FLORENCE NIGHTINGALE, NURSING, AND HEALTH CARE TODAY

LYNN MCDONALD, PhD, LLD (HON)

Contributes new insights to Nightingale’s relevance for nursing today

This in-depth analysis of Nightingale’s legacy goes beyond established scholarship to examine her lesser known—and arguably even more important—writings beyond Notes on Nursing. The book demonstrates afresh her unparalleled and ongoing influence on professional nursing and on the core concepts of health, disease, and access to care as we understand them today. It introduces readers to the “real” Florence Nightingale—who pioneered evidence-based health care, campaigned for hospital safety, promoted economic opportunities for women, and mentored two generations of nursing leaders.

The first part of the book focuses on Nightingale’s core nursing concepts: gender and women’s issues, education, health promotion, infection control, professional ethics, pediatrics, and palliative care, and how they have transcended time to influence professional nursing today. The author draws on comments from current nursing and medical literature to demonstrate the ongoing relevance of Nightingale’s work. In the second part of the book, the author presents key writings by Nightingale, including the little-known background work that shaped her iconic Notes on Nursing. This section covers key later writings, which show how her ideas evolved with advances in medical science and nursing practice.

Key Features:
- Expands on established scholarship to reveal Nightingale’s contributions to theory, science, and policy in greater breadth and depth
- Demonstrates the remarkable relevance of her work to nursing issues today
- Highlights Nightingale’s core nursing concepts of health promotion, disease prevention, and access to care
- Disseminates Nightingale’s writing especially relevant to nursing leaders and policy advocates
Florence Nightingale, Nursing, and Health Care Today
Lynn McDonald, PhD, LLD (Hon), completed her doctorate at the London School of Economics and then went on to pursue an academic career, publishing in criminology, political sociology, women’s studies, the environment, and classical social theory, with a focus on women theorists. She also served as the president of Canada’s largest women’s organization and represented it when Canadian women got their “equal rights amendment” in the Charter of Rights. She went on to pursue a parliamentary career, variously working on issues of justice, communications and culture, and the environment. Her Non-Smokers’ Health Act, 1988, was the first legislation in the world to establish smoke-free work and public places and influenced similar legislation in many countries. Her main work in recent years has been as director of the 16-volume (peer-reviewed) Collected Works of Florence Nightingale (www.uoguelph.ca/~cwfn), available in print and as ebooks. A short book, with highlights from the series, is Florence Nightingale at First Hand (2010).

Dr. McDonald currently gives much time and energy to work on the climate crisis. She is a co-founder of JustEarth: A Coalition for Environmental Justice, a voluntary organization, and a former member of the Board of Directors of Climate Action Network, Canada. She is a member of the Order of Canada and has an honorary doctorate.
Florence Nightingale, Nursing, and Health Care Today

LYNN MCDONALD, PHD, LLD (HON)
Contents

Reviewers vii
Preface ix
Acknowledgments xi
Share Florence Nightingale, Nursing, and Health Care Today

PART I: Nightingale’s Nursing: Then and Now
1. Florence Nightingale: The Challenge, the Impact 3
2. Nursing: The New Profession of Patient Care 35
3. Health Promotion 61
4. Ethics 81
5. Infection Control 97
6. Pediatric Nursing 109
7. Long-Term and Palliative Care 123
8. Administration 137
9. Research and Policy Development 153

PART II: In Nightingale’s Own Words
10. Nightingale’s Early Writing on Hospitals and Nursing 173
11. Nightingale’s Writing on Nursing for the Poorest 207
12. Nightingale’s Late Writing on Nursing, Hospitals, and Disease Prevention 221

Appendix: Timeline—Nightingale’s Nursing and Health Care and Its Influence 243

Index 257
Reviewers

Laurie N. Gottlieb, PhD, RN, LLD (Hon), Professor, Ingram School of Nursing, McGill University, Montreal, Canada

Edward J. Halloran, PhD, RN, FAAN, Professor Emeritus, School of Nursing, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Charlene Harrington, PhD, RN, FAAN, Professor Emeritus, School of Nursing, University of California San Francisco, San Francisco, California

Dame Janet Elizabeth Murray “Betty” Kershaw, DBE, RNCN, CStJ, Dean Emeritus, School of Nursing and Midwifery, University of Sheffield, Sheffield, United Kingdom
So much has been written about Florence Nightingale, as a war heroine, role model, nursing founder, and public health reformer, that one might wonder why another book, now. This book is geared to telling a story that has often been missed or botched by the use of poor secondary sources.

The extent and originality of Nightingale’s writing is not fully appreciated. Along with her well-known *Notes on Nursing*—the only one of her books many nurses have read—are two other full books, plus numerous scholarly journal articles; letters to the editor (several substantial); pamphlets; and thousands of letters, professional and personal.

Nightingale material is now available to the dedicated scholar in a 16-volume *Collected Works*, in print and as ebooks. Seven of these volumes have significant amounts of nursing material but busy nurses, administrators, and nursing academics, as well as other health care professionals, may not want to wade their way through so much detail.

*Florence Nightingale, Nursing, and Health Care Today* is addressed to them, to nursing students, and to the interested general reader. Nightingale was far ahead of her time in setting out the core principles of the new nursing profession, with demanding ethical standards and continuing education to keep up with best practice. She was a gifted political activist who saw enormous strides made in the provision of quality services, including access to care for the most disadvantaged. Yet some of what she advocated has yet to be implemented.

Part I of the book shows what she wrote and did in key areas of nursing and health care: patient care, health promotion, ethics, pediatric care, long-term and palliative care, administration, and research and policy advocacy. Each chapter in this part of the book concludes with a discussion of where we are today on each of these issues.
Part II of the book takes the reader into Nightingale’s best writing itself. Much of this material is new, even to nursing academics, for it goes well beyond her *Notes on Nursing*. Indeed, the excerpts from that book are from a seldom-read edition, the one geared to more educated readers. Her late papers show how far nursing had progressed in the decades after *Notes on Nursing* of 1860. The technical demands made on nurses by then were much tougher, reflecting the progress made in medical science. Two of the papers were written specifically for Americans.

*Florence Nightingale, Nursing, and Health Care Today* also shows how Nightingale interacted with leading physicians and other health science experts. She could draw on the latest information in medicine, medical statistics, and hospital architecture and engineering. She mentored nurses around the world, who brought her new information—material that has received scant attention to date.

My acquaintance with Nightingale comes from her expertise in social science—I am a social scientist, not a nurse or physician. I have also been a successful public health advocate when, as a Canadian Member of Parliament, I authored the Non-Smokers’ Health Act of 1988. Thus, I have great appreciation for her ability to use the political process. As nursing and other health care leaders confront today’s challenges—access to quality care, the rising cost of services, climate change, and the complications of globalization—Nightingale’s willingness to take on the big issues can give us courage. Her goal was always to save lives, and with an impressive team working with her, she used the latest science available. She, and they, did save lives and published the data to prove it!

Nightingale faced and met the greatest challenges of her day. Why should today’s nursing and health care leaders not aim just as high?

*Lynn McDonald*
Acknowledgments

Many colleagues assisted in the preparation of the book, hundreds if the background material on which it drew is considered—the 16 volumes of *The Collected Works of Florence Nightingale*. For the book itself, thanks go to several academic nurses who read an earlier draft of the book (in alphabetical order): Marilyn Gendek, MA, RN; Laurie N. Gottlieb, PhD, RN, LLD (Hon); Charlene Harrington, PhD, RN, FAAN (ret); Edward J. Halloran, PhD, RN, FAAN (ret); Betty Kershaw, DBE, FRCN, CStJ; and Marie Dietrich Leurer, PhD, RN.

Thanks to Patricia Warwick for much assistance in fact checking and proofing. Thanks to Janice Hicks for technical support at the University of Guelph, to Ken Simons, who also acts as technician for the Nightingale Society website, for technical support. Thanks to Margaret Zuccarini, nursing publisher emeritus, at Springer Publishing Company, who was wisdom and practicality at many stages of bringing this book into existence.
Share
Florence Nightingale, Nursing, and Health Care Today
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,
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.

©Springer Publishing Company
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

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, &

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 surround-
ings” (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 Mss1 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 whistle-blower 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 in 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?

REFERENCES


“Hospital nurses as they are and as they ought to be.” (1848, May). Fraser’s Magazine, 539–542.


McDonald, L. (2001, July). Florence Nightingale and the early origins of evidence-based nursing. Evidence-Based Nursing, 43, 68–69. doi:10.1136/ebn.4.3.68


Nightingale, F. (1876, April 14). Trained nurses for the sick poor. The Times, 6CD.


Robb, I. H. (1912). *Nursing ethics: For hospital and private use*. Cleveland, OH: E. C. Koeckert [1900].


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.
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.
Chapter 10: Nightingale’s Early Writing on Hospitals and Nursing

Sick people are more susceptible than healthy people, and if such people be shut up together without sufficient space and sufficient fresh air, there will be produced, not only fever, but erysipelas, pyemia, and the usual tribe of hospital-generated epidemic diseases.

—Nightingale (1858c)

FIRST EDITION OF NOTES ON HOSPITALS, 1858

This, the original version of what became a full book in 1863, Notes on Hospitals, consists of the two papers Nightingale wrote for the National Association for the Promotion of Social Science, which met in Liverpool in October 1858. They draw on her earlier work on the Crimean War hospitals (Nightingale, 1858a, 1858b).

The papers were read on two consecutive days by the secretary of the association, Dr. Holland. The chair was Lord Shaftesbury, Nightingale’s ally on so many issues. The sessions were well attended and the discussion exceptionally well informed. There were papers also in that section by sanitary expert Edwin Chadwick and Robert Rawlinson, the civil engineer on the Sanitary Commission who had gone to the Crimean War. Newspaper coverage of the sessions was sympathetic and detailed, especially for the second paper (The Times, 1858).

In the papers, Nightingale held that good nursing depended greatly on the hospital itself, its design and materials. The influence of the war hospital experience is obvious, although both papers included much material on civil hospitals, as did her war analyses. Hospitals—all hospitals—had and still have much in common; sociologists call them “total institutions” and include prisons and barracks in the category.

©Springer Publishing Company
The papers were first published in the association’s *Transactions* (Nightingale, 1859a) then republished by Nightingale herself, with additional material (Nightingale, 1859b), in both cases with slight changes in the text and titles from the original handwritten papers (Nightingale). In the papers, we see her advancing her ideas on adequate space, air, and light that would be featured in *Notes on Nursing*. The first paper specifies four defects in the hospital construction, the second no fewer than 16 defects.

There are two important connections between this hospital material and nursing. One is that Nightingale considered it to be the nurse’s task to ensure fresh air, light, and so on for the patient. The second is that nurses themselves were vulnerable to sickness and death from defects in hospital construction. Nightingale wanted to build a new profession, without losing its valuable recruits to sickness and death from hospital-acquired infections.

She used Dr. William Farr’s term “zymotic disease,” derived from the Greek word for fermentation, for such epidemic diseases as typhus and typhoid fever, cholera, smallpox, scarlet fever, and measles, before the bacilli causing them had been identified. It can be seen as a step in the direction of germ theory, for it presupposes a living entity, as opposed to a chemical poison, although the terms “poison” and “noxious” continue to appear in her writing and other sources.

Nightingale considered that good hospital construction was crucial to efficient nursing as well as to the safety of patients and staff. Hospital design should ensure adequate space for bedside care and minimize the distance nurses had to walk to provide it. In her brief to the Parliamentary committee on cubic space, she argued that “the efficiency of nursing is to a considerable extent dependent on hospital construction” (Nightingale, 1867, in Chapter 11). The large number of deaths from hospital-acquired infections that continue to occur shows that safety continues to be a major concern.

The titles given to the papers here are the original ones, as read to the Liverpool meetings. The source lines give a cross-reference to the volume and page numbers of the work in the *Collected Works of Florence Nightingale*, where the full work is available, with much more context.

* * * * *


No stronger condemnation of any hospital or ward could be pronounced than the simple fact that any zymotic disease has originated in it, or that such diseases have attacked other patients than those brought in with them (Nightingale, 1858c).
Feeling very desirous of contributing whatever I can to aid to improvement in hospital construction and administration—especially at this time, when several new hospitals are being built—it has occurred to me to transmit a few notes on defects which have come under my own observation in an extended experience of these institutions.

No one, I think, who brings ordinary powers of observation to bear on the sick and maimed can fail to observe a remarkable difference in the aspect of cases, in their duration, and in their termination, in different hospitals. To the superficial observer, there are two things only apparent—the disease and the remedial treatment, medical or surgical. It requires a considerable amount of experience, in hospitals of various constructions and varied administrations, to go beyond this....

The facts flow almost of necessity from ascertained sanitary experience. But it is not often, excepting perhaps in the case of intelligent house surgeons, that the whole process whereby the sick, who ought to have had rapid recoveries, are retained week after week, or perhaps month after month, in hospital....I have known a case of slight fever received into hospital, the fever passed off in less than a week, and yet the patient, from the foul state of the wards, not restored to health at the end of eight weeks.

The defects to which such occurrences are mainly to be attributed are four:

1. The agglomeration of a large number of sick under the same roof.
2. Deficiency of space.
3. Deficiency of ventilation.
4. Deficiency of light.

These are the four radical defects in hospital construction....

It is an all-important question to decide whether the propagation of such diseases is inevitable or preventable. If the former, then the whole question must be considered as to whether hospitals, necessarily attended with results so fatal, should exist at all. If the latter, then it is our duty to prevent their propagation....

Sick people are more susceptible than healthy people, and if such people be shut up together without sufficient space and sufficient fresh air, there will be produced, not only fever, but erysipelas, pyemia, and the usual tribe of hospital-generated epidemic diseases.

Again, if we have a fever hospital with overcrowded, badly ventilated, wards, we are quite certain to have the air become so infected as to poison the blood, not only of the sick, so as to increase their mortality, but also of the medical attendants and nurses, so that they also shall become subjects of fever. It will be seen at a glance that, in every such case and in every such
example, the “infection” is not inevitable, but simply the result of carelessness and ignorance.

No stronger condemnation of any hospital or ward could be pronounced than the simple fact that any zymotic disease has originated in it, or that such diseases have attacked other patients than those brought in with them. And there can be no stronger condemnation of any town than the outbreak of fatal epidemics in it.

It is a vulgar error to suppose that epidemics are occasioned by the spread of disease from person to person, either by infection or contagion. Epidemics do not spread—they develop themselves in constitutions already made ripe for them by neglect of natural laws. Unless these laws be ignored, epidemics, as experience seems to show, will not occur, the epidemic being, in fact, the last or, so to speak, retributive stage of a succession of antecedent phenomena extending over months or years, and all traceable to the neglect of natural laws.

It was necessary to say thus much to show to what hospital diseases are not due. To defects in site and construction and to defective management they are mainly to be attributed.

1. The Agglomeration of a Large Number of Sick Under One Roof: It is a well-established fact that, other things being equal, the amount of sickness and mortality on different areas bears a ratio to the degree of density of the population. Why should undue agglomeration of sick be any exception to this law? Is it not rather to be expected that, the constitutions of sick people being more susceptible than those of healthy people, they should suffer more from this cause?

But, if anything were wanting in confirmation of this fact, it would be the enormous mortality in the hospitals which contained perhaps the largest number of sick ever at one time under the same roof, viz., those at Scutari. The largest of these two famous hospitals had at one time 2500 sick and wounded under its roof, and it has happened that, out of these, two out of every five have died. In the hospital tents of the Crimea, although the sick were almost without shelter, without blankets, without proper food or medicines, the mortality was not above one half what it was at Scutari. Nor was it even so high as this in the small Balaclava General Hospital, while in the huts of the Castle Hospital, on the heights above Balaclava, at a subsequent period, the mortality among the wounded did not reach 3 percent.

But it is not to this, however, that we appeal as the only proof of the danger of surface overcrowding so much as it is to the fact of 80 cases of hospital gangrene having been recorded during one month at Scutari (and many, many, more passed unrecorded), to the fact that, out of 44 secondary
amputations of the lower extremities consecutively performed, 36 died, and to the cases of fever which broke out in the hospital, not by tens but by hundreds.

All experience tells the same tale, both among sick and well. Men will have a high rate of mortality in large barracks, a low one in separate huts, even with a much less amount of cubic space. (It must never be forgotten that, during the last six months of our occupation in the Crimea, the death rate among our men barracked in huts was actually less than it is among the men in barracks at home.)

2. **Deficiency of Cubic Space:** The master of some large works in London lately mentioned the following fact: he was in the habit of sending those of his workmen who met with accidents to two different metropolitan hospitals. In one, they recovered quickly; in the other, they were frequently attacked with erysipelas, and some cases were fatal. On inquiry, it appeared that, in the former hospital, a larger amount of cubic space was allowed than in the latter, which is also so deficient in external ventilation and in construction that nothing but artificial ventilation could effectively change its atmosphere.

It is no less important to have a sufficient surface area between the adjoining and the opposite beds. Piling cubic space above the patient is not at all that is wanted. In the lofty corridors of Scutari, I have seen two long rows of opposite beds with scarcely three feet from foot to foot. Certainly it cannot be thought too much, under any circumstances, to give to each bed a territory to itself of at least eight feet wide by twelve feet long.

3. **Deficiency of Ventilation:** The want of fresh air may be detected in the appearance of patients sooner than any other want. No care or luxury will compensate indeed for its absence. Unless the air within the ward can be kept as fresh as it is without, the patients had better be away. Except in a few cases well known to physicians, the danger of admitting fresh air directly is very much exaggerated. Patients in bed do not catch cold…. Although in badly constructed hospitals, or in countries where fuel is dear and the winter very cold, artificial ventilation may be necessary, it never can compensate for the want of the open window. The ward is never fresh….

If this be so for the well, how much more will it be so for the sick? for the sick, the exhalations from whom are always highly morbid and dangerous, as they are one of Nature’s methods of eliminating noxious matter from the body, in order that it may recover health.
One would think that the first and last idea in constructing hospitals would be to contrive such means of ventilation as would be perpetually and instantly carrying off these morbid emanations. One would think that it would be the first thing taught to the attendants to manage such means of ventilation. Often, however, it is not even the last thing taught to them.

4. **Deficiency of Light:** What is the proportionate influence of the four defects enumerated in delaying recovery I am not competent to determine.

Second only to fresh air, however, I should be inclined to rank light in importance for the sick. Direct sunlight, not only daylight, is necessary for speedy recovery, except, perhaps, in ophthalmic and a small number of other cases. Instances could be given, almost endless, where, in dark wards or in wards with a northern aspect, even when thoroughly warmed, or in wards with borrowed light, even when thoroughly ventilated, the sick could not by any means be made speedily to recover.

Among kindred effects of light I may mention, from experience, as quite perceptible in promoting recovery, the being able to see out of a window, instead of looking against a dead wall, the bright colours of flowers, the being able to read in bed by the light of a window close to the bedhead. It is generally said that the effect is upon the mind. Perhaps so, but it is no less so upon the body on that account.

All hospital buildings in this climate should be erected so that as great a surface as possible should receive direct sunlight—a rule which has been observed in several of our best hospitals but, I am sorry to say, passed over in some of those most recently constructed. Window blinds can always moderate the light of a light ward, but the gloom of a dark ward is irremediable.

The axis of a ward should be as nearly as possible north and south, the windows on both sides so that the sun shall shine in (from the time he rises till the time he sets) at one side or the other. There should be a window to at least every two beds, as is the case now in our best hospitals. But, while we can generate warmth, we cannot generate daylight, or the purifying and curative effect of the sun’s rays.

* * * * *

**SIXTEEN SANITARY DEFECTS IN THE CONSTRUCTION OF HOSPITALWARDS**

In this second paper, given only the following day at the same conference (paper given at the National Association for the Promotion of Social
Science, Liverpool. Manuscript, Liverpool Record Office, in McDonald, 2012, pp. 60–72), Nightingale went into much more detail on what was wrong with the hospital design. There are points on the necessary cubic space for safety and much on sewers and drains, favorite Nightingale themes. Here we see her focus not only on ventilation but also on the importance of sunlight, for which she had no hard evidence but only her suspicions. She would pursue evidence on the value of sunlight in *Notes on Nursing*.

Today’s reader feels some relief that so many of the urgent defects she portrayed have been dealt with, thanks to improved technology.

Nightingale used this second paper also to raise her philosophical/religious objections to utility theory—the greatest good for the greatest number. She noted the appearance of the idea in a government report, calling for “what is best for the *majority* of the sick in a hospital.” Her opposition was faith based, for God’s love was for all, not only the majority. She countered, if we cannot do the best possible for *all* the sick, by all means let us leave the rest at home” (Nightingale, 1858c, Part II, section 13). She wanted no less than that hospitals be built and administered so as to be of benefit to *all* their patients, not only a portion of them.

This second paper ended with a political crack at France, which was ahead of Britain in hospital design at that time. She regretted that great advances were being made by a “despotic government,” meaning that of Emperor Napoleon III, when (democratic) England “ought to take the lead in everything good” (Nightingale, 1858c, Part II, section 16).

* * * * *

*Sewers may become cesspools of the most dangerous description, if improperly made and placed. At Scutari, if the wind changed so as to blow up the open mouths of the sewers, such change was frequently marked by outbreaks of fever among the patients, and by relapses among the convalescents from fever.*

—Nightingale (1858c, Part II, Section 15.)

Considering, then, that the conditions essential to the health of hospitals are principally these (a) fresh air, (b) light, (c) ample space, and (d) subdivision of sick into separate buildings or pavilions, let us examine the causes in the usual ward construction that prevent us from obtaining these conditions. The principal causes are as follows:

1. Defective means of natural ventilation and warming;
2. Defective height of wards;
3. Excessive width of wards between the windows;
4. Arranging the beds along the dead walls;
5. Having more than two rows of beds between the opposite windows;
6. Having windows only on one side or having a closed corridor connecting the wards;
7. Using absorbent materials for walls and ceilings;
8. Defective condition of water closets;
9. Defective ward furniture;
10. Defective accommodation for nursing and discipline;
11. Defective hospital kitchens;
12. Defective hospital laundries;
13. Selection of bad sites and bad local climates for hospitals;
14. Erecting hospitals in towns;
15. Defects of drainage;

1. **Defective means of ventilation and warming.** When the question of ventilation first assumed a practical shape in this country, it was supposed that 600 cubic feet of air per hour were sufficient for a healthy adult, in a room where a number of people are congregated together. Subsequent experience, however, has shown that this is by no means enough. As much as 1,000 cubic feet have been found insufficient to keep the air free from closeness and smell, and it is highly probable that the actual quantity required will ultimately be found to be at least 1500 cubic feet per hour per man.

   In sick wards, we have more positive experience as to the quantity of air required to keep them sweet and healthy. It has been found in certain Parisian hospitals in which the ventilating arrangements were deficient that pyemia and hospital gangrene had appeared among the patients. These diseases disappeared on the introduction of ventilating arrangements whereby 2,500 cubic feet of air per bed per hour was supplied to the wards.

2. **Defective height of wards.** It is not possible to ventilate sufficiently a ward of 10 or 12 feet high. And, again, it is not possible to ventilate a ward where there is a great height above the windows. A ward of 30 beds can be well ventilated with a height of about 17 feet, provided the windows reach to within one foot of the ceiling. Otherwise, the top of the ward becomes a reservoir for foul air.

3. **Too great width of wards between the opposite windows.** It does not appear as if the air could be thoroughly changed if a distance of more than 30 feet intervenes among the opposite windows…. If you make your length too great in proportion to the width, your ward becomes a tunnel—a
form fatal to good ventilation. This was the case with the great corridor wards at Scutari.

If, on the other hand, you make your wards too short in proportion to this width, you multiply corners in a greater ratio than you multiply sick. And direct experiment has shown that the movement of the air in the centre of a ward is three or four times as great as it is at the corners.

4. Arranging the beds along the dead walls. This deprives the patient of the amount of light and air necessary to his recovery and has, besides, the disadvantage that, when the windows are opened, the effluvia must blow over all the intervening beds before escaping.

5. Having more than two rows of beds between the windows. These double wards are nearly 20 feet wider than they ought to be between the opposite windows for a thorough ventilation. The partition down the middle, with apertures, makes matters rather worse.

6. Having windows only on one side, or having a closed corridor connecting the wards. These corridors are the certain means of engendering a hospital atmosphere. If anyone had wished to see the corridor plan in all its horrors, Scutari would have shown them on a colossal scale. But they may be seen on a smaller scale in almost every hospital in London.

7. Absorbent materials for floors, walls, and ceilings of hospitals. The amount of organic matter given off by respiration and in other ways from the sick is such that the floors, walls, and ceilings of hospital wards—if not of impervious materials—become the most dangerous absorbents. The boards are in a time saturated with organic matter and only require moisture to give off noxious effluvia.

In Scutari, where the wards were overcrowded, the cases offensive and the floors ill-laid, rotten, and dirty, the accumulated saturations of weeks and months were such that the floors could not be scoured without literally poisoning the patients.

As to the walls and ceilings of wards, plaster or brick white-washed are equally objectionable. Pure, white, polished nonabsorbent cement is the only material fit for hospital walls.

8. Defective condition of water closets. It is hardly necessary to say more than this. There can be no safety for the sick if any but water closets of the best construction are used, as also, if they are not built externally to the main building, and cut off by a lobby, separately lighted and ventilated, from the ward.

9. Defective ward furniture. Hospital bedsteads should always be of iron, the rest of the furniture of oak. For all eating, drinking, and washing vessels, and for other utensils, the use of glass or earthenware is
superior to that of tin or any other metal, on account of its greater cleanliness.

10. **Defective accommodation for nursing and discipline.** The simplicity of construction in hospitals is essential to discipline. Effectual and easy supervision is essential to proper care and nursing.

Every unneeded closet, scullery, sink, lobby, and staircase represents both a place that must be cleaned, which must take hands and time to clean, and a hiding or skulking place for patients or servants disposed to do wrong. And no hospital will ever be free. Every 5 minutes is wasted upon cleaning what had better not have been there to be cleaned is something taken from and lost by the sick.

**Distribution of sick in convenient numbers for attendance and position of nurses’ rooms.** To return to large general hospitals, these “casualty” wards, as they are called, for noisy or offensive cases, are much better placed apart, with a completely appointed staff of their own, than attached one small ward to each larger one. Patients requiring much attention, whose condition fits them the most for the small wards, cannot be put there because either they are more or less neglected or they unduly monopolize the service of the ward attendants.

11. **Defective hospital kitchens.** Two facts every careful, experienced observer of the sick can establish from experience:

(1) The necessity of variety in food as an essential element of health, owing to the number of materials required to preserve the human frame. In sickness, it is still more important because, the frame being in a morbid state, it is scarcely possible to prescribe beforehand with certainty what it will be able to digest and assimilate. The so-called fancies of disease are in many cases valuable indications.

(2) The importance of cooking to secure the greatest digestibility and the greatest economy in nutritive value of food.

I have often been surprised by the primitive kitchens of some of our civil hospitals with which little variety of cooking is possible. These things show how little diet and cooking are even thought of as sanitary and curative agents.

12. **Defective hospital laundries.** It is hardly necessary to go back to the time of the Crimean War when, in a Scutari hospital, six shirts were washed in a month for a number of 2,000 patients, which was constantly changing, when the number per man per month of all articles of all descriptions washed was less than three. The pestilential filth of that time is known now to all.

Let laundries be constructed with sufficient area and cubic space for each washer, with an abundance of water, with proper means of
drainage and ventilation for removing the vapor, properly constructed drying and ironing rooms, and we shall cease to hear of washerwomen “catching” fever.

13. Selection of bad sites and bad local climates for hospitals. As the object to be attained in hospital construction is to have pure, dry, air for the sick, it is evident that this condition cannot be fulfilled if a damp climate is selected....Self-draining, gravelly, or sandy subsoils are best. River banks, estuary shores, valleys, marshy, or muddy ground ought to be avoided. It might seem superfluous to state that a hospital should not be built over an old dung heap, or over a crowded graveyard, did we not know that such things were being done at the present moment.

Although hospitals are intended for the recovery of health, people are very apt to forget this, and to be guided in the selection of sites by other considerations—such as cheapness, convenience, and the like—whereas, the professed object in view being to secure the recovery of the sick in the shortest time and to obtain the smallest mortality, that object should be distinctly kept in view as one that must take precedence over all others.

A doctrine has recently been promulgated, in a government report, that we are only to consider what is best for the majority of the sick in a hospital. If we cannot do the best possible for all the sick, by all means, let us leave the rest at home. In practice, a hospital may be found to benefit a majority and to inflict suffering on the remainder. Let us use our intelligence to see whether we cannot have hospitals constructed so as to be of equal benefit to all.

14. Erecting hospitals in towns. Nearly all that has been said under the last head, mutatis mutandis (with appropriate changes), may be repeated here. If the recovery of the sick is to be the object of hospitals, they will not be built in towns. If medical schools are the object, surely it is more instructive for students to watch the recovery from, rather than the long duration of, sickness....

According to all analogy, the duration of cases, the chances against complete recovery, the rate of mortality, must be greater in town than in country hospitals....

15. Defects in drainage. Sewers may become cesspools of the most dangerous description if improperly made and placed. At Scutari, if the wind changed so as to blow up the open mouths of the sewers, such change was frequently marked by outbreaks of fever among the patients, and by relapses among the convalescents from fever. Where there are no means for externally ventilating the sewers, no means for cleansing or flushing them, and where the bottoms are rough and uneven, such
occurrences cannot fail to take place…. Where sewers pass close to or under occupied rooms, the walls or covers being defective, exhalations infallibly escape into those rooms. Such could be distinctly perceived in Scutari hospitals, and cases of cholera distinctly traced to such a cause.

Not very long ago, five fatal cases of fever occurred in rapid succession in one of our best civil hospitals, which were traced to a defective drain.

16. Construction of hospitals without free circulation of external air. To build a hospital with one closed court with high walls, or, what is worse, with two closed courts, is to stagnate the air ….

Even in the pavilion structure, unless the distance between the pavilions is double the height of the walls, the ventilation and light are seriously interfered with. For this, among other reasons, two stories are better than three, and one is preferable to two ….

To build a hospital in the midst of a crowded neighborhood of narrow streets and high houses, as is now being done in the case of a well-known London hospital, is to ensure a stagnation of the air outside, which no ventilation within, no cubic space, however ample, will be able to remedy.

I have here given the defects; few have had so sad or large an experience of their results as I have had. I appeal to those who are wiser and have more practical power than I have for the remedies, architects, hospital committees, civil and royal engineers, medical officers, officers of health, to all the men of science and benevolence, of whom our country is so justly proud. It is hard that, in a country where everything is done by a despotic government [France under Napoleon III], such advances in the sanitary construction of hospitals should have been made, and that our England, which ought to take the lead in everything good, should be left behind.

* * * * *

NOTES ON NURSING, 1860

I use the word nursing. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient.

—Nightingale (1860)
Notes on Nursing: What It Is and What It Is Not was the original title of Nightingale’s best-known book. The title was shortened to Notes on Nursing in the edition published soon after her death. She revised the text significantly twice. The version used here is the second, called by the editor of the first critical edition of the book, the “library standard version” (Skretkowicz, 1996). It was published only months after the first, badly printed edition. Nightingale not only corrected the many typographical errors in it but added much new material, such as quotations from eminent scientists and literary and political figures. It is far more sophisticated in language than the original. For the following edition, Notes on Nursing for the Labouring Classes, 1861, she removed all the extraneous material, simplified the language, and added the famous chapter “Minding Baby.”

As anyone reading the material now is well educated compared with women during Nightingale’s time, this second edition seems the best to use. “Minding Baby” is largely advice to girls looking after their younger siblings at home, not pediatric nursing. Sadly, the edition most available is the first, with all its misprints, and without the merits of either of the subsequent two editions.

Most of the material, in every version of Notes on Nursing, is out-of-date, ventilation, heating, water supply, beds, bedding, and so on, have all been improved, and adequate, sanitary toilets greatly reduce the need for bedpans. Thus, the excerpts here give the bare bones of principle, with as little dated material as possible. Anyone reading the full text, however, is struck with its guiding principle of patient care and comfort: patients come first.

It is also obvious, even in the extracts selected here, that Nightingale drew on her experience of being ill. She remarked on the “most acute suffering produced” from not being able “to see out the window,” when “the knots in the wood” were her only view, and recalled how “a nosegay of wild flowers” sped her recovery (Nightingale, 1860a, 1860b, Chapter 5). Her disease was probably brucellosis (Young, 1995), one that would be easily treated today with antibiotics but back then had a high mortality rate. For survivors, chronic pain, partial paralysis, and fatigue typically followed.

Nightingale’s reference to diarrhea “merging into cholera” reflects thinking before germ theory. Under germ theory, cholera is a specific disease, produced by a distinct bacillus, while diarrhea simply refers to the looseness of stools, which could be caused by any number of bacilli or parasites. In a hospital with a large number of bowel patients, of diarrhea, dysentery, and cholera, it might well seem that diarrhea merged into cholera.

Some of the comments on disease are not of concern to nurses in developed countries, where “consumption,” or tuberculosis, is now rare, as is scrofula (a tubercular disease), pyemia, and erysipelas. Moreover, in most places, people
do not bring in “organic matter,” manure, on their feet into a sickroom, as they did in Nightingale’s days when horse-drawn conveyances were in common use. It is also not necessary now to warn against the evils of the four-poster bed. Given that modern hospitals have adjustable mattresses, the advice on arranging pillows for patient comfort is not needed, although one can imagine that the human interaction in such arrangement might be comforting.

Some of Nightingale’s advice, in every edition of Notes on Nursing, is as useful now as it was when it was written, none more than, “Every nurse ought to be careful to wash her hands very frequently during the day. If her face, too, so much the better.” Still in the 21st century, “proper hand hygiene” remains “the primary method for reducing infections” (Gawande, 2004).

Notes on Nursing is also the source of key Nightingale definitions, such as disease being a “reparative process” of nature, the nurse’s task being to aid it. Nightingale made the point that the patient might suffer as much from bad conditions in the sick room as from the disease itself.

Advertisements for the sale of the book, and then excerpts from it, began to appear in The Times and other British newspapers in January 1860. Small provincial newspapers often reprinted reviews and excerpts from the major London dailies (Hampshire Advertiser, 1860; Liverpool Mercury, 1860).


The distinguished Boston doctor, Oliver Wendell Holmes, Sr. (father of the Supreme Court justice) was an early reader, pleased with Nightingale’s making disease a “reparative process.” He praised her in a famous article, “Currents and Counter-Currents,” after noting that Hippocrates, “august father of the healing art,” had made a case for nature 2000 years earlier, “Miss Florence Nightingale begins her late volume with a paraphrase of his statement. But from a very early time to this there has been a strong party against ‘Nature’” (Holmes, 1861). It is noteworthy that the very first sentence of Notes on Nursing makes a point of disease as a “reparative process.”

The book reached Australia by steamer in April 1860, duly listed among recently arrived “New Publications.” Again, it was widely advertised. Newspapers in the Australian colonies, Tasmania, and New Zealand soon produced reviews and excerpts, some of them lengthy (Bathurst Free Press and Mining Journal, 1860; Hawke’s Bay Herald, 1860; Hobart Town Daily Mercury, 1860; Illawarra Mercury, 1860; Nelson Examiner and New Zealand Chronicle, 1860; Perth Gazette and Independent Journal of Politics and News, 1860; South Australian Advertiser, 1860; South Australian
Key points of her message were highlighted and applied to local circumstances:

Were these Notes of Miss Nightingale’s, together with her Notes on Hospitals, taken advantage of, we should not see the corridors of a main part of an hospital ventilated from the passages of a fever ward when, by a slight sacrifice, they could be made to communicate directly with the external air. (Cornwall Chronicle [Tasmania], 1860)

On the 1930 sale of the publishing company that had published Notes on Nursing, the price paid to Nightingale was noted, a considerable £1,000. The book was reprinted “again and again” and still found large sales (The Times, 1930).

Although Notes on Nursing won wide praise, there were dissenters from the start. Elizabeth Blackwell, the first woman to qualify as a medical doctor and a friend of Nightingale’s, called it, in a private letter, a “capital little book in its way,” even useful, practical, and readable, but not a book “in the usual meaning of the word.” Nightingale threw together “a mass of hints and experiences,” but was “not able to digest them into a book which will remain as a classic” (Blackwell letter, April 25, 1860, cited in Boyd, 2005, p. 185).

A 1992 Commemorative Edition of Notes on Nursing (the badly printed first edition) has comments by 12 American nursing leaders on their use, or not, of Nightingale in their work. All but one were highly positive, as would be expected for a commemorative edition. Several provide a good discussion of her environmental theory (Commemorative Edition, 1992). Several presented Nightingale’s ideas well and brought in the pertinent material of their own (Roy, Newman, & Rogers). Roy showed how her adaptation theory was “congruent” with Nightingale’s (Roy, in Commemorative Edition, 1992, p. 64). Thompson flagged the emphasis on prevention and noted its influence on nursing in the American Civil War (Thompson, Commemorative Edition, 1992, p. 76). Some held that Nightingale’s ideas were still needed (Watson, Newman, & Rogers, in Commemorative Edition, 1992). One saw her importance as a “symbol” of nursing (Styles, in Commemorative Edition, 1992, p. 74).

There are odd errors, also, in these introductions, such as that Nightingale “assigned readings in the humanities” to increase nursing students’ understanding “of human ethics and morals,” which she could not have done, for she never taught a class in her school. A largely instructive chapter misinterprets Nightingale’s views of philosophers, turning her negative views of Hegel and Comte into commendation (Schuyler, in Commemorative Edition, 1992, pp. 11, 13). Fitzpatrick read Nightingale
as an empiricist, while Schuyler had her integrating idealism with empiricism (Fitzpatrick, in Commemorative Edition, 1992, p. 5). Watson had her repudiate empiricism to root her instead in “ancient feminine wisdom and knowledge, a cosmology of wholeness, connectedness, and harmony.” Watson gave no specific reference, nor do any spring to mind, for Nightingale’s supposed use of “women’s wisdom and knowledge” (Watson, in Commemorative Edition, 1992, p. 81). Nightingale was a thorough and consistent empiricist.

Several commentators castigated Nightingale for failures in theory, even that she never defined “caring” or “other key terms (Leininger, in Commemorative Edition, p. 30). Levine had her accepting “false theory, laden with superstition and error”; she “stubbornly preached ‘atmospherics’ while scientific evidence of contagion was being gathered around her” (Levine, in Commemorative Edition, 1992, p. 40). Nightingale’s detailed advice on avoiding septicemia includes the necessity of nurses knowing the difference between “contagion and infection, and the distinctions between deodorants, disinfectants, and antiseptics” (Nightingale, 1883; see Chapter 12). Several commentators, as other authors noted in Chapter 1 of this book, chided Nightingale for (supposedly) rejecting germ theory, when in fact in time she came to accept it.

**Peplau’s Critique of Notes on Nursing**

A major American nursing theorist, Hildegard E. Peplau, thoroughly derided Notes on Nursing in her chapter, calling it at best a “notable marker in Nursing’s progress toward becoming a profession.” It was a “period piece,” a reflection of Nightingale’s “commonly held views about women,” a “failure to specify processes,” although it “skirted discussion of nurse-patient interactions or relationships.” She further faulted Nightingale for, when specifying pure air, failure to state “respiratory processes.” She complained that Nightingale sometimes spelled Nature with a capital N, sometimes lower case. God or Nature confused her, although for Nightingale there was no contradiction, God ran the world by laws, which were scientific, discoverable laws of natural and social science. She has Nightingale ignoring Darwin and rejecting germ theory (Peplau, in Commemorative Edition, 1992, pp. 49–52).

Peplau was also critical of Nightingale for excluding men from nursing, and not recognizing male nurses of previous centuries in religious orders (Peplau, in Commemorative Edition, 1992, p. 148). These orders, notably the Knights of St. John of Jerusalem, the “Johanniter,” existed in Nightingale’s time and were prominent in the Franco-Prussian War. The Crown Princess of Prussia judged that all their hospitals were “so bad, not only at first but continuously,” inferior “in cleanliness, ventilation, management, in every vital sanitary condition,” to the regular military hospitals (Crown
Princess, letter, September 22, 1870, in McDonald, 2011, p. 715). Letters to Nightingale from other sources refer to these male nurses as being, with some exceptions, ignorant, unhygienic, unqualified, incompetent, heartless, and dishonest—and they diverted donations to the Prussian military (letter, November 16, 1870, Wellcome Ms 9004/145, and letters, December 9, 1870, ca. January 1871, February 1, 1871, April 16, 1871, in McDonald, 2011, pp. 711, 770, 772, 790).

Peplau, a pioneer in psychiatric nursing, was also critical of Nightingale for not including the subject in any of her published works, stating that mental illness and asylums existed in her time (Peplau, in Commemorative Edition, 1992, p. 49). Not one asylum in Nightingale’s time—and Peplau named not a single one—had anything close to professional nursing. Nightingale, in fact, was well aware of the horrors of most mental asylums of her day and knowledgeable about the early efforts at humane care, such as by Dr. John Conolly.

Peplau did not like Nightingale’s definition of nursing as a restorative process. She proposed instead,

The work of nurses is to support the person’s processes of bodily repair until the functional bodily processes are restored and begin to function fully again, or nurses support the person’s functional bodily processes in some way until their normal functions are restored. (Peplau, in Commemorative Edition, p. 52)

Is this a “refinement” of Nightingale’s too simplistic wording? “Nursing is putting us in the best possible conditions for Nature to restore or to preserve health—to prevent or to cure disease or injury” (Nightingale, 1882, p. 1043; see Chapter 12).

Overall, the great failure in the commemorative commentaries are the authors’ apparent ignorance of Nightingale’s later writing. Notes on Nursing seems to them to be the first, last, and only book she wrote. One commentator acknowledged the production of 147 books, articles, pamphlets, and other publications, over her lifetime (Schuyler, in Commemorative Edition, 1992, p. 8); they are listed in an appendix in the official biography (Cook, 1913, Vol. 2). However, no commentator made any comparisons from Notes on Nursing to these later works. Those who pointed out the lack of discussion of germ theory reveal a critical lapse, for a book written in 1859 could hardly have discussed a theory nowhere then in the literature.

For our purposes, these commentaries serve to reflect how Nightingale was seen by major nursing leaders over a good part of the 20th century and in the 21st century. The extent of the misrepresentation of her views,
particularly by failure to look at anything she wrote after *Notes on Nursing*, applies to the present also.

* * * *


**Preface**

The following notes are by no means intended as a rule of thought by which nurses can teach themselves to nurse, still less as a manual to teach nurses to nurse. They are meant simply to give hints for thought to women who have personal charge of the health of others…. Everyday sanitary knowledge, or the knowledge of nursing, or in other words of how to put the constitution in such a state as that it has no disease, or that it can recover from disease, takes a higher place. It is recognized as the knowledge which everyone ought to have—distinct from medical knowledge—which only a profession can have.

**Introductory**

Shall we begin by taking it as a general principle that all disease, at some period or other of its course, is more or less a reparative process, not necessarily accompanied with suffering, an effort of Nature to remedy a process of poisoning or of decay which has taken place weeks, months, sometimes years beforehand, unnoticed, the termination of the disease being then, while the antecedent process was going on, determined? …

In watching disease, both in private houses and in public hospitals, the thing which strikes the experienced observer most forcibly is that the symptoms or the sufferings generally considered to be inevitable and incident to the disease are very often not symptoms of the disease at all, but of something quite different—the want of fresh air, or of light, or of warmth, or of quiet, or of cleanliness, or of punctuality and care in the administration of diet, of each or of all of these…. The reparative process which Nature has instituted, and which we call disease, has been hindered by some want of knowledge or attention in one or in all of these things, and pain, suffering, or interruption of the whole process sets in…. I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultices. It ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—all at the least expense of vital power to the patient.
Chapter 1. Ventilation and Warming

The very first canon of nursing, the first and the last thing upon which a nurse’s attention must be fixed, the first essential to the patient, without which all the rest you can do for him is as nothing…is this: TO KEEP THE AIR HE BREAThes AS PURE AS THE EXTERNAL AIR, WITHOUT CHILLING HIM.

To have the air within as pure as the air without, it is not necessary, as often appears to be thought, to make it as cold…. It is very desirable that the windows in a sick room should be such as that the patient shall if he can move about, be able to open and shut them easily himself (Note: Delirious fever cases, where there is any danger of the patient jumping out of window, are, of course, exceptions. …).

In laying down the principle that the first object of the nurse must be to keep the air breathed by her patient as pure as the air without, it must not be forgotten that everything in the room which can give off effluvia, besides the patient, evaporates itself into his air. And it follows that there ought to be nothing in the room, excepting him, which can give off effluvia or moisture. Out of all damp towels, etc., which become dry in the room, the damp, of course, goes into the patient’s air.

Of the fatal effects of the effluvia from the excreta it would seem unnecessary to speak, were they not so constantly neglected…. The use of any chamber utensil [bedpan] without a lid should be utterly abolished…. But never, never, should the possession of this indispensable lid confirm you in the abominable practice of letting the chamber utensil remain in a patient’s room unemptied, except once in the twenty four hours.

Let no one ever depend upon fumigations, “disinfectants,” and the like for purifying the air. The offensive thing, not its smell, must be removed.

Chapter 2. Health of Houses

There are five essential points in securing the health of houses:

1. Pure air
2. Pure water
3. Efficient drainage
4. Cleanliness
5. Light

Without these, no house can be healthy. And it will be unhealthy just in proportion as they are deficient…. Without cleanliness within and without your house, ventilation is comparatively useless.
A dark house is always an unhealthy house, always an ill-aired house, always a dirty house. Want of light stops growth and promotes scrofula, rickets, etc., among the children. People lose their health in a dark house, and if they get ill, they cannot get well again in it.

Chapter 3. Petty Management

All the results of good nursing, as detailed in these notes, may be spoiled or utterly negatived by one defect, viz., in petty management, or in other words, by not knowing how to manage that what you do when you are there shall be done when you are not there.

Apprehension, uncertainty, waiting, expectation, fear of surprise, do a patient more harm than any exertion. Remember, he is face to face with his enemy all the time, internally wrestling with him, having long conversations with him. You are thinking of something else. “Rid him of his adversary quickly” is a first rule with the sick.

To be “in charge” is certainly not only to carry out the proper measures yourself but to see that everyone does so too.

Chapter 4. Noise

Unnecessary noise, or noise that creates an expectation in the mind, is that which hurts a patient. It is rarely the loudness of the noise, the effect upon the organ of the ear itself, which appears to affect the sick. How well a patient will generally bear, e.g., the putting up of a scaffolding close to the house, when he cannot bear the talking, still less whispering, and especially if it be of a familiar voice, outside his door.

I need hardly say that the other common course, namely, for a doctor or friend to leave the patient and communicate his opinion on the result of his visit to the friends just outside the patient’s door is, if possible, worst of all.

All hurry or bustle is peculiarly painful to the sick.

The friend who remains standing and fidgeting about while a patient is talking business to him, or the friend who sits and proses, the one from an idea of not letting the patient talk, the other from an idea of amusing him, such is equally inconsiderate.

Always sit down when a sick person is talking business to you; show no signs of hurry, give complete attention and full consideration if your advice is wanted, and go away the moment the subject is ended.

How to visit the sick and not hurt them: always sit within the patient’s view, so that when you speak to him he has not painfully to turn his head round in order to look at you. If you make this act a wearisome one on
the part of the patient, you are doing him harm. So also, if by continuing to stand, you make him continuously raise his eyes to see you…. This brings us to another caution. Never speak to an invalid from behind, nor from the door, nor from any distance from him, nor when he is doing anything…. 

Conciseness and decision are, above all things, necessary with the sick. Let your thought expressed to them be concisely and decidedly expressed. What doubt and hesitation there may be in your own mind must never be communicated to them.

Chapter 5. Variety

The effect in sickness of beautiful objects, of variety of objects, and especially of brilliancy of colour, is hardly at all appreciated. Such cravings are usually called the “fancies” of patients. And often doubtless patients have “fancies,” as, e.g., when they desire two contradictions. But, much more often, their (so-called) “fancies” are the most valuable indications of what is necessary for their recovery. And it would be well if nurses would watch these (so-called) “fancies” closely…. 

People say the effect is only on the mind. It is no such thing. The effect is on the body, too. Little as we know about the way in which we are affected by form, by colour and light, we do know this, that they have an actual physical effect. A variety of form and brilliancy of colour in the objects presented to patients are actual means of recovery…. 

Flowers. The folly and ignorance which reign too often supreme over the sick room cannot be better exemplified than by this: while the nurse will leave the patient stewing in a corrupting atmosphere, the best ingredient of which is carbonic acid [carbon dioxide], she will deny him, on the plea of unhealthiness, a glass of cut flowers or a growing plant. Now, no one ever saw “overcrowding” by plants in a room or ward. And the carbonic acid they give off at nights would not poison a fly. Nay, in overcrowded rooms, they actually absorb carbonic acid and give off oxygen. Cut flowers also decompose water and produce oxygen gas. It is true there are certain flowers, e.g., lilies, the smell of which is said to depress the nervous system. These are easily known by the smell and can be avoided.

Volumes are now written and spoken upon the effect of the mind on the body. Much of it is true. But I wish a little more thought of the effect of the body on the mind…. 

Sick suffer to excess from mental as well as bodily pain. It is a matter of painful wonder to the sick themselves how much painful ideas predominate over pleasurable ones in their impressions; they think themselves ungrateful; it is all of no use…. A patient can just as much move his leg...
when it is fractured as change his thoughts when no external help from
variety is given him. This is, indeed, one of the main sufferings of sick-
ness, just as the fixed posture is one of the main sufferings of the broken
limb.

We will suppose the diet of the sick is to be cared for. Then, this state
of nerves is most frequently to be relieved by care in affording them a
pleasant view, a judicious variety as to flowers, and pretty things. Light
by itself will often relieve it. (No one who has watched the sick can doubt
the fact.)

Chapter 6. Taking Food

Every careful observer of the sick will agree in this, that thousands of
patients are annually starved, in the midst of plenty, from want of attention
to the ways which alone make it possible for them to take food. This want
of attention is as remarkable in those who urge upon the sick to do what is
quite impossible to them, as in the sick themselves, who will not make the
effort to do what is perfectly possible to them.

For instance, to the large majority of very weak patients, it is quite
impossible to take any solid food before 11 a.m., nor then, if their strength
is still further exhausted by fasting till that hour. A spoonful of beef-
tea, of arrowroot, and wine, of egg flip, every hour, give them the requisite
nourishment, and prevent them from being too much exhausted to take,
at a later hour, the solid food which is necessary for their recovery.

To leave the patient’s untasted food by his side from meal to meal, in
hopes that he will eat it in the interval, is simply to prevent him from taking
any food at all. A patient should, if possible, not see or smell either the
food of others, or a greater amount of food than he himself can consume at
one time, or ever hear food talked about or see it in the raw state.

That the more alone an invalid can be when taking food the better is
unquestionable, and, even if he must be fed, the nurse should not allow him
to talk, or talk to him, especially about food, while eating.

You cannot be too careful as to quality in sick diet: a nurse should never
put before a patient milk that is sour, meat or soup that is turned, an egg that
is bad, or vegetables underdone.

Chapter 7. What Food

Common errors in diet. One is the belief that beef-tea is the most nutritive
of all food articles. Now, just try and boil down a pound of beef into beef-
tea, evaporate your beef-tea and see what is left of your beef. Eggs, again,
it is an ever ready saw that an egg is equivalent to a lb. of meat, whereas it is
not at all so. Also, it is seldom noticed with how many patients, particularly of nervous or bilious temperament, eggs disagree.

Milk and the preparations from milk are a most important article of food for the sick. Butter is the lightest kind of animal fat, and though it wants the sugar and some of the other elements which are there in milk, yet it is most valuable both in itself and enabling the patient to eat more bread. Flour, oats, groats, barley, and their kind are, as we have already said, preferable in all their preparations to all the preparations of arrowroot, sago, tapioca, and their kind. Cream, in many long chronic diseases, is quite irreplaceable by any other article whatever. It seems to act in the same manner as beef-tea, and to most it is much easier of digestion than milk. In fact, it seldom disagrees. Cheese is not usually digestible by the sick, but it is pure nourishment for repairing waste, and I have seen sick, and not a few either, whose craving for cheese showed how much it was needed for them.

In the diseases produced by bad food, such as scrofulous dysentery and diarrhea, the patient’s stomach often craves for and digests things, some of which certainly would be laid down in no dietary that ever was invented for sick, and especially not for such sick. These are fruit, pickles, jams, gingerbread, fat of ham or of bacon, suet, cheese, butter, milk. These cases I have seen, not by ones nor by tens, but by hundreds. And the patient’s stomach was right, and the book was wrong.

There is often a marked difference between men and women in this matter of sick feeding. Women’s digestion is generally slower.

But, if fresh milk is so valuable food for the sick, the least change or sourness in it makes it, of all articles perhaps, the most injurious; diarrhea is a common result of fresh milk allowed to become at all sour.

In laying down rules of diet by the amounts of “solid nutriment” in different kinds of food, it is constantly lost sight of what the patient requires to repair his waste, what he can take, and what he can’t. You cannot diet a patient from a book; you cannot make up the human body as you would make up a prescription—so many parts “carboniferous,” so many parts “nitrogenous,” will constitute a perfect diet for the patient. The nurse’s observation here will materially assist the doctor—the patient’s “fancies” will materially assist the nurse.

For instance, sugar is one of the most nutritive of all articles, being pure carbon, and is particularly recommended in some books. But the vast majority of patients in England, young and old, male and female, rich and poor, hospital and private, dislike sweet things, and, while I have never known a person take to sweets when he was ill, who disliked them when he was well, I have known many fond of them when in health, who in sickness would leave off anything sweet, even to sugar in tea—sweet puddings, sweet drinks, are their aversion—the furred tongue
almost always likes what is sharp or pungent. Scorbutic patients are an exception; they often crave for sweetmeats and jams.

Jelly is another article of diet in great favor with nurses and friends of the sick; even if it could be eaten solid, it would not nourish, but it is simply the height of folly to take 1/8 oz. of gelatine and make it into a certain bulk by dissolving it in water, and then to give it to the sick as if the mere bulk represented nourishment....

Chemistry has as yet afforded little insight into the dieting of the sick. All that chemistry can tell us is the amount of “carboniferous” or “nitrogenous” elements discoverable in different dietetic articles. It has given us lists of dietetic substances, arranged in order of their richness in one or other of these principles, but that is all. In the great majority of cases, the stomach of the patient is guided by other principles.... No doubt, in this as in other things, Nature has very definite rules for her guidance, but these rules can only be ascertained by the most careful observation at the bedside. She teaches us that living chemistry, the chemistry of reparation, is something different from the chemistry of the laboratory. Organic chemistry is useful, as all knowledge is when we come face to face with Nature, but it by no means follows that we should learn in the laboratory any one of the reparative processes going on in disease.

Again, the nutritive power of milk and of the preparations of milk, is very much undervalued; there is nearly as much nourishment in half a pint of milk as there is in a quarter of a lb. of meat. But this is not the whole question or nearly the whole. The main question is what the patient’s stomach can assimilate or derive nourishment from, and of this the patient’s stomach is the sole judge. Chemistry cannot tell this. The diet which will keep the healthy man healthy will kill the sick one....

Home-made bread or brown bread is a most important article of diet for many patients. The use of aperients [laxatives] may be entirely superseded by it. Oat cake is another.

To watch for the opinions, then, which the patient’s stomach gives, rather than to read “analyses of foods,” is the business of all those who have to settle what the patient is to eat—perhaps the most important thing to be provided for him after the air he is to breathe....

A great deal too much against tea is said by wise people, and a great deal too much of tea is given to the sick by foolish people. When you see the natural and almost universal craving in English sick for their “tea,” you cannot but feel that nature knows what she is about. But a little tea or coffee restores them quite as much as a great deal, and a great deal of tea and especially of coffee impairs the little power of digestion they have....

Cocoa is often recommended to the sick in lieu of tea or coffee. But, independently of the fact that English sick very generally dislike cocoa, it
has quite a different effect from tea or coffee. It is an oily starchy nut, having no restorative power at all, but simply increasing fat. It is pure mockery of the sick, therefore, to call it a substitute for tea.

Chapter 8. Bed and Bedding

A few words upon bedsteads and bedding, and principally as regards patients who are entirely, or almost entirely, confined to bed. Feverishness is generally supposed to be a symptom of fever—in nine cases out of ten it is a symptom of bedding. The patient has had reintroduced into the body the emanations from himself, which, day after day and week after week, saturate his unaired bedding...

If you consider that an adult in health exhales by the lungs and skin in the twenty four hours three pints at least of moisture, loaded with organic matter ready to enter into putrefaction, that in sickness the quantity is often greatly increased, the quality is always more noxious—just ask yourself next where does all this moisture go? Chiefly into the bedding, because it cannot go anywhere else. And it stays there because, except perhaps a weekly change of sheets, scarcely any other airing is attempted…

The only way of really nursing a real patient is to have an iron bedstead, with rheocline springs, which are permeable by the air up to the very mattress (no vallance, of course), the mattress to be a thin hair one, the bed to be not above 3½ feet wide.

If the patient be entirely confined to his bed, there should be two such bedsteads, each bed to be “made” with mattress, sheets, blankets, etc., complete—the patient to pass twelve hours in each bed, on no account to carry his sheets with him. The whole of the bedding to be hung up to air for each intermediate twelve hours. Of course, there are many cases where this cannot be done at all—many more where only an approach to it can be made. I am indicating the ideal of nursing, and what has actually been done….

A patient’s bed should always be in the lightest spot in the room, and he should be able to see out of window….

It may be worthwhile to remark that, where there is any danger of bedsores, a blanket should never be placed under the patient. It retains damp and acts like a poultice.

Chapter 9. Light

It is the unqualified result of all my experience with the sick that, second only to their need of fresh air, is their need of light, that, after a close room, what hurts them most is a dark room, and that it is not only light, but direct sunlight, they want…. People think the effect is upon the spirits
only. This is by no means the case…. Without going into any scientific exposition, we must admit that light has quite real and tangible effects upon the human body….

A very high authority in hospital construction has said that people do not enough consider the difference between wards and dormitories in planning their buildings. But I go further and say that healthy people never remember the difference between bedrooms and sick rooms in making arrangements for the sick. To a sleeper in health, it does not signify what the view is from his bed….

But the case is exactly reversed with the sick, even should they be as many hours out of their beds as you are in yours, which probably they are not. Therefore, that they should be able, without raising themselves or turning in bed, to see out of a window from their beds, to see sky and sunlight at least, if you can show them nothing else, I assert to be, if not of the very first importance for recovery, at least something very near it….

Again, the morning sun and the midday sun—the hours when they are quite certain not to be up—are of more importance to them, if a choice must be made, than the afternoon sun….

It is hardly necessary to add that there are acute cases (particularly a few ophthalmic cases and diseases where the eye is morbidly sensitive), where a subdued light is necessary. But a dark north room is inadmissible even for these….

Heavy, thick, dark window or bed curtains should, however, hardly ever be used for any kind of sick in this country. A light white curtain at the head of the bed is, in general, all that is necessary, and a green blind to the window, to be drawn down only when necessary….

Without sunlight, we degenerate body and mind. One of the greatest observers of human things (not physiological) [statistician L.A.J. Quetelet], says, in another language [French], “Where there is sun, there is thought.” All physiology goes to confirm this. Where is the shady side of deep valleys, there is cretinism. Where are cellars and unsunned sides of narrow streets, there is the degeneracy and weakness of the human race—mind and body equally degenerating. Put the pale withering plant and human being into the sun, and, if not too far gone, each will recover health and spirit.

It is a curious thing to observe how almost all patients lie with their faces turned to the light, exactly as plants always make their way toward the light.

**Chapter 10. Cleanliness of Rooms and Walls**

It cannot be necessary to tell a nurse that she should be clean or should keep her patient clean—seeing that the greater part of nursing consists in
preserving cleanliness. No ventilation can freshen a room or ward where the most scrupulous cleanliness is not observed.

Without cleanliness, you cannot have all the effect of ventilation; without ventilation, you can have no thorough cleanliness.

Very few people, be they of what class they may, have any idea of the exquisite cleanliness required in the sickroom. For much of what is here said applies less to the hospital than to the private sickroom.

“What can’t be cured must be endured,” is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation in her are, but, other words for carelessness or indifference—contemptible if in regard to herself, culpable if in regard to her sick.

Chapter 11. Personal Cleanliness

Ventilation and skin cleanliness equally essential. The amount of relief and comfort experienced by sick after the skin has been carefully washed and dried is one of the commonest observations made at a sickbed. But it must not be forgotten that the comfort and relief so obtained are not all. They are, in fact, nothing more than a sign that the vital power have been relieved by removing something that was oppressing them.

Just as it is necessary to renew the air round a sick person frequently, to carry off morbid effluvia from the lungs and skin, by maintaining free ventilation, so it is necessary to keep the pores of the skin free from all obstructing excretions. The object both of ventilation and of skin cleanliness is pretty much the same, to wit, removing noxious matter from the system as rapidly as possible.

Care should be taken in all these operations of sponging, washing, and cleansing the skin not to expose too great a surface at once, so as to check the perspiration, which would renew the evil in another form.

In several forms of diarrhea, dysentery, etc., where the skin is hard and harsh, the relief afforded by washing with a great deal of soft soap is incalculable. In other cases, sponging with tepid soap and water, then with tepid water and drying with a hot towel, will be ordered.

Every nurse ought to be careful to wash her hands very frequently during the day. If her face too, so much the better.

Compare the dirtiness of the water in which you have washed when it is cold without soap, cold with soap, hot with soap. You will find the first has hardly removed any dirt at all, the second—a little more, the third a great deal more.

Washing, however, with a large quantity of water, has quite other effects than those of mere cleanliness. The skin absorbs the water and becomes softer and more perspirable. To wash with soap and soft water is, therefore,
desirable from other points of view than that of cleanliness. But the water must be soft.

Chapter 12. Chattering Hopes and Advices

Wonderful is the face with which many friends, lay and medical, will come in and worry the patient with recommendations to do something or other, having just as little knowledge as to its being feasible or even safe for him, as if they were to recommend a man to take exercise, not knowing he had broken his leg.

No mockery in the world is so hollow as the advice showered upon the sick. How little the real sufferings of illness are known or understood. How little does anyone in good health fancy him or even herself into the life of a sick person.

Do you who are about the sick or who visit the sick try and give them pleasure, remember to tell them what will do so. A sick person does so enjoy hearing good news, for instance, of a love and courtship while in progress to a good ending. If you tell him only when the marriage takes place, he loses half the pleasure, which God knows he has little enough of, and ten to one, but you have told him of some lovemaking with a bad ending.

Tell him one benevolent act which has really succeeded practically—it is like a day’s health to him.

A small pet animal is often an excellent companion for the sick, for long chronic cases especially. A bird in a cage is sometimes the only pleasure of an invalid confined for years to the same room. If he can feed and clean the animal himself, he ought always to be encouraged and assisted to do so. An invalid, in giving an account of his nursing by a nurse and a dog, infinitely preferred that of the dog: “above all, it did not talk.”

Do observe these things, especially with invalids. Do remember how their life is to them disappointed and incomplete. You see them lying there with miserable disappointments from which they can have no escape but death, and you can’t remember to tell them of what would give them so much pleasure, or at least an hour’s variety. They don’t want you to be lachrymose and whining with them—they like you to be fresh and active and interested, but they cannot bear absence of mind, and are so tired of the advice and preaching they receive from everybody.

Chapter 13. Observation of the Sick

The most important practical lesson that can be given to nurses is to teach them what to observe—how to observe—what symptoms indicate
improvement—what is the reverse—which are of importance—which are of none—which are the evidence of neglect—and of what kind of neglect.

All this is what ought to make part, and an essential part, of the training of every nurse. At present how few there are, either professional or unprofessional, who know at all whether any sick person they may be with is better or worse….

Leading questions useless or misleading…. The question is generally a leading question, and it is singular that people never think what must be the answer to this question before they ask it, for instance, “Has he had a good night?” Now, one patient will think he has a bad night if he has not slept ten hours without waking. Another does not think he has a bad night if he has had intervals of dosing occasionally…. Why cannot the question be asked, How many hours’ sleep has __ had? and at what hours of the night? This is important because on this depends what the remedy will be. If a patient sleeps two or three hours early in the night, and then does not sleep again at all, ten to one it is not a narcotic he wants, but food or stimulus, or perhaps only warmth. If on the other hand, he is restless and awake all night, and is drowsy in the morning, he probably wants sedatives, either quiet, coolness or medicine, a lighter diet, or all four….

It is useless to go through all the particulars, besides sleep, in which people have a peculiar talent for gleaning inaccurate information. As to food, for instance, I often think that most common question, How is your appetite? can only be put because the questioner believes the questioned has really nothing the matter with him…. Again, the question, How is your appetite? is often put when How is your digestion? is the question meant. No doubt the two things often depend on one another. But they are quite different….

There may be four different causes, any one of which will produce the same result, viz., the patient slowly starving to death from want of nutrition.

1. Defect in cooking;
2. Defect in choice of diet;
3. Defect in choice of hours for taking diet;
4. Defect of appetite in patient

Yet all these are generally comprehended in the one sweeping assertion that the patient has “no appetite.”

Surely many lives might be saved by drawing a closer distinction, for the remedies are as diverse as the causes. The remedy for the first is to cook better; for the second to choose other articles of diet; for the third to watch for the hours when the patient is in want of food; for the fourth to show him
what he likes, and sometimes unexpectedly. But no one of these remedies will do for any other of the defects not corresponding with it.

Again, the question is sometimes put, Is there diarrhea? and the answer will be the same whether it is just merging into cholera, whether it is a trifling degree brought on by some trifling indiscretion, which will cease the moment the cause is removed, or whether there is no diarrhea at all, but simply relaxed bowels.

In the case of infants, everything must depend upon the accurate observation of the nurse or mother who has to report. And how seldom is this condition of accuracy fulfilled. It is the real test of a nurse whether she can nurse a sick infant.

Almost all superstitions are owing to defective knowledge, to bad observation, the post hoc, ergo propter hoc [after this, therefore because of this], and bad observers are almost all superstitious. Farmers used to attribute disease among cattle to witchcraft.

The nurse’s attention should be directed to the extreme variation there is not unfrequently in the pulse of such patients during the day. A very common case is this: between 3 and 4 a.m. the pulse becomes quick, perhaps 130, and so thready it is not like a pulse at all, but like a string vibrating just underneath the skin. After this, the patient gets no more sleep. About midday the pulse has come down to 80, and, though feeble and compressible, is a very respectable pulse. At night, if the patient has had a day of excitement, it is almost imperceptible. But, if the patient has had a good day, it is stronger and steadier and not quicker than at midday.

A nurse ought to be able to understand what the variations of the pulse imply, what its character indicates. It is not the absolute rate of the pulse, which it signifies so much, for you to know. At least, you ought to be able to form an accurate enough guess at its rate without counting. It is the character of the pulse which signifies. There is the “splashing” pulse, which implies aneurysm. There is the pulse without an edge, which feels not like a ribbon, but a thread running along a space which it does not fill. There is the intermittent pulse of heart disease, the pulse of acute pleurisy, the pulse of peritonitis, the throbbing pulse which indicates acute inflammation or risk of hemorrhage. There is the rapid pulse of exhaustion in fever, which is the sign that the time has come for wine and stimulants.

In dwelling upon the vital importance of sound observation, it must never lose sight of what observation is for. It is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort.

And remember every nurse should be one who is to be depended upon, in other words, capable of being a “confidential” nurse. She does not know how soon she may find herself placed in such a situation; she must be no gossip.
no vain talker; she should never answer questions about her sick, except to those who have a right to ask them; she must, I need not say, be strictly sober and honest, but more than this, she must be a religious and devoted woman; she must have a respect for her own calling, because God’s precious gift of life is often literally placed in her hands; she must be a sound and close and quick observer, and she must be a woman of delicate and decent feeling.

Conclusion

The whole of the preceding remarks apply even more to children and puerperal [birthing] women than to patients in general. They also apply to the nursing of surgical, quite as much as to that of medical, cases. Indeed, if it be possible, cases of external injury require such care even more than sick. In surgical wards, one duty of every nurse certainly is prevention. Fever, or hospital gangrene, or pyemia, or purulent discharge of some kind may else supervene. Has she a case of compound fracture, of amputation, or of erysipelas, it may depend very much on how she looks upon the things enumerated in these notes, whether one or other of these hospital diseases attacks her patient or not. If she allows her ward to become filled with the peculiar close fetid smell, so apt to be produced among surgical cases, especially where there is great suppuration and discharge, she may see a vigorous patient in the prime of life gradually sink and die, where, according to all human probability, he ought to have recovered. The surgical nurse must be ever on the watch, ever on her guard, against want of cleanliness, foul air, want of light, and of warmth.

Nevertheless, let no one think that, because sanitary nursing is the subject of these notes, therefore what may be called the handicraft of nursing is to be undervalued. A patient may be left to bleed to death in a sanitary palace. Another who cannot move himself may die of bedsores, because the nurse does not know how to change and clean him, while he has every requisite of air, light, and quiet.

To revert to children. They are much more susceptible than grown people to all noxious influences. They are affected by the same things, but much more quickly and seriously, viz., by want of fresh air, of proper warmth, want of cleanliness in house, clothes, bedding, or body, by startling noises, improper food, or want of punctuality, by dullness, and by want of light, by too much or too little covering in bed or when up, by want of the spirit of management generally in those in charge of them. One can, therefore, only press the importance as being yet greater in the case of children, greatest in the case of sick children, of attending to these things.

That which, however, above all, is known to injure children seriously is foul air, and most seriously at night. Keeping the rooms where they sleep
tight shut up is destruction to them. And, if the child’s breathing be disordered by disease, a few hours only of such foul air may endanger its life, even where no inconvenience is left by grown-up person in the same room.

Pathology teaches the harm that disease has done. But it teaches nothing more. We know nothing of the principle of health, the positive of which pathology is the negative, except from observation and experience. And nothing but observation and experience will teach us the ways to maintain or to bring back the state of health. It is often thought that medicine is the curative process. It is no such thing: medicine is the surgery of functions, as surgery proper is that of limbs and organs. Neither can do anything but remove obstructions: neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound. So it is with medicine; the function of an organ becomes obstructed; medicine, so far as we know, assists nature to remove the obstruction, but does nothing more. And what nursing has to do in either case is to put the patient in the best condition for nature to act upon him.

Supplementary Chapter: What Is a Nurse?

This book takes away all the poetry of nursing, it will be said, and makes it the most prosaic of human things. . .

What is it to feel a calling for anything? Is it not to do your work in it to satisfy your own high idea of what is the right, the best, and not because you will be “found out” if you don’t do it? This is the “enthusiasm” which everyone from a shoemaker to a sculptor must have in order to follow his “calling” properly. Now the nurse has to do, not with shoes or with chisel and marble, but with human beings, and if she, for her own satisfaction, does not look after her patients, no telling will make her capable of doing so.

* * * * *

REFERENCES


Liverpool Mercury. (1860, January 29). Miss Florence Nightingale on nursing the sick.


Nightingale, F. (1858a). Answers to written questions addressed to Miss Nightingale by the Commissioners. Report of the Commissioners appointed to inquire into the regulations affecting the sanitary condition of the Army and the treatment of the sick and wounded (pp. 361–394) London, UK: Her Majesty’s Stationery Office.


Nightingale, F. (1859a). Notes on the sanitary condition of hospitals, and on the defects in the construction of hospital wards. In Transactions of the National Association for the Promotion of Social Science 1858 (pp. 462–482). London, UK: John W. Parker & Son.

Nightingale, F. (1859b). Nightingale, notes on hospitals, being two papers read before the National Association for the Promotion of Social Science, at Liverpool, in October 1858, with evidence given to the Royal Commissioners on the State of the Army in 1857 (2nd ed.) London, UK: John W. Parker.


Nightingale, F. (1867). Suggestions on the subject of providing training and organizing nurses for the sick poor in workhouse infirmaries (pp. 64–76). London, UK: Her Majesty’s Stationery Office.
Saturday Evening Post. (1860, March 10 to May 26).
South Australian Advertiser. (1860, April 20). Miss Nightingale’s notes, 3.
South Australian Register. (1860, July 30). Miss Nightingale’s Notes on Nursing, 3.
The Times. (1858, October 15 & 16). National Association of Social Science, 6EF and 7F.
The Times. (1930, February 8). St. Martin’s Lane, 21C.
Toronto Globe. (1860, February 13 and 21). Notes on Nursing, 4 and 2.