, nursing needs to be more and more of a moral calling" (in McDonald, 2009b, p. 749). Clearly, calling and profession were not either/or for Nightingale but both/and.

As early as her *Notes on Nursing,* Nightingale expressed her appreciation of the increase in knowledge in the medical sciences. Pathology especially—she became interested in it during the Crimean War—had seen a "vast" increase in knowledge, but there was "scarce any in the art of observing the signs of the change while in progress" (Nightingale, 1860, Chapter 13). In a later paper, she deplored doctors behaving "as if the scientific end were the only one in view, or as if the sick body were but a reservoir for stowing medicines into, and the surgical disease only a curious case the sufferer has made for the attendant's special information" (Nightingale, 1860, Chapter 13).

"Calling" for Nightingale personally was religious, as it was for many nurses of her time. Angelique Lucille Pringle (1846–1920) was nursing director at the Edinburgh Royal Infirmary, then later at St. Thomas' Hospital, who shared this sense (she later converted to Roman Catholicism). A Nightingale letter to Pringle refers to God showing "His love in calling us to His work" (letter, August 30, 1873, in McDonald, 2009b, p. 288). In her tribute on the death of Sarah Wardroper, director of nursing at St. Thomas' Hospital, Nightingale credited her with upgrading nursing from its disreputable past, to become a "new calling" (Nightingale, 1894, in McDonald, 2009b, p. 392). The Archbishop of Canterbury, who unveiled the memorial to Wardroper in the chapel at St. Thomas', made it a "high and holy calling" (Archbishop of Canterbury, 1894). In a late letter to nurses in 1897, Nightingale prayed that they would all be "true to our calling" (in McDonald, 2009b, p. 879), all the while insisting that the profession be open to believers of any or no faith.

In her last "address" to nursing students and former students, in 1900, Nightingale affirmed that nursing had "become a profession." Trained nursing was no longer an object, but "a fact." She also urged her nurses to "always keep up the honor of this honorable profession" (in McDonald, 2009b, pp. 880–881).

Working and Living Conditions for Nurses

All the while, Nightingale was also active in promoting decent wages and salaries and working and living conditions for nurses, all essential for the

recruitment of better qualified people to the profession, in place of the old-style drunken nurses. She accepted that hours would be long for nursing students and nurses, but was most insistent that, when they reached the "Home" at the end of the day, they would find comfortable and warm quarters, good food with adequate variety, and a glass of wine. Much correspondence went to this endeavor. The point had to be made forcefully and often to hospital architects and administrators that nurses' residences had to provide private rooms (the walls must go up to the ceiling), have a window (which must open to the outside), decent furniture (chair, bookcase), and adequate washing and toilet facilities (separate from those used by patients). These were the responsibility of the director of nursing to ensure.

Nursing was onerous work, A nurse who had to get her own food and cook it, "'dog tired' from her patients," could be only "half a nurse," Nightingale explained in a fund-raising letter for a residence for district nurses: "she cannot do real nursing, for nursing requires the most undivided attention of anything I know . . . all the health and strength, both of mind and body," She repeated the point at the end of her appeal, asserting that "district nurses have quite other things to do than to cook for and wait upon themselves. They are the servants, and the very hard-worked servants, of the poor sick" (Nightingale, 1876, in McDonald, 2009a, p. 756, in Part II, Chapter 11).

Nightingale stipulated a month's holiday for all nurses. Isabel Hampton Robb, an American nursing leader, was content to accept 2 weeks. She, however, was successful in instituting an 8-hour day and substantially reduced the drudgery.

GENDER ISSUES IN NURSING

The profession Nightingale founded was geared to women, for good, historic reasons. When her school opened in 1860, women were not permitted in any profession—not the civil service, armed forces, politics, or religion as priests, ministers, or rabbis. Her goal in founding the profession was to improve patient care, not to provide jobs for women, but such jobs, with good salaries and working conditions, were a serious secondary objective. Nightingale recognized that men could be good nurses, and she expected that army nursing would be done mainly by men. She accordingly paid great attention to the selection, training, administration, and working conditions of men providing nursing care. This also held for nursing in the navy, but she was only peripherally involved in this issue.

Nightingale did not believe that being a woman made one a nurse, although women were typically expected, as women, to take on those tasks.

She was complimentary about men who were good nurses. Men in nursing are a logical development as the health care professions opened up to women. Here Nightingale's references to nurses are put into the plural where possible, to avoid expressions such as "the nurse, she," often coupled with the "doctor, he," which of course were correct statements in her day, with the occasional exception, late in her life, of a female doctor.

Many nursing leaders seem not to have understood the gender differences in education and opportunities that shaped the founding of their profession. Given these realities, why would anyone accuse Nightingale of "gender bias" or discrimination (Burkhardt, Nathaniel, & Walton, 2010, p. 7)?

A paper on men in nursing was critical of Nightingale, citing many negative secondary sources on the point, but not one by Nightingale herself (Brown, Nolan, & Crawford, 2009). These authors, further, had Nightingale's (presumed) opposition to men in nursing to cause her to "denounce male asylum nurses," considering that their duties were more like those "of prison warders than to nurses in general hospitals." Given that mental asylums at that time lacked trained nurses, they probably were.

Treiber and Jones (2015) oversimplified considerably, and incorrectly dated *Notes on Nursing* to 1881, having it set the "foundations for nursing as women's work" and even that Nightingale believed that it was "by its very definition, 'women's work,'" when she herself stressed that *training* was essential.

Nightingale knew men with good nursing skills, as correspondence with and about them shows. Sir Harry Verney's butler, for example, was an able observer on his employer's and other family members' illnesses, trusted to report both to the doctor and to her, and to administer medicines and food. He was the "excellent" and "admirable" Morey in 1889 correspondence, when he sent telegrams with urgent specifics and kept an hourly diary on the patient. Captain, later Sir, Edmund Verney was another who merited the "admirable nurse" title, again not for professional nursing but in the care of a family member at home (letter, February 6, 1889, Wellcome Ms 9012/110).

General Charles Gordon (1833–1885) would become known as "Chinese Gordon" for his exploits in China, then "Gordon of Khartoum," when he was assassinated there, but Nightingale saw him as a fellow nurse and hospital reformer. She praised him after his death for making his "battlefield" the hospital, the workhouse, the slums, the streets, and ragged schools: "His love of the sick and his experience made him of the same profession as I am." She commended him also for his earlier work in England when he looked after "waifs and strays" with fever at his own home. She recounted later that he had told her that, if his country did not require him for other

service, "he hoped to devote the remainder of his life to hospitals" (letter, August 30, 1886, in 5:508).

That Gordon's opinion of nurses was high can be seen in his statement that he had not suffered "1/20 the part" of what the hospital nurse suffers, who, "forgotten by the world, drudges on in obscurity" (Gordon letter, April 22, 1880, in 5:492). He looked after his men when they were sick, and won their loyalty.

NURSE–PHYSICIAN RELATIONS

The physician prescribes for supplying the vital force, but the nurse supplies it.
—Nightingale (1893, p. 186, in McDonald, 2004, p. 208, in Part II, Chapter 12)

In Nightingale's conceptualization, the nurse would always work under the orders of a physician or surgeon who made the diagnosis, prescribed any drugs and stimulants, and directed the treatment. Given the low educational level of nurses in her time, this could not have been otherwise. Women were excluded from universities and even secondary schools. Yet this seems to have escaped the notice of more recent commentators, so that Nightingale is said to have "deprofessionalized" relations between nursing and medicine (Gamarnikow, 1978, p. 114), as if those relations had been professional before.

Nightingale's challenge was to raise the status of the old-style nurse from that of a domestic servant to a junior professional. To make persons short of a secondary school education the equals of those holding a university degree and professional qualifications would be unrealistic.

With the great improvement in education since then, greater independence of nurses is possible. Nurse practitioners are a logical development of Nightingale's nursing. She anticipated—and promoted—rising standards in the proficiency required. Nurses had to keep up with advances in medical science and practice.

Nightingale has been much criticized for her insistence that nurses work under medical orders. It should be noted, however, that obedience was always qualified, "*intelligent* obedience," as she often said, meaning with discretion. She was influenced on this point by her early experience at Kaiserswerth: "There were the young deaconesses with their intelligent, animated, countenances, no mere instruments yielding a blind and passive obedience, but voluntary and enlightened agents, obeying, on conviction, an inward principle" (cited by Robb, 1912, p. 27). A Christmas letter

to the first trained nursing director and nurses at Addenbrooke's Hospital, Cambridge, remarked on the obedience expected in the past. Then a nurse "was simply told what had to be done, and ordered to go and do it. *Now*, the utmost pains are taken to show her *why* it has to be done and *how*" (Nightingale, 1877).

Nightingale continued to make the point, for example, in 1890, that a nurse was not an "automaton," but "an intelligent human being who has to do with matters of life and death" (Nightingale, 1890, in McDonald, 2012, pp. 829–830). In her Quain's *Dictionary of Medicine* article on hospital nursing of 1883, the qualification was that the nurse must act "intelligently, using discretion" (in McDonald, 2009b, p. 751). In the nurse training article, also, she described training as enabling "the nurse to act for the best in carrying out her orders, not as a machine but as a nurse." The nurse was not to be "servile, but loyal to medical orders and authorities" (in McDonald, 2009b, p. 735). She contrasted the obedience required of a nurse with that of a soldier, who had no discretion to disobey orders.

While the doctor determined the diagnosis and treatment, the nurse had the ongoing task of carrying out the plan, observing its effects, and reporting back. As Nightingale put it, "The physician prescribes for supplying the vital force, but the nurse supplies it" (Nightingale, 1893, in McDonald, 2004, p. 208, in Chapter 12). In serious cases, long before the availability of antibiotics, the nurse's role could be critical. Some early doctors called for the establishment of nurse training for nurses precisely because this role was so crucial. The point is pursued in Chapter 2.

Status Issues and Titles: "Doctor," "Nurse," and First Names

Finally, on the use of titles and honorifics, it should be noted that Nightingale always referred to both doctors and nurses by their titles and surnames, such as "Dr. Sutherland," "Miss Jones," "Mrs. Wardroper," "Sister Charity," that being the name of the ward in her charge, never by their first names. Doctors and nurses, then, spoke to each other as fellow professionals, although not on an equal basis. The practice began some decades ago of nurses using first names for themselves and patients (whether they like it or not), while deferring to doctors with title and surname: "Dr. Smith will see you now, Sally," whatever the respective ages of the doctor and patient. This practice also violates Nightingale's goal that nurses be the patient's "advocate," for doctor superiority is enforced even when the patient objects. Why should today's nurses be status enforcers for doctors?

Raising the status of nurses took concerted efforts over many years. Nightingale was ever the stickler for cleanliness, and nurses should clean when the cleaner failed to do the job (the nurse had to check on the result).

But trained nurses were not the hospital cleaners of the old system. It was the hospital's responsibility to hire adequate staff, an ongoing problem as hospitals trim their budgets by contracting out these essential services.

> *A nurse must not be a scrubber. And a scrubber cannot be a nurse.*
>
> —Nightingale (1863, p. 54)

Nightingale's use of surnames and honorifics for nurses and nursing students shows her insistence that they be treated as professionals, when domestic servants were called by their first name if they were young, or surname if older, but not an honorific and surname. She insisted that the nursing director and nurses sent to Australia travel first class, as medical doctors would.

NIGHTINGALE'S MENTORING OF NURSES

Nightingale became a long-term mentor for many nurses trained at her school, assisting them with applications for higher posts, writing and organizing letters of references, and helping with advice and moral support when problems arose, as they very often did with those who became nursing directors.

To ensure that they were well prepared for the post in question, she sought short-term placements to give the person relevant experience. This could be done by the nurse filling in for a nursing director on a summer break.

Many of the nurses who obtained administrative positions needed advice and assistance on occasion. Nightingale made time for periodic meetings and invited those with difficulties to let her know. A number of nursing administrators faced opposition from their hospital authorities. Several were subjected to protracted investigations. Nightingale was usually able to help considerably, always gave comfort, but could not get every hospital to reverse a decision against a nursing head.

To boost a new director's status, Nightingale often sent a gift, such as flowers, to be delivered on her starting day, signaling to the administration that the new head had Nightingale herself watching over her.

Much information is available on this mentoring process, since Nightingale kept both the letters these nursing heads and senior nurses sent her and the notes she took of meetings with them. Correspondence from them shows gratitude for the understanding and support they got (often, Nightingale's letter to the nurse is missing). Nightingale understood that these early nursing administrators were on the firing line. They were typically the first trained head the hospital had ever had, for the old-style "matron" was merely the housekeeper, in charge of the female servants and

linen. Some doctors were content with the old-style nurses or even preferred them. Nightingale mentored the next two generations of nursing leaders, not only in the United Kingdom, but also in Europe and the United States.

Nightingale understood that nursing, as medicine, surgery, and public health, was a work in progress. Nurses would have to renew and upgrade their skills to keep up with the demands on them. That was one reason why she so adamantly opposed the state registration scheme as it was initially formulated: It certified nurses immediately after their training and could not reflect the person's competence even a few years later. The answer to that concern is now typically met, in nursing as in many other professions, with required upgrading courses.

In her article on nurse training for Quain's *Dictionary of Medicine*, Nightingale suggested that a nurse needed "every five or ten years . . . after leaving the hospital, a second training nowadays." This followed from the advances made by "medicine, surgery, pathology, and above all hygiene [public health]" (Nightingale, 1883, Vol. 2, p. 1043).

Nightingale's writing shows that she paid great attention herself to keeping up with developments. She continued to debrief knowledgeable people about their work, into late in life. Her papers show her tracking operating theater preparations in 1896 (notes, August 1896, in McDonald, 2009b). Nurses visiting from other countries told her of improvements made there. British nurses visiting Europe reported back on innovations in place. A plague nurse in India gave her the latest news on inoculation in 1898. Nightingale was a dedicated and effective networker, yet one more reason why her writing is of such great interest.

NIGHTINGALE'S REPUTATION: HIGHS, LOWS, AND MISCONCEPTIONS

Nightingale was revered as the founder of nursing for decades after her death. Her status as a national heroine in the Crimean War was only the start. Her own school and her decades-long mentoring of nursing leaders around the world ensured that she was held in high regard. Nightingale's principles still appear frequently in nursing textbooks, but the fact of their origin in her writing is often unacknowledged.

The image of the "lamp" and use of the Nightingale pledge, which she did not write, are tributes to her influence but convey nothing of her own considered views. She has not been taught seriously in nursing schools in the West for decades. She typically gets casual mention in classes or a few lines or a paragraph or two in nursing texts, but seldom more.

Some nursing textbooks give at least minimal recognition of her work (Burkhardt et al., 2010; Chaska, 2001; D'Antonio, 2010; Ellis, Nowlis, &

Bentz, 1992; Haynes, Boese, & Butcher, 2004; Hinchliff, Norman, & Schober, 1994; Kelly & Joel, 1996; Lindeman & McAthie, 1999; Meleis, 1991; Taylor, Lillis, & LeMone, 1993).

Gottlieb is a significant exception to the general trend in drawing inspiration from Nightingale in her "strengths-based" philosophy of nursing (Gottlieb, 2012, pp. 41–42). "Strengths-based care" placed the person and family at the center; encouraged people to take charge of their own health, recovery, and healing; and required collaboration between the person/family and the health care provider. Gottlieb saw Nightingale using "strengths" in formulating health care policy, entailing "knowledge of people, their environments, and the political and social structure." The approach, Gottlieb contended, would help nursing get back on to Nightingale's vision and would move both nursing and the health care system in a new and better direction (p. 41).

Environmentally oriented nurses are also exceptional in continuing to find favor in Nightingale, for her highlighting the importance of environmental conditions in disease causation and healing (Libster, 2008; Selanders, 1993). For example, "Nightingale's environmental theory provides a basis for further theoretical development in nursing" (Hegge, 2013, p. 219). Her "thirteen canons," on ventilation, and so forth, differ "in specifics of application today, but the underlying principles remain sound" (Lobo, 2002, p. 59). A school of "holistic nursing" draws considerably on Nightingale (Dossey & Keegan, 2013), with a journal that reports on her influence, *The Journal of Holistic Nursing*. She is given enormous credit by environmentalists who work on health issues (Davies, 2013).

Meleis concluded that "Nightingale's attempts to establish professional nursing based on nursing's unique concern with environment for promotion of health were pre-empted by an illness-oriented training," which made it dependent on medicine (Meleis, 1991, p. 35). He evidently regretted that her followers, who continued to accept her advice on education and apprenticeship, "failed to continue in her footsteps, to differentiate the focus and goals of nursing and medicine and failed to further her theorization of nursing. Somehow the medical paradigm, better developed and more powerful, replaced what was starting to become a nursing paradigm (that is, concept of health, hygiene, environment and care)." The environment, he judged, has continued to be a central concept in nursing, but it is not treated with the same depth and conviction that Nightingale gave it (Meleis, 1991, pp. 190–191).

A nursing textbook credited Nightingale with being "an environmentalist before the term was ever coined." Both her *Notes on Nursing* and *Notes on Hospitals* provided "guidelines for ensuring the optimal physical environment for health and healing," including, in the latter, "detailed instructions

on unit design so that patients are in clean, safe, and attractive surroundings" (Lindeman & McAthie, 1999, p. 895).

Otherwise, however, it seems that the occasional reprinting of her iconic *Notes on Nursing* has been deemed a sufficient memorial to Nightingale, but typically not the best edition is chosen, and the introductions, by busy nursing administrators and academics, have missed a lot. *Notes on Nursing* predates the founding of her school and was not intended for professional hospital nurses, much as it is useful for setting out the basic principles of her environmental theory. A major example of comments from a "commemorative" edition is given in Part II, Chapter 10. These include obvious factual errors and even snide remarks.

Nursing textbooks with lists of models or systems of nursing begin with Nightingale's, typically noting its environmental focus. A major example specified 24 models, in five categories, beginning with Nightingale, flagging her "conditions for reparative process" theme (Potter, Perry, Ross-Kerr, & Wood, 2009, Table 5.1, p. 95). Henderson and Nite in 1978 cited three medical doctors and eight nursing theorists who articulated theories of nursing after Nightingale (Chapter 1). A more recent source has more than 20 theorists from Nightingale's environmental theory in 1860 to 2001 (Johnson & Webber, 2010).

Numerous examples could be cited of textbooks that use core Nightingale points without mentioning her name once. In a chapter on infection prevention and control, for example, five specific practices were outlined as necessary for all health care workers: handwashing, safe disposal of clinical material, wearing protective clothing, aseptic technique, and personal hygiene (Peto, 2004). All of these were assiduously promoted by Nightingale in her various writings.

Nightingale's reputation, as Sellman put it mildly, has been "tarnished" with the distortion of her approach, notably "by the zeal in which obedience above all else came to be seen as the primary virtue in a nurse." He referred to the "backlash of opinion" on her, adding, in understatement: "It is not fashionable to hold Nightingale in high esteem." He thought that she was unduly blamed for much of what is wrong in contemporary nursing, the result of her followers developing "a narrow interpretation of much of her work" (Sellman, 1997). This, in turn, results in her not being read directly, in favor of reliance on inadequate secondary sources.

The decline of interest in Nightingale's nursing in the West was accelerated by a series of attacks, beginning with one by an Australian medical historian (Smith, 1982). The second major author to attack her, focusing on her Crimean War work, was a management consultant (Small, 1998). Nurses, in other words, were not the instigators, but neither did any leading nurse or nursing organization defend her against either book, both of which

were based on gross neglect of key sources and incorrect citation of others. Two films of the British Broadcasting Corporation broadcast hostile views of Nightingale to large audiences (BBC1, 2001; BBC2, 2008), rebroadcasted often in other countries. Several detailed refutations of Smith's often preposterous claims (1982) have already been published, with references to primary sources that counter his points (McDonald, 2001, Appendix B, 2009a, 2010, Secondary sources on Nightingale and the Crimean War). Further material on the attack on her reputation is provided in the Appendix to this chapter.

Statisticians have consistently, from her day to the present, treated Nightingale as a major and valuable contributor to their discipline. The president of the American Statistical Association in 2016 focused on Nightingale in her "President's Corner" article (Utts, 2016). A Nobel Prize winner in economics, Sir Richard Stone, gave her a high place in the history of social statistics (Stone, 1997).

That Nightingale continues to be valued as a social scientist can be seen in her inclusion in the *Palgrave Handbook of Social Theory in Health, Illness, and Medicine* (McDonald, 2015). There are sections on her in three earlier books on social theorists (McDonald, 1993, 1994, 1998), with substantial excerpts from her writing in the last of these three.

Hospital architects continue to pay tribute to her great reforms in the late 19th century and see parallels in the more "environmental" approach of the 21st century (Hammond, 2005; Marcus & Barnes, 1999; M. Nightingale [no relation], 1982; Verderber, 2005). Her high reputation in these fields holds for Britain, the United States, and Canada.

Misconceptions about Nightingale include unwarranted praise. She has often been credited with achievements not due her, nor which she ever claimed. The prime example is that of attributing the dramatic decline in hospital death rates during the Crimean War to her and her nurses' work (Haynes et al., 2004; Hood & Leddy, 2006; Kelly & Joel, 1996). She has also been incorrectly credited with inventing the triage of wounded soldiers during the war (Munro, 2010). These, and other, errors occur from citing poor secondary sources, not using Nightingale's own work. She herself gave the credit for the great reductions in death rates to the Sanitary and Supply Commissions.

Misconceptions on Germ Theory

One old favorite misconception has Nightingale as a lifelong denier of germ theory, stated by American (Kelly & Joel, 1996; Lundy & Bender, in Lundy & Janes, 2009), British (Baly & Matthew, 2004), Australian (Godden, 2006), Dutch (van der Peet, 1995), and Canadian (Helmstadter, 1997) nursing

academics. There are misinformed medical doctors (Ayliffe & English, 2003; Cope, 1963; Wolstenholme, 1971), a director of the Army Medical Department (Cantlie, 1974), medical, military, and political historians (Brighton, 2004; Cannadine, 1998; Hays, 1998), plus a historian of ideas (Reverby, 1987); one medical historian published this incorrect view three times (Rosenberg, 1979, 1989, unpaged introduction, 1992).

According to a social historian, Nightingale was such a staunch opponent of germ theory that she went to her grave "believing that disease was caused by a bad smell" (Halliday, 2007, p. 81). Yet, if so, why did she state that the nurse "must be taught the nature of contagion and infection, and the distinctions between deodorants, disinfectants, and antiseptics," and that lives might have been saved had precautions always been "scrupulously observed" (Nightingale, 1883, Vol. 2, p. 1047)? She warned, in a late note, that "the risk with 'disinfectants'" was "that people think, if the smell is destroyed, the danger is gone" (note, British Library, Add Mss[1] 47767 f212).

Hospital architects tend to be highly favorable to Nightingale, but several, nonetheless, fell for the denier-of-germ-theory line (Stevenson, 2000; Thompson & Goldin, 1975). Numerous other examples are available (McDonald, 2009b), but those cited here are exceptional in coming from highly reputable authors and publishers, indeed from authors who otherwise made excellent contributions on her work.

One would have to have a badly distorted understanding of history to expect to see germ theory in her books of 1858 to 1863, before there was any documentation of the theory. That she did accept it can be seen in a publication in an Indian journal, where she urged that lectures be organized for villagers, with slides to show "the noxious living organisms in foul air and water," and thus prompt them to examine their water supply and take precautions (Nightingale, 1892, in Vallée, 2007, p. 363).

This "elite" list of misinformed authors should serve as a caution: Misconceptions about Nightingale are all too available, and great care must be taken in using sources.

FROM NIGHTINGALE'S VISION TO NURSING TODAY

The prime purpose of this book is to bring Nightingale's ideas and work to the attention of nurses today, not as a historical figure but as a source of principles, vision, and sound practice in the here and now. It is directed especially to nurses who have heard almost nothing about her in their training, or heard only the "tarnished" version.

[1] Further references to Add Mss (Additional Manuscripts) are also to the British Library.

This is not the place to describe what Nightingale did to establish professional nursing in any particular country, as much material is available elsewhere (McDonald, 2009a). The point is that she is a particularly useful source for nursing in countries where educational requirements are high and the profession well developed. In the United States and Canada, nurse practitioner positions are increasingly available. Many nurses take degrees past the bachelor's level, increasingly of doctorates. "Centers of excellence" promote a high level of professional activity. Some professional associations speak out on health care policy generally, not only professional nursing concerns, in line with Nightingale's own example of political activism.

The situation is quite different in Asia. Nightingale is still taught both in the school system and in nursing faculties in major Asian countries. She is seen as a moral example, as well as a source of relevant principles on nursing. After the dropping of the atomic bomb at Hiroshima in August 1945, hospital nurses treating the victims were brought together twice a day to recite the Nightingale pledge. The solemn pledge and reminder of their duty helped them to endure appalling conditions—vast numbers of dying in a nearly collapsed hospital (Nelson, in Nelson & Rafferty, 2010).

In Japan, not only is Nightingale's *Notes on Nursing* taught to nursing students, but her later, more advanced, writings are also available in Japanese translation. Professional societies exist to apply her principles in practice, notably the Nightingale KomiCare Society, which holds conferences and publishes a journal. Nurses at professional conferences discuss how they apply Nightingale's principles in acute, community, and palliative care, with patients reporting great satisfaction. There is, to my knowledge, nothing equivalent to this in Western nursing. However, so far, nurses in Japan have not taken on policy tasks nor pointed out failings in the health care system.

Nightingale is a serious model and example for nurses in India and China. In the case of India, there are links through her own attempts (with limited success) to bring in professional nursing in the late 19th century. In China, as in Japan, she has been revered as an example of self-sacrifice for the greater good. Yet again, her example as a policy advocate and whistleblower is ignored.

In the mid and late 20th century, nurse training made the transition to university, the United States and Canada leading the way. Yet continuities in priorities (health promotion and prevention), and even definitions of nursing, continue to show their roots in Nightingale. A leading American 20th-century nurse, Virginia Henderson, updated the definition of nursing to include the wider roles of administration and education, and to make clear that the work was *paid*, points left implicit in Nightingale's formulation.

Henderson's lengthier definition also follows Nightingale in assuming medical jurisdiction in diagnosis and prescription:

> The practice of professional nursing means the performance for compensation of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatment as prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social science. The foregoing shall not be deemed to include acts of diagnosis or prescription of therapeutic or corrective measures. (Henderson, 1967, p. 3)

Henderson next defined "practical nursing" and gave its relationship to professional nursing. This definition is very much in line with the demarcation common in Nightingale's day, of a trained or "head nurse" and an untrained "assistant nurse" (Henderson, 1967, p. 3).

NIGHTINGALE'S LINK TO AMERICAN NURSING

That the first nursing schools in the United States, dating to 1873, were based on Nightingale's principles is well known (see the Appendix at the end of this book for a timeline of Nightingale's influence). Less well known is Nightingale's role in the important advances made in nursing organization late in the century, notably at the International Congress of Charities held in Chicago in 1893, which featured a paper by Nightingale, excerpted in Part II, Chapter 12. The congress brought together nursing leaders from many places in the United States and the United Kingdom. Isabel Hampton, principal of the training school at Johns Hopkins University Hospital, and before that at Cook County, Chicago, took advantage of the occasion to foster the formation of an organization of directors of nursing schools. It later became the National League for Nursing (she was president in 1909). She had earlier been instrumental in forming an alumnae organization at Johns Hopkins University Hospital (D'Antonio, 2000). The next step was a national organization of all accredited nurses. This was the Nurses' Associated Alumnae of the United States (and Canada), which became the American Nurses Association. She was the first president, 1897–1901. Nightingale was made an honorary member in 1899. Hampton Robb (as she was subsequently known) was also, later, a major force in the creation of the International Council of Nurses.

Shortly before she married, Hampton visited Nightingale in London in 1894 (Nightingale sent her the bridal bouquet). Hampton had published a full and comprehensive textbook, *Nursing: Its Principles and Practice for Hospital and Private Use* (Robb, 1893), a copy of which she gave to Nightingale (letter, September 20, 1894, Add Mss 45812 f189). She had extended the Johns Hopkins program from 2 to 3 years.

She was a gifted, innovative teacher. At Johns Hopkins she, as well as the doctors, gave lectures. For her lectures, she used such visual aids as a skeleton, a manikin for "visceral anatomy," specimens, and pictures. She is said to have been excellent also in bedside instruction. Hampton Robb highlighted lessons from Nightingale, on thorough cleanliness in the wards, pure air, and a sympathetic attitude (Baer, *Enduring Issues in American Nursing*). She drew on her lecture material when writing her influential textbook, *Nursing: Principles and Practices*.

It is perhaps no coincidence that Hampton looked to Nightingale for guidance when they met, specifically for advice on the new organization of nursing directors. From Nightingale's notes of the meeting, they evidently discussed this, as well as British–American differences in nursing and expectations (notes, July 8, 1894, in McDonald, 2009a).

Hampton Robb's own books, again no coincidence, can be seen as important bridges from Nightingale's core principles to the development of nursing in the 20th century, with a great increase in academic content and reduction in drudgery (D'Antonio, 2000). Her *Nursing: Its Principles and Practice* nowhere mentions Nightingale, but the influence is evident throughout in the stress on the biophysical environment, relations with doctors, and ethical concerns. It notably gives copious details of what nurses must learn, which go far beyond *Notes on Nursing*. By then, a 3-year program was in place, in contrast with 1 year at the Nightingale School. Hampton Robb used the material she taught in her classes at Johns Hopkins.

Hampton Robb's *Nursing Ethics* (1903), cites Nightingale explicitly and deferentially, and, again, shows Nightingale's considerable influence. It, however, has much on hospital "etiquette," or procedures, as well as ethics as such. Her *Educational Standards for Nurses* (1907) reflects another shared concern, a rigorous academic program for nurse education.

While Nightingale grudgingly accepted germ theory, Hampton Robb saw its importance and argued for at least the "broad principles of bacteriology" to be included in the curriculum for nurses. "How hopeless and dull, not to say irritating, would be the many washings and the various aseptic precautions which are now required from the nurse by the physician unless she had learned from bacteriology to appreciate the fact that there exists a surgical, a microscopical, cleanliness" (Robb, 1907, p. 99). In her ethics book also, she said that "bacteriologically practical training" was needed, and

that the operating room nurse was no less important than any other member of the surgeon's staff (Robb, 1912, p. 35).

Nightingale continued to make (occasional) disparaging remarks about germ theory, even after accepting it, for example, in her paper on rural health, "Not bacteriology, but looking into the drains is the thing needed" (Nightingale, 1894, in McDonald, 2004, p. 617). Yet the two need hardly be either/or, as Hampton Robb well understood. Both were, and are, needed.

Nightingale's writing from the mid-19th century continued to be taught to nursing students well into the mid-20th century. Hampton Robb published a second edition of her *Principles and Practice* in 1906; then, after her death, her doctor husband brought out a third edition, with slight revisions, in 1914. The text was, at least partially, translated into Chinese for use when professional nursing was introduced into China (Dock, 1912, Vol. 4). Harmer brought out her similarly titled *Textbook of the Principles and Practice of Nursing* in 1922.

Nursing with its health approach would continue to be complementary to medicine, as Nightingale saw it (Potter et al., 2009). Harmer and Henderson were used into the late 20th century. Roy's Adaptation Model, noted in Chapter 2, gained much acceptance. It was based on core Nightingale ideas.

American nursing's ascendancy in the 20th century must owe something to its large numbers, but doubtless much must be attributed to its early promotion of university training and research. Hampton Robb was central to this development.

How well established was hospital nursing in the United States and Canada before Nightingale set to work? Florence Lees, on an inspection tour in 1873 to 1874 for William Rathbone, found nothing satisfactory to report. She visited New York, Albany, Boston, Chicago, and Cincinnati in the United States and Hamilton, Toronto, Ottawa, and Montreal in Canada. She found "scores" of young women willing to take nurse training in both countries, if any training school were established, but she knew of none, nor any serious plans to start one (this would soon change in the United States).

Lees judged the schooling of girls in Canada to be "admirable," for all children there learned "at least the *elements* of anatomy, physiology, and chemistry." Her opinion of Canadian hospitals, however, was even lower than that of American hospitals. There was "*nothing* to learn" in them, but they were "alike miserable in construction and arrangement," as well as "in their defiance of all sanitary laws, and in their miserably insufficient *nurses* for the sick" (Lees letter, December 3, 1873, Add Mss 47756 f219).

Her opinion was confirmed a couple of months later from Boston. Lees wrote to Nightingale: "The nursing in Canadian hospitals and (so far as I have yet seen) in the States, is utterly unworthy of the name" (Lees letter, February 12, 1874, Add Mss 47756 f228).

AN OVERVIEW OF CHAPTERS

From the abundant material Nightingale herself wrote on nursing, health promotion, and hospital safety, the task is to make the best of it available to active professionals today. As is shown in Chapter 2, Nightingale is still a good source on patient care. Have patients changed so much? Her positive, holistic definition of health and her pioneering analysis of the social determinants of health status still apply (Chapter 3). So also do her ideas on ethics (in Chapter 4).

Nightingale's most famous work took place during the Crimean War, under terrible hospital conditions. The lessons she learned from that experience took her into what came to be called infection control (Chapter 5). Ironically, her earliest and simplest advice on frequent handwashing remains the single most important method of combating the spread of infection. Large numbers of lives are lost annually around the world from lapses.

Nightingale never did pediatric nursing herself, but she was frequently asked for advice on it and she liaised with experienced people to provide answers. One of the first hospital plans on which she worked was for a children's hospital in Lisbon, and she continued to pay particular care to the needs of children in hospital care (Chapter 6).

Nightingale's own example in providing palliative care is of interest (see Chapter 7). Conditions have changed, and the numbers only increased as people live longer, increasingly in long-term care agencies. That she went beyond the call of duty is evident in this chapter.

Chapter 8 takes up the thorny issue of administration, relating Nightingale's own experience of it, her teaching on what is needed, and issues that arose in her ongoing mentoring of senior nurses. A number of the early nursing directors faced serious opposition by their hospital administrations, and Nightingale devoted time and energy to defend them. A recent example of gross failures in nursing (and other) care, the Mid-Staffordshire NHS Hospital, is examined in relation to Nightingale's principles of administration.

Finally, Nightingale's insistence on good research and its application in policy is as needed now as ever (Chapter 9). Many nurses want to play a stronger role in health care policy. The growing numbers of nurses with graduate degrees are prime candidates for this more significant role, but they require adequate tools. Nightingale is a formidable inspiration and an ongoing source of sound ideas for these challenges. That she led an interdisciplinary team of doctors, engineers, statisticians, and architects is scarcely known by today's nurses. Nor that the leading public health expert of Britain, if not the world, Dr. John Sutherland, for decades acted as her (unpaid) research and editorial assistant. Are there any nurses today that

have such a team or produce anything comparable to what she and her team produced?

Part II gives selections, in chronological order, of Nightingale's writing of most enduring value. Chapter 10 has her first papers on hospital reform (1858), followed by the book that nurses most know, her *Notes on Nursing* (1860). Chapter 11 is devoted to her work to provide quality care for the poorest. It begins with her landmark 1867 brief for a Parliamentary committee, which made the case for quality, trained nursing in those dreaded places (e.g., the workhouse infirmaries). Next comes her 1868 tribute on the death of the first trained nursing director of a workhouse infirmary, Agnes Jones—a spirited call to women to take on the challenge. Then there is her letter to *The Times* promoting "district nursing," or home visiting or community nursing, to provide quality care while keeping patients out of hospitals and workhouse infirmaries.

Chapter 12 covers her last years of work on nursing, hospitals, and public health. Two items from the 1880s show how much nursing and hospitals had evolved since the opening of her school in 1860: an unpublished paper of 1880, and her entries in Quain's *Dictionary of Medicine* in 1883. A letter from 1884 written for *The New York Herald* gave urgent advice on an impending cholera epidemic. Finally, there is her paper for a world congress in Chicago in 1893. A tour de force, the paper goes back to key Nightingale ideas from her earliest work, with insights added from her decades of guiding the development of the growing profession. That congress also marks a great step in the evolution of the profession, with many nurses themselves giving papers of high standard. Isabel Hampton, then director of nursing at Johns Hopkins University Hospital solicited the paper, and read it for Nightingale.

In each case of the selected writings, the focus is on what is still relevant in the work. Thus, the rationale for a 28-bed ward and the horsehair mattress are omitted as no longer germane. Rather, the purpose is to relate Nightingale's core principles and their value today. The evolution of her ideas can be traced as nursing, medicine, and the health sciences generally developed. From early to late, her great gift of succinct and often witty expression will impress.

The chapters in Part I, apart from this introductory chapter, conclude with "Questions for Discussion." Some of the questions (not those first listed) are tough, suitable for nursing students doing degrees beyond the baccalaureate.

WHAT THIS BOOK IS NOT ABOUT

This book is not a biography, of which so many already exist. The best is still the two-volume official biography, for it quotes fully from Nightingale's

own writing, a considerable merit (Cook, 1913). The secondary literature on Nightingale is vast and continues to grow: full books, scholarly articles, children's books, the popular press, websites, radio, and television. However, as is pointed out from time to time, it is highly error prone. Nightingale's writing is the best source of her views, and it is readily available, now more than ever before. She gave her best to her writing and wanted to be known by it. She was seldom boring, often provocative, and sometimes inspiring. Even when she exaggerated, she had something worth saying, as, for example: "The fear of dirt is the beginning of good nursing" (Nightingale, 1883, p. 1046, in McDonald, 2009b, p. 745).

QUESTIONS FOR DISCUSSION

1. Is Nightingale's short definition of health adequate for use today? What definition do you/your nursing school prefer?
2. How do Nightingale's views on the purpose of nursing relate to broader issues of health care?
3. How do nurses, in practice, cover the components of health promotion/disease prevention and giving patient care? Must these be specialized occupations?

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APPENDIX: THE ATTACK ON NIGHTINGALE'S REPUTATION

From examining misconceptions as to Nightingale's influence and reputation, in both directions, the focus here moves to two particularly influential negative sources. Both are British, for indeed American and other sources tend to be far more positive. Given their weight, however, and the tendency for bad news to travel, it seemed advisable to report on them here, so that readers, especially nursing leaders, can be forewarned.

David Cannadine's History of Our Time

The first source is David Cannadine, fellow of too many scholarly organizations and recipient of too many awards to mention, knighted for his "services to scholarship" in 2009. His *History of Our Time*, nonetheless, has numerous errors of fact, and, interspersed with many favorable comments on Nightingale's work, slurs on her character and achievements.

Cannadine depicted Nightingale as enormously selfish and demanding in personal relationships. For example, when her great collaborator Sidney Herbert became ill, according to him she "scarcely noticed" that he "was collapsing under the strain" (Cannadine, 1998, p. 203). But Herbert wanted to keep working as long as possible, and continued to write her with ideas for new projects; see his letters to her (Add Mss 43395); Nightingale thought that he was a bad patient—he went to a Belgian spa for treatment when he was dying of kidney disease. Her letters to him, as those to his wife (Add Mss 43396), do not suggest callousness, and Cannadine gave not one concrete example.

He had Nightingale "imperiously" telling newly qualified nurses "where to take employment, shamelessly promoting her proteges" (Cannadine, 1998, p. 202). Yet a massive number of letters by nurses to her is on record asking for her help in getting posts. She wrote numerous letters of reference, usually after meeting with the person herself to explore options (she kept the notes). Nightingale tried numerous times to get such leading nurses as Mary Jones and Florence Lees to take on workhouse infirmary work, yet continued to support them when they did not (Jones ran a convalescent home, Craven led in district nursing).

Cannadine blamed Nightingale for not acknowledging "those nurses who were not directly under her control" (Cannadine, 1998, p. 202), a matter belied by correspondence to her by nurses at many hospitals. Eva Luckes, nursing director at the London Hospital, is a good example, a nursing leader who sought her advice and help; yet she did not train at Nightingale's school and was never under her authority (Add Mss 47746). Alfhild Ehrenborg, first principal of the nursing school established by Queen Sophia in Sweden in 1883, is another example, as is Linda Richards, the first U.S.-trained nurse,

who took Nightingale standards and methods to many American hospitals and, later, to Japan. Three Canadian-born American nurses were never under Nightingale's control but sought her advice and help—and got it; all ran their nursing services according to their own views, moving beyond her ideas: Isabel Hampton Robb, Louise Robinson Scovil, and Charlotte Macleod. Much surviving correspondence shows nurses reporting valuable material to her on best practice in their own and other hospitals. This was networking, and Nightingale benefited from material they brought her.

Another character flaw, according to Cannadine, Nightingale felt "personally affronted" if nurses under her "dared to get married" (1998, p. 203). Yet she sent greetings and good wishes on the wedding to some, sometimes the bridal bouquet, for example, Isabel Hampton, noted earlier in this chapter, and Emily Mansel Cheadle (Cheadle letter, August 6, 1892, Add Mss 45811 f124). Florence Lees was given both a wedding gift, one she would "treasure always," and a "beautiful" bouquet (Lees Craven letters, September 21 and November 23, 1879, Add Mss 47756 ff344 and 348). Nightingale took on such tasks as looking for help for Mrs. Craven and was godmother to a son. She sent a "nosegay" to a nurse of Adelaide ward on her wedding day (Haydon letter, September 13, 1897, Add Mss 45815 f9) and good wishes in 1901 to another on her wedding (Carpenter Davis letter, January 19, 1901, Add Mss 45815 f158).

On the development of nursing, Cannadine had Nightingale opposed "to the professionalization of nursing, to public examinations, and to state registration" (Cannadine, 1998, p. 204). Not quite: She opposed the scheme of state registration proposed by the Royal British Nursing Association for its giving too much power to doctors and for emphasizing written examinations, which would have excluded able working-class nurses from the profession (McDonald, "State registration of nurses," in McDonald, 2009b); she strongly supported high and increasing professional standards, but did not believe that written examinations sufficed to judge competence.

Yet another unfounded judgment has Nightingale not interested "in women's issues and women's rights" and no "feminist role model" (Cannadine, 1998, p. 206). Why then did she sign numerous petitions for the right to vote, support married women's property rights and higher education for women, mentor the first woman to win a senior civil service post, and vigorously oppose the discriminatory "Contagious Diseases Acts" that targeted female prostitutes? Suffrage leaders appreciated her support, as did John Stuart Mill, who led the struggle for the vote in Parliament.

The Oxford Dictionary of National Biography *on Nightingale*

The other highly prestigious negative source (again with positives interspersed) is the entry on Nightingale in *The Oxford Dictionary of National*

Biography (Baly & Mathew, 2004). Baly, who wrote the initial text, was the leading nursing historian at the time it was commissioned. Mathew, then the editor of the *Dictionary*, added much material from Smith (1982), a cool 15 additional citations, although Smith was known to be both inaccurate and derogatory.

In February 2017, the Nightingale Society protested the inadequate and hostile coverage to the then editor of the *Dictionary*, the same Sir David Cannadine, who succeeded to the editorship in 2014 (Nightingale Society, 2017). Disproportionate space went to Nightingale's family background, the complaint stated, leaving little for discussion of her work. There was no discussion of her influential *Notes on Hospitals* or her analysis of high death and illness rates in aboriginal schools and hospitals, none of her Franco-Prussian War work or her later nursing papers, and only scant coverage of her *Introductory Notes on Lying-in Institutions* and work on district nursing, which it dated incorrectly.

A heading in the entry has Nightingale "out of office" as early as 1870, a time when she was highly productive. The expression "out of office" was one she used, casually, in private correspondence, when a viceroy leaving for India did not come to see her (nor did the next one). However, the next three viceroys after them did call on her, and two became close collaborators on public health and broader social reforms (Lords Ripon and Dufferin). Far from being "out of office," she found new allies in Indian nationals, and wrote much for their public health journals.

The *ODNB* is grossly misleading as well in relegating Nightingale to "old age" in 1880, when she had 20 more years of useful work, including some of her best publications, which are simply ignored (they are excerpted in Part II, Chapter 12 of this book). These late works include new initiatives, a development entirely missed in the entry. And, while Nightingale continued to be sought out by leading medical and public health experts, the *ODNB* has her "out of touch" on those issues. The school itself is judged to have failed at providing good nursing training, although it gave not one example of a better school.

That these two examples are of sources normally considered reliable must suggest great caution to researchers in using sources. Primary sources, and biographies that rely heavily on them, such as Cook (1913), are recommended.