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Florence Nightingale and Responsibility for Healthcare in the Home

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Abstract

The focus for this article is the approach taken by the famous British nurse and public health reformer Florence Nightingale (1820–1910) to responsibility for care, with particular reference to healthcare as practised in the home. It begins by examining Nightingale's involvement as a young woman in 'Lady Bountiful' style upper-class charitable health visiting in the period before 1850. It goes on to consider the district nursing model designed by Nightingale and William Rathbone in the 1860s as an attempt to adapt this localised model of charitable care to the demands of industrial Victorian cities. The final section broadens the lens to examine Nightingale's views on religious vocations in care work and the state's expanding role in regulating the nursing profession. Nightingale's ideal vision of care combined multiple elements: attachment to a local community, a sense of religious vocation, and the scalability and fundraising of national or governmental organizations.

Keywords

Florence Nightingale – William Rathbone – district nursing – charity – philanthropy – Lady Bountiful – state registration of nurses – nineteenth-century healthcare – religious vocations

The career of the famous British nurse and public health reformer Florence Nightingale (1820–1910) reflected the nineteenth-century shift towards a greater degree of formal organization in the practice of healthcare. Nightingale's first care work, in the 1830s and 1840s, occurred as part of a longstanding tradition of small-scale, upper-class charity. Following the nursing mission to the Crimean War that made her an international celebrity, by the 1860s she had instituted a nurse training centre and was pressuring the British government to provide proper hospital care to the poor in workhouse infirmaries, as well as to implement major reforms to the army medical system. Nightingale's career, and the wider trend towards more organized and specialised healthcare, took place in the context of contemporary debates over where the emphasis should lie in terms of who took responsibility for providing and funding that care, especially for the industrial poor. Did primary responsibility lie with individuals to help themselves, or was it the duty of wealthy citizens to provide assistance? What was the proper role of religious organizations, civil society groups, or – even if the welfare state still lay some way into the future – of the broader national community? Should healthcare be organized mainly at a very local level, or more centrally?

This article examines how Nightingale navigated these debates in her work, with particular regard to healthcare as practised in the nineteenth-century home. Despite nineteenth-century developments in institutional healthcare, the home remained the primary site of treatment for sickness.¹ Throughout the British nineteenth century, most of the population preferred to avoid hospitals for non-surgical conditions. The workhouse infirmaries funded through the parish poor rates, which were generally the poor's only recourse, had terrible reputations, high death rates, and associations with the shame of indigence. Wealthy people had doctors and nurses come to their houses just as they would any other tradesperson; only towards the end of the century did specialised hospitals emerge that came to seem more desirable than home care for conditions such as smallpox. So-called 'voluntary' hospitals, funded by charitable donations, catered to a restricted clientele of gentfolk fallen on hard times, or working people boasting letters of recommendation from the charity's subscribers – who regularly reminded each other of the moral, social, and financial pitfalls of bestowing support on 'improper objects.'²

1 Anne Summers, "The Costs and Benefits of Caring: Nursing charities, c.1830–c.1860," in *Medicine and Charity Before the Welfare State*, ed. Jonathan Barry & Colin Jones (London, 1991), 133–148, 134.

2 See Paul Crawford, Anna Greenwood, Richard Bates and Jonathan Memel, *Florence Nightingale at Home* (London, 2020), 120–128 for the significance that Nightingale placed on the home during her time running the Harley Street Establishment. For a discussion in the context of the

Private homes, then, remained the favoured location for those who fell ill in nineteenth-century Britain. Furthermore, the home was idealised in Victorian society and literature as the pre-eminent site of health and flourishing and the most suitable location for convalescence and recovery.³ Healthcare institutions consciously and ostentatiously modelled their décor and routines on those of upper-class houses.⁴ When Nightingale ran the Establishment for Gentlewomen During Illness in London's Harley Street in 1853–1854 (before departing for the Crimean War), she did so with the aim of making it “as much like a home as possible,” in the words of one observer.⁵ Thus, the model, and the norm, was home care.

This article is divided into three sections. The first two look at Nightingale's approach to care provided in the homes of the poor by visitors in two distinct periods. The first section considers her involvement in charitable health visiting as a young woman prior to 1850, in order to understand the customary and longstanding responsibility for care placed on landowning families in the parish setting. It shows that while the so-called ‘Lady Bountiful’ custom of upper-class charity was diligently practised by several female members of the Nightingale family, including Florence, the conclusion she drew from this experience was that charitable gentlewomen inevitably failed to meet the needs of industrial populations, since they lacked the training and organization required to tackle the problem at scale. The second section considers the attempt made by Nightingale and William Rathbone from the 1860s onwards to adapt this model of charitable care to the demands of industrial Victorian cities via a carefully organized system of district nursing. It demonstrates that this resulted in a hybrid model of care, combining the idea of upper-class obligation from the Lady Bountiful tradition with elements of a self-funding model borrowed from religious institutions. It also shows how Nightingale and Rathbone fought for localised, organic models of district nursing as opposed to homogenous, centralised ones. The final section broadens the lens to examine Nightingale's views on the role of religious vocations in motivating people to work in healthcare, in the context of the state's expanding role in regulating

Huddersfield Dispensary and Infirmary, see Hilary Marland, “Lay and Medical Conceptions of Medical Charity During the Nineteenth Century – The case of the Huddersfield General Dispensary and Infirmary,” in *Medicine and Charity Before the Welfare State*, ed. Jonathan Barry and Colin Jones (London, 1991), 149–171.

- 3 Hosanna Krienke, *Convalescence in the Nineteenth-Century Novel: The Afterlife of Victorian Illness*, Cambridge Studies in Nineteenth-Century Literature and Culture (Cambridge, 2021).
- 4 Jane Hamlett, *At Home in the Institution: Material Life in Asylums, Lodging Houses and Schools in Victorian and Edwardian England* (Basingstoke, 2015).
- 5 Crawford, Greenwood, Bates and Memel, *Florence Nightingale at Home*, 124.

the nursing profession. It demonstrates that Nightingale was wary of either religious institutions or the state becoming too predominant: the first, because it would lead to ecclesiastical concerns interfering with optimal health practices, and the latter, because it would generate a bureaucratic system that would not value and reward the qualities that characterised the best nurses.

Nightingale's approach to health in the home and her contribution to changing ideas about where to place the responsibility for care have been relatively rarely studied. Most writing on Nightingale remains biographical in focus or centred either on her Crimean War mission or her nursing reforms, seen primarily through the prism of the creation of the Nightingale School.⁶ With some exceptions, notably the works by Anne Summers, Martha Vicinus, and Mary Poovey from the 1980s, few studies place Nightingale in the broader context of nineteenth-century upheavals in how responsibility for care was socially assigned.⁷ This article seeks to redress this by focusing on the specific question of healthcare in the home. In doing so, it aims to situate Nightingale within a more nuanced understanding of nineteenth-century discourse around healthcare. It sees her not as merely concerned to raise the social status of nursing, but as someone deeply involved in debates around charity, religion, and individual, communal, and national responsibility. Nightingale sought to develop new and ambitious healthcare schemes that both drew on these emerging currents in contemporary thinking and retained echoes of the localised, grass-roots experiences with which she had grown up.

1 Nightingale and Charitable Care in the Early Nineteenth Century

Britain's Protestant Reformation destroyed the networks of hospitals and religious congregations that had provided charitable care in the medieval period. In their absence, and that of newer religious orders such as the Daughters

6 The Nightingale biographies that remain of most value to historians are: Edward Cook, *The Life of Florence Nightingale*, 2 vols. (London, 1913); Ida O'Malley, *Florence Nightingale 1820–1856: A Study of Her Life Down to the End of the Crimean War* (London, 1931), and Mark Bostridge, *Florence Nightingale: The Woman and Her Legend* (London, 2009). On the Nightingale School, see: Monica Baly, *Florence Nightingale and the Nursing Legacy* (Beckenham, 1986); Roy Wake, *The Nightingale Training School 1860–1996* (London, 1998); Lucy Seymer, *Florence Nightingale's Nurses: The Nightingale Training School* (London, 1960).

7 Anne Summers, *Angels and Citizens: British Women as Military Nurses, 1854–1914* (London, 1988); Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850–1920* (Chicago, IL, 1985); Mary Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England* (Chicago, IL, 1988).

of Charity founded during the Counter-Reformation period in continental Europe, the Elizabethan Poor Law of 1601 formalised parish-based poor relief distribution but did not provide for institutional healthcare.⁸ Early modern British hospitals, dispensaries, and schools were funded by private charity, according to what Colin Jones has termed (in the French context) a “charitable imperative” characterised by “a matrix of moral obligation, religious dutifulness, and social exigency and expectation”.⁹ A significant component of this charitable matrix, well into the nineteenth century, was the paternalistic support provided by the female members of landowning families to the rural poor.¹⁰ Georgian women from educated and propertied families were encouraged to see themselves as especially sensitive to the needs of the dependent and afflicted.¹¹ In this ‘Lady Bountiful’ tradition, landed women, who typically also oversaw the local school and Sunday School and made other charitable endowments, visited the cottages of the elderly, sick, and destitute with gifts of food, medicine, and other goods such as clothing or bedding. They would also offer advice (solicited or not) on topics of household management or childcare, and might read the Bible with their tenants. The practice drew on longstanding Christian tradition (“I was sick and you visited me,” Matthew 25:36), and the idea of seeing God in the faces of the poor, as articulated by Vincent de Paul. However, as Jessica Gerard has shown, this practice of face-to-face, un-institutionalised charity was also about reinforcing relationships of social subordination and deference, cultivating gratitude and dependence among the people assisted.¹² Acts of charity, though undertaken sincerely and for their own sake, were also a performative enactment of social status. Sylvia Pinches has written of how “bourgeois women, circumscribed by law and convention,

8 Mathieu Brejon de Lavergnée, *Histoire des Filles de la Charité, XVIIe–XVIIIe siècle* (Paris, 2011), now translated into English as *The Streets as a Cloister: History of the Daughters of Charity* (New York, 2020).

9 Colin Jones, *The Charitable Imperative: Hospitals and Nursing in Ancien Regime and Revolutionary France* (London, 1989), 1.

10 The extent to which male and female charity differed in the eighteenth century remains contested historically; see Sylvia Pinches, “Women as Objects and Agents of Charity in Eighteenth-Century Birmingham,” in *Women and Urban Life in Eighteenth-Century England*, ed. Rosemary Sweet and Penelope Lane (Aldershot, 2003), 65–86; M. C. Martin, “Women and Philanthropy in Walthamstow and Leyton, 1740–1870,” *London Journal*, 19 (1994): 119–150.

11 Michael J. D. Roberts, “Head versus heart? Voluntary associations and charity organization in England, c. 1700–1850,” in *Charity, Philanthropy and Reform: From the 1690s to 1850*, ed. Hugh Cunningham and Joanna Innes (Basingstoke, 1998), 66–86, 71.

12 Jessica Gerard, “Lady Bountiful: Women of the Landed Classes and Rural Philanthropy,” *Victorian Studies*, 30 (1987): 183–210, 184. For comparative international perspectives on this issue, see the various essays in Cunningham and Innes, eds., *Charity, Philanthropy and Reform*.

often treated as objects by their men folk, could only express agency in relation to objects more powerless than themselves".¹³

The Nightingale family's relationship to their local communities was paternalistic. As a teenager, Nightingale wrote of how she enjoyed the family's "pleasant country life" and "our intercourse with the poor people".¹⁴ Her father William (1794–1874) had inherited a 2,200-acre estate in central Derbyshire from his great-uncle Peter Nightingale (1737–1803), a lead-industry magnate in the county, and in 1825 purchased a further, 3,500-acre estate in southern England, mostly in Hampshire. The Hampshire estate was rural and agricultural, but within relatively easy reach of London and also close to army and navy installations – in keeping with the kind of world depicted in the novels of fellow Hampshire resident Jane Austen. William Nightingale built an imposing eighty-bedroom house there and integrated himself into the world of local Liberal politics, in particular befriending his neighbour Lord Palmerston, a cabinet member. In November 1830, a group of 400 agricultural labourers targeted the Nightingales' house during the Swing Riots, demanding food and money and threatening to smash the windows.¹⁵ William's response was to embark on a paternalistic work-creation programme, offering unemployed labourers digging work on the estate. Such measures were a means of social control as much as relieving poverty; William also joined a new landowners' militia, overseen by the Duke of Wellington, formed in case of further riots. His practice of having his (male) farmer tenants come to the manor on rent days might be seen as the obverse of the female visiting tradition. The farmers came to William to pay their dues, eat cold beef in the servants' hall, and chat apparently light-heartedly with the landowner about their economic woes ("the grumblers are so merry in their lamentations over their *last penny*, that we made a laugh over our misfortunes," wrote William in an 1830 letter).¹⁶

Florence Nightingale was introduced to Lady Bountiful-style routines of home visiting by her elder female relatives. Her mother and other relatives visited the Hampshire poor in their homes and also oversaw the school at Wellow, sponsoring the fees of individual poor children and donating clothing. On the Derbyshire estate of Lea Hurst in the Derwent Valley, where the family spent its summers, the local population had a somewhat different character. A significant feature was the presence of textile workers employed in a cotton factory

13 Pinches, "Women as Objects and Agents of charity," 85.

14 Florence Nightingale to her mother, 8 August 1834, Claydon House archives, N29/10.

15 Alex Hoss to William Nightingale, 25 November and 5 December 1830, Claydon N27/2–3.

16 William to Fanny Nightingale, 5 July 1830, Claydon N213, original emphasis. This letter was written following a storm that had damaged local crops.

at Lea, built in 1784 by Peter Nightingale in imitation of his better-known contemporary, the industrial pioneer Richard Arkwright (1732–1792), at nearby Cromford. Though the Nightingales as a family opposed slavery, and in some cases played active roles in anti-slavery campaigns, the fact that the Derwent Valley mills used cotton grown on slave plantations around the Caribbean does not seem to have had a particular impact on her developing social consciousness.¹⁷ Rather, Nightingale concerned herself with what became the biggest social question of mid-nineteenth century Britain: how to respond to the growth and needs of industrial workers and their families? In Nightingale's family, her mother Frances (Fanny, 1788–1880), her aunt Julia Smith (1799–1883, an active campaigner for a variety of philanthropic and progressive political causes), and her great-aunt Maria Coape took a particular interest in visiting the industrial poor, as surviving 1830s correspondence between the three women demonstrates. "The sick list has been rather formidable," wrote Coape in one 1834 letter, recording how she had obtained "boxes of pills" from Dr Poyser, a prominent local physician, that had restored the health of two villagers who were now "at the mill again".¹⁸ Many visits were to the old and dying: Smith began one 1826 letter by stating that "the poor dear old woman is still alive – and conscious, she knew me and said she was very glad to see me," while Coape described a Mrs Burton of Lea who "had a stroke about three weeks ago after which she never left her bed and died in about ten days, and I hope she had every comfort during the time that I could give her".¹⁹ Smith described how the young Nightingale formed part of a group of visitors spending "a considerable time" with the terminally ill: "we talked much about you all but more particularly Flo[rence], for whom she [the ill person] offered up a silent prayer".²⁰ In 1836 Nightingale's sister Parthenope wrote to her mother that "Flo has been very busy paying visits in the village [meaning Lea or nearby Holloway, close to the family's Derbyshire home]. The people about here are very fond of her, and she likes them and is always sorry to leave them."²¹

Given the reluctance of the poor to enter workhouse infirmaries and their infrequent admittance to voluntary hospitals, it is plausible to suppose, in

17 On the sources of Derwent Valley cotton, see Susanne Seymour, Lowri Jones and Julia Feuer-Cotter, "The global connections of cotton in the Derwent Valley mills in the later eighteenth and early nineteenth centuries," in *The Industrial Revolution: Cromford, The Derwent Valley and The Wider World*, ed. Chris Wrigley (Cromford, 2015), 150–170.

18 Maria Coape to Fanny Nightingale, 18 March 1834, Claydon N15/28.

19 Julia Smith to Fanny Nightingale, 9 January 1826, Claydon N24/3; Maria Coape to Fanny Nightingale, undated [1834], Claydon N15/31.

20 Julia Smith to Fanny Nightingale, undated [1834], Claydon N15/31.

21 Parthenope Nightingale to Mary Shore, July 1836, cited in Bostridge, *Florence Nightingale*, 50.

Anne Summers's words, "that those members of the charitable classes who were in closest touch with the medical needs of the sick poor were not those who founded and governed their hospitals, but those who visited them in their homes."²² Poverty was a perennial problem, but industrialisation and demographic growth changed its nature and scope. An early response to industrialisation – encouraged by Evangelical writings such as Hannah More's *Coelebs in Search of a Wife* (1809) which sought to bring "the affluent to a nearer knowledge of the persons and characters of their indigent neighbours" – was to increase the pace of home visiting.²³ Frank Prochaska has shown that the decades up to 1830 were characterised by a "rapidly expanding system of district visiting," of which leisured women formed the backbone.²⁴ Nightingale was struck in the 1840s by the scale of the problems confronting such visitors, writing that "when I go into a cottage I long to stop there all day, to wash the children, relieve the mother, stay by the sick one. And behold there are a hundred other families unhappy within half a mile."²⁵ Home visiting began to seem an insufficient, sticking-plaster response to the problem; a gesture that salved consciences without effecting either the necessary material or psychological transformation. Nightingale wrote in 1851 that "to visit [the poor] in carriage and give them money is so little like following Christ, who made himself like his brethren". She could not bring herself, per the Lady Bountiful tradition, "to preach patience to them, when they saw me with what they thought every blessing".²⁶ She was also conscious of her lack of nursing skills and training (and that of other lady home visitors), asking rhetorically "but what good do I do? ... I see disorder, dirt, unthrift, want of management, but I don't know how to help it ... I see illness but I don't know how to manage it". The "want of capacity to *visit well*," Nightingale concluded, "depresses and discourages our best-meant efforts".²⁷ To address nineteenth-century ailments properly would

22 Summers, "Costs and Benefits of Caring," 134.

23 Hannah More, *Coelebs in Search of a Wife* (London, 1809), 356.

24 Frank Prochaska, "Women in English Philanthropy, 1790–1830," *International Review of Social History*, 19 (1974): 426–445.

25 Nightingale's diary, 16 July 1846, quoted in O'Malley, *Florence Nightingale*, 119–120.

26 Nightingale's "Lebenslauf" for Kaiserswerth, 24 July 1851, in *The Collected Works of Florence Nightingale, Volume 1: An Introduction to Her Life and Family*, ed. Lynn McDonald (London, ON, 2001), 93. Subsequent references to the sixteen volumes of Nightingale's *Collected Works*, edited by Lynn McDonald and Gérard Vallée, and published by Wilfrid Laurier University Press between 2001 and 2012, will be given in the form '*Collected Works*' followed by the volume number. Details of their contents can be found at <<https://cwfn.uoguelph.ca/>>, accessed 14 May 2021.

27 Florence Nightingale, *The Institution of Kaiserswerth on the Rhine, for the Practical Training of Deaconesses* (1851, written 1850), reproduced in *Collected Works* 7, 492–511, here 508–509.

require a new mindset and a much greater level of organization. Industrial populations required new forms of care; the Lady Bountiful concept no longer sufficed as a response, and new forms of social organizations would need to assume the responsibility.

The solutions that Nightingale identified during this phase of her life, during her battle to be allowed to escape the confines of family life and undertake useful work in the world, were generally small-scale and remained within the boundaries of religiously-inspired charity. Nightingale was above all inspired by the religious sisterhoods and religious houses aimed at facilitating women's work, both Catholic and Protestant, that were gaining ground across Europe in the middle decades of the century. The appeal of the sisterhoods, for Nightingale and those of similar backgrounds, was that they made it possible for women to dedicate themselves full-time to socially useful work among the poor without compromising their personal safety or social respectability – the grounds on which Nightingale's parents had refused her initial request in 1845 to work as a hospital nurse. By contrast with the Lady Bountiful tradition, they also offered training, pastoral care, and the possibility of career development. The congregation that served as a model to all others was the Daughters of Charity of the Order of St Vincent de Paul, created in Paris in 1633, which had successfully institutionalised forms of care for various vulnerable sections of the population in France and beyond.²⁸ In Rome in 1848, Nightingale had noted the “nice clean merry active clear-complexioned, clear-starved, clear-minded women” of the Order, who were, in their capacity as nurses, “much better than anything there is in Rome”.²⁹ She subsequently tried to intern with the Daughters of Charity in Dublin in 1852 and in Paris in 1853, but with limited success as the Order was not set up to welcome visitors in this way.³⁰ She found a much warmer welcome at the Protestant Deaconesses' Institution at Kaiserswerth, in the Rhineland, where she stayed for two weeks in 1850 and three months in 1851. Already in 1845, Nightingale had articulated a desire to establish “something like a Protestant sisterhood, without vows, for women of educated feelings”.³¹ She returned from her foreign trips with a clearer vision for a nursing order, substantially modelled on Kaiserswerth but with certain important differences. Though she had been impressed with the religious commitment of the Kaiserswerth sisters (“I saw what power their

28 Including in Britain: see Susan O'Brien, *Leaving God for God: The Daughters of Charity of St Vincent de Paul in Britain, 1847–2017* (London, 2017).

29 Nightingale to her mother, 25 January 1848, *Collected Works* 7, 224.

30 See Matthieu Brejon de Lavergnée, *Le Temps des cornettes: Histoire des Filles de la Charité XIXe–XXe siècle* (Paris, 2018), 362.

31 Cited in Cook, *Life of Florence Nightingale*, vol. 1, 44.

having devoted all to God has in refining the intellect and giving grace to the character”), and by the spiritual guidance offered by the pastor, Nightingale envisioned a secular structure headed by two women: a paid nursing superintendent and a self-funding (and thus upper-class) ‘mother’ figure who – rather than a male pastor or chaplain – would oversee the “moral guardianship”.³² While this can be read as a feminist attempt to create a female-only hierarchy free from male interference (the Daughters of Charity, similarly, operated independently of episcopal authority and answered only to the distant oversight of the papacy),³³ the ‘mother’ figure might also be seen as an attempt to recuperate something of the Lady Bountiful role: a wealthy lady whose presence would uplift the atmosphere and exert a beneficial influence on working-class junior nurses.

2 Nightingale and District Nursing: New Models of Care

When Nightingale returned from the Crimean War in 1856, she did so with a new national (indeed international) public profile and with larger-scale models of care in mind. Her Crimean War nursing project had, in itself, been a kind of innovative public-private partnership, a government commission involving personnel from religious orders and enormous financial and material contributions from the British public. The high level of public interest in the army’s welfare during the Crimean War, facilitated by an uncensored press able to report in near-real time, inspired numerous subsequent humanitarian initiatives and effectively inaugurated a new phase in the relationship of care between civilians and the military.³⁴ After 1856 Nightingale’s ideas about healthcare became more systematic and ambitious, often envisaging larger roles for government and civil society and with a greater awareness of the potential of mass communications. Her work with Edwin Chadwick (1800–1890), the leading anti-contagionist and sanitary reformer of the age, was notable in this respect. Chadwick’s 1840s accounts of domestic squalor in the working-class slums of

32 Nightingale to her father, 15 August 1850, *Collected Works* 1, 232; eadem, “Draft Rules for a Protestant Nursing Order,” 1853, *Collected Works* 12, 66–70.

33 For an in-depth study of competing male and female authority in nineteenth-century orders of this kind, see Kristien Suenens, *Humble Women, Powerful Nuns: A Female Struggle for Autonomy in a Men’s Church*, KADOC Studies on Religion, Culture and Society 26 (Leuven, 2020).

34 Crawford, Greenwood, Bates and Memel, *Florence Nightingale at Home*, 143–178; James Crossland, *War, Law, and Humanity: The Campaign to Control Warfare, 1853–1914* (London, 2018).

Victorian Britain had brought about a transformation in municipal sanitation, while the 1848 Public Health Act that he oversaw marked a turning point after which “government intervention into matters of health and sanitation [would] seem not only acceptable but inescapable”.³⁵ This was an interesting evolution from Chadwick, given that he had previously been an architect of the 1834 Poor Law, legislation designed to minimize taxpayer liability for poor relief and place the onus of responsibility on individuals to take care of themselves. Like Chadwick, Nightingale had moved away from the kind of absolute self-reliance upheld by British Liberals in the 1830s. On this point, she clashed with her father (who ran for Parliament in 1835 as a tax-cutting Liberal), arguing that taken to its extreme it would forbid education as well as poor relief: “would not your principle ... lead to not teaching the infant, but leaving it to self-tuition?”, she asked in 1850.³⁶ While dependency on welfare was certainly to be discouraged, people needed help to help themselves, she argued.

Nightingale was therefore receptive, in 1858, to a proposal from Chadwick that she author a short book aimed at educating working women on matters of domestic sanitation and caring for the sick at home, in order to bring principles of disease “prevention within the means of popular appreciation”.³⁷ This was an opportunity for Nightingale to deploy her writing talents and her post-Crimea public profile to influence health in individual homes, but on a national scale. It was a chance to ameliorate what Nightingale saw as the biggest public health challenge of the day: the sanitary state of working-class housing. As she put it in 1861, “in all European countries, more sickness, poverty, mortality and crime is due to the state of our poor men’s dwellings than to any other cause ... I would rather devote money to remedying this than to any institution”.³⁸

Aimed at “women who have personal charge of the health of others” and assuming no pre-existing medical or nursing knowledge, the resulting work, *Notes on Nursing* (1860), explained in careful detail how house occupants could prevent or contain illness by overseeing minor domestic improvements and behavioural adaptations such as opening windows, thorough cleaning, and using better-quality materials for building and decoration. The book, especially in its later 1861 edition as *Notes on Nursing for the Labouring Classes*, was essentially geared towards explaining to working-class women what they could

35 William Farr, *Tenth Annual Report of the Registrar-General* (London, 1847), xv; Edwin Chadwick, *Report on the Sanitary Conditions of the Labouring Classes of Britain* (1842).

36 Nightingale, draft letter to her father, 4 November 1850, *Collected Works* 5, 168.

37 Beatrice Smith to Edwin Chadwick, 18 September 1858, and Edwin Chadwick to Nightingale, 8 December 1858, *Collected Works* 1, 533.

38 Nightingale to Harry Verney, 2 April [1861 or 1862], *Collected Works* 5, 170.

do to promote health in the home in the absence of any medical or other external intervention. It thereby tapped into the mid-nineteenth century enthusiasm for learning how to practise self-help, buoyed by Samuel Smiles's book of that name published in 1859, as well as women's advice and conduct literature such as the *Englishwoman's Domestic Magazine* (1852–1879) and Isabella Beeton's *Book of Household Management* (1861).³⁹ In contrast to the didactic, patronising associations of the 'Lady Bountiful' model, *Notes on Nursing* modelled a vision in which the public at large would have access to the knowledge and practices that promoted good health. Subsequent works, such as Osborne Reynold's *Sewer Gas, and How to Keep It Out of Houses: A Handbook on House Drainage* (1872), similarly taught women at home how to accommodate and adapt to the new sanitary landscape, carrying what Anthony Wohl terms the "cult of cleanliness ... with religious fervour down to the masses".⁴⁰ Rather than waiting for the occasional visits of their social superiors, readers with the assistance of these books could help themselves to become healthy.

This trend did not lead to the immediate demise of the Lady-Bountiful ideal, but did force it to adapt to new circumstances. Upper- and upper-middle-class women founded new movements that sought to assist and encourage the poor to maintain healthy houses. Women affiliated with organizations such as the Ladies' Sanitary Association (LSA, founded in 1857) and the National Health Society (1871) gave lectures, visited individual homes, and wrote penny pamphlets and advice manuals on topics like maternity health, child-rearing, housekeeping, cooking, and nursing.⁴¹ No longer claiming overall responsibility for care, such women instead served as agents and educators, creating channels through which the sanitarian message could be effectively delivered into otherwise unreachable homes. As Bessie Rayner Parkes (1829–1925), an LSA campaigner, explained:

We want the action of *women* in every parish; we want the clergyman's wife and the doctor's daughter to know the laws of health, and to enforce them in the perpetual intercourse which we hope and believe they maintain with their neighbours. The squire's lady, and the peeress whose

39 Florence Nightingale, *Notes on Nursing for the Labouring Classes* (London, 1861); Samuel Smiles, *Self-Help: With Illustrations of Character and Conduct* (London, 1859).

40 Michelle Allen, "From Cesspool to Sewer: Sanitary Reform and the Rhetoric of Resistance, 1848–1880," *Victorian Literature and Culture*, 30 (2002), 383–402; Anthony Wohl, *Endangered Lives: Public Health in Victorian Britain* (London, 1983), 66.

41 M. Allen-Emerson, "Sanitary Reform," in *The Palgrave Encyclopaedia of Victorian Women's Writing*, ed. Lesa Scholl (Cham, 2020), https://link.springer.com/referenceworkentry/10.1007/978-3-030-02721-6_1-1, accessed 16 May 2021.

husband owns half the county, the district visitor who cares for the soul, and the parish nurse who attends upon the sick.⁴²

Perceived to be innate carriers of (specifically feminine) sympathy, able to communicate to all classes, and occupying a social position that obliged them to interact with their poorer neighbours, ladies were, as Parkes explained, well placed to ensure that sanitary knowledge was “worked into the public mind” and “condensed in domestic conversation”.⁴³

These middle-class initiatives may be understood as secular, sanitarian successors to an earlier set of efforts in the 1830s and 1840s, when both the established and dissenting Protestant churches formed district visiting societies to distribute spiritual, material, and medical comforts to poor households throughout Britain.⁴⁴ The main objective of these societies was to proselytise among industrial populations and attack poverty at its presumed root by instilling a capacity for self-help among the poor, but some also undertook additional functions such as creating their own dispensary or funding medical visits.⁴⁵ An umbrella organization, the General Society for Promoting District Visiting, fostered in its members a sense of their being part of a collective, national, and Christian endeavour as well as a local and personal one. In 1840 the General Society produced a handbook, *The District Visitor's Manual*, which celebrated the “social, moral, spiritual benefit” of practising religious and paternalist duty towards the weak and unwell.⁴⁶ Though district visitors provided only limited relief, they held symbolic importance as carriers of sympathy across otherwise stark class divides. Moreover, as an “attempt to re-create the social relations of the rural parish in a period of rapid urbanization” these societies marked an

42 Bessie Rayner Parkes, “The Ladies' Sanitary Association,” *The English Woman's Journal* III, no. 14 (April 1859): 73–85, 82.

43 Ibid., 84. For analysis of this role within the context of the ‘communion of labour,’ see Eileen Janes Yeo, “Social Motherhood and the Sexual Communion of Labour in British Social Science, 1850–1950,” *Women's History Review*, 1 (1992): 63–87.

44 See Frank Prochaska, *Christianity and Social Service in Modern Britain: The Disinherited Spirit* (Oxford, 2006), 61–97.

45 Summers, “Costs and Benefits of Caring,” 134–135; H. D. Rack, “Domestic Visitation: A Chapter in Early Nineteenth Century Evangelism,” *Journal of Ecclesiastical History*, 24 (1973): 357–376.

46 Prochaska, “Women in English Philanthropy, 1790–1830,”; More, *Cælebs in Search of a Wife*, 4, 356; Dorice Williams Elliott, *The Angel Out of the House: Philanthropy and Gender in Nineteenth-Century England* (Charlottesville, VA, 2002), 60–61; Christopher Benson, *The District Visitor's Manual* (London, 1840), vi; Martin Gorsky, *Patterns of Philanthropy: Charity and Society in Nineteenth-Century Bristol* (Woodbridge, 1999).

early effort to rework the existing balance of responsibility for care in the new context of Victorian Britain.⁴⁷

In the 1860s, this district visiting model was adapted to support the specific health needs of the industrial poor. William Rathbone (1819–1902), from a wealthy Liverpool merchant family, had collected subscriptions on behalf of the District Provident Society from 1849 and found its model of care well suited to the changing terrain of the industrialized Victorian city. In the 1860s, he borrowed elements of its organizational model to develop a comparable form of home visiting focused explicitly on the urban poor's healthcare needs. District nursing, as it became known,⁴⁸ provided the capacity to have illnesses and injuries attended to in the home, away from institutions, for those who could not pay for this service themselves – and on a more systematic and reliable basis to that which Lady Bountiful figures could generally sustain. A district nurse would typically have some hospital experience and be prepared to address complex health needs; her responsibilities are thought to have included taking pulse and temperature readings (tasks which in hospitals would be undertaken by doctors or medical students). District nurses were also tasked with “nursing the home,” which meant overseeing the connections between cleanliness and disease prevention.⁴⁹ Rathbone had witnessed the benefits of personalized home nursing care when his wife became severely ill; after her death in 1859, he resolved to spread the provision more widely. He began by employing his wife's nurse, Mary Robinson, to visit and care for local poor people in their homes. But soon, overwhelmed by demand, he wrote to Nightingale for her advice on acquiring further nurses.⁵⁰

In their correspondence, Nightingale and Rathbone debated what the proper role of the district nurse was to be. It was assumed that this was to be women's work, but the training arrangements and funding system were up for discussion. As their correspondence progressed, Nightingale and Rathbone variously retained, rejected, or adapted particular characteristics of older models to the new context. They were keen to retain some of the eclecticism and local connection that characterised Lady Bountiful's role in the parish. However, recognizing the complexity involved in nursing the ill at home, Nightingale's most persistent concern was that district nurses be properly trained, stressing that it

47 Summers, “Costs and Benefits of Caring,” 134.

48 Summers argues that the scheme got its name from the earlier visiting societies, see “Costs and Benefits of Caring,” 134.

49 McDonald, *Collected Works* 13, 712.

50 On the Liverpool scheme's origins, see Gwen Hardy, *William Rathbone and the Early History of District Nursing* (Ormskirk, 1981).

is “no amateur work” but one that required a “considerable amount of knowledge, both of the laws of health and of disease”.⁵¹ Since district nurses would work independently, they needed to be of “a higher stamp” and “fuller training” than hospital nurses, in order to “combine the [functions of the] servant with the teacher and with the gentlewoman”.⁵² Appropriate training would, in other words, not only prepare district nurses to fulfil their roles effectively, but also provide them with something approaching the social status of their lady visitor predecessors. Responsibility for treating the poor at home would be granted only once nurses had undergone a year’s challenging training in hospital that included successive stints on surgical and medical wards.⁵³

Taking this on board, as well as practical advice received from Mary Jones of Kings College Hospital, Rathbone set out his plans for the Liverpool Training School and Home for Nurses, which opened on 1 July 1862.⁵⁴ District nurses soon proved their worth. The initial cohort of thirty-one were commended by local doctors as a valuable supplement to medical care. Their work, so Rathbone claimed, “saved many lives, and alleviated much intense suffering”.⁵⁵ District nursing associations conceived along similar lines soon appeared in other industrial cities such as Manchester and Derby from the mid-1860s, at least partly informed by Rathbone’s *Organization of Nursing: An Account of the Liverpool Nurses’ Training School* (1865), for which Nightingale wrote a foreword. Rathbone provided some Liverpool-trained nurses to these other cities, while Nightingale diverted trainees from the Nightingale Training School in London. However, by the 1870s Nightingale was growing frustrated at the size and the range of tasks falling to district nurses. In addition to dispensing medication, providing personal care, and responding to patients’ queries – without, as in a hospital, being able to call upon a nearby doctor – district nurses found themselves undertaking non-medical tasks like cooking, liaising with sanitary inspectors or parish relief officers, or even finding employment or school places for recovered patients.⁵⁶ For Nightingale, such a wide remit threatened to return the district nurse back to earlier models in which women were “mere

51 Florence Nightingale, “Introduction,” in William Rathbone, *Organization of Nursing* (Liverpool, 1865), 11; eadem, “Prospectus,” in Rathbone, *Organization*, 29.

52 Florence Nightingale, “Training nurses for the sick poor,” *The Times*, 14 April 1876, *Collected Works* 13, 754.

53 Rathbone, *Organization*, 50.

54 Monica E. Baly, *A History of the Queen’s Nursing Institute* (London, 1987), 8.

55 Rathbone, *Organization*, 19.

56 Nightingale to Rathbone, 19 April 1875, *Collected Works* 13, 741. For the relationship between the district nurse and the growth of sanitary reform, see Crawford, Greenwood, Bates and Memel, *Florence Nightingale at Home*, 94–102.

givers”.⁵⁷ “There are agencies for all these things,” wrote Nightingale, with undisguised impatience, “a nurse cannot be a cook ... a relieving officer, district visitor, letter writer, general storekeeper, upholsterer, almoner, purveyor, lady bountiful, head dispensary and medical comforts shop”.⁵⁸ If earlier practices had modelled a holistic approach to care that mediated varying home-based support through a small number of charitable figures, Nightingale, responding to the increasingly sophisticated apparatus of social support developing in the society around her, felt that the district nurse had to retain a distinct specialism.

In Liverpool, the ‘district’ had become significant as a geographical unit around which charity could be administered, allowing the sprawling city to be divided into eighteen smaller areas in which caring relations between the rich and poor could be more easily overseen. Each district contained around 25,000 inhabitants, and district boundaries generally followed those of parishes in order to encourage cooperation with the Anglican clergy.⁵⁹ In Rathbone’s scheme, each district was overseen by a lady superintendent, supported by a committee, who was responsible for helping nurses find lodgings and daily meals “so that the nurse’s strength and care,” as Nightingale wrote, “should not be absorbed in ‘fending’ for herself”.⁶⁰ Nightingale was in favour of the district arrangement because it meant that superintendents, as well as nurses working under them, could operate fairly independently while still maintaining a sense of shared endeavour across the city as a whole – “an *esprit de corps*”, or rather “*de ville*”, as she reflected in 1874.⁶¹ Since district nursing could, in comparison to hospital work, be an isolating experience, the city-wide nurses’ training school and home, which contained a shared living space (all nurses in the Liverpool scheme lodged together there for their probationary year), were important elements of the scheme, helping to create a sense of a shared endeavour.⁶²

In terms of financing, Rathbone’s scheme was a hybrid, embodying what Vanessa Heggie terms a “private-philanthropic, *self-funding* form of charity”.⁶³ Rathbone funded the construction of the Liverpool Training School himself,

57 Nightingale, [Note], 16 June 1874, *Collected Works* 13, 729.

58 Florence Nightingale, “Training Nurses for the Sick Poor,” 14 April 1876, *Collected Works* 13, 753.

59 Baly, *Queen’s Nursing Institute*, 9; Rathbone, *Organization*, 55–56.

60 Nightingale to Parthenope Verney, 13 November 1881, *Collected Works* 13, 776.

61 Nightingale to Rathbone, 13 June 1874, *Collected Works* 13, 724.

62 Rathbone, *Organization*, 50–51.

63 Vanessa Heggie, “Health Visiting and District Nursing in Victorian Manchester,” *Women’s History Review*, 20 (2011): 403–422, 410.

while what he called a “system of parochial payment”, overseen by the lady superintendents, utilised donations from clergy, industrialists, and wealthy residents to fund nurses’ accommodation and maintenance expenses and purchase medicines.⁶⁴ This enabled the charitable organization to remain extremely localised, as on the old philanthropic landowner model, with donors not necessarily supporting nursing beyond their own district. In addition to this philanthropic funding, Rathbone raised money for wages and the Liverpool School’s overheads by contracting out nurses to private households.⁶⁵ This idea, of offsetting the costs of charitable cases by surpluses generated from paid work, had also been employed by both Catholic and Protestant religious congregations – but the downside, as Nightingale acknowledged, was that it could end up leaving relatively few nurses available for the original charitable purpose.⁶⁶

The Liverpool model was adopted in other English industrial cities, but not immediately in the capital. In 1874, Sir Edward Lechmere of the English branch of the Order of St. John of Jerusalem proposed a district nursing scheme for London, but one with broader ambitions, as made clear in its name: the Metropolitan and National Nursing Association (MNNA). The MNNA’s ambition was typical of a wider 1870s agenda, one that sought to replace forms of charity and relief thought to encourage dependency with more systemized and organized forms of aid rooted in self-help – as seen, for example, in Octavia Hill’s Charity Organization Society, founded in 1869.⁶⁷ The state was also becoming more involved with healthcare at a local level – in 1871 the Local Government Board replaced the Poor Law Board, ensuring that public health came into the same administrative department as poor relief. Such moves towards centralised, systematic approaches to health and care were met with opposing concerns about the abandonment of well-established practices adapted to local conditions. Nightingale and Rathbone embodied this opposition in their initial response to the MNNA, emphasizing “the needs of *local* districts” and the advantages of “the smaller place”, and failing to see any advantage in a central society beyond a “certain power of getting money”.⁶⁸ Their clear preference was for an organic model that grew from the ground upwards according to

64 Rathbone, *Organization*, 19, 56.

65 *Ibid.*, 32.

66 Nightingale to Laura E. Edwards (Honorary Secretary of the Bristol Training Institute, Clifton), 20 April 1867, *Collected Works* 13, 716; Baly, *Queen’s Nursing Institute*, 5.

67 For the Charity Organization Society, see Michael E. Rose, *The Relief of Poverty, 1834–1914* (London, 1986), 34–49.

68 Nightingale, [Note], 16 June 1874, *Collected Works* 13, 729; Nightingale to Rathbone, 13 June 1874, *Collected Works* 13, 724–725.

local needs and conditions, rather than a uniform model imposed from the centre.

Ultimately, district nursing, at least in its Victorian form, settled on a compromise between local and national priorities. Nightingale and Rathbone eventually supported the MNNA, influencing it via a strategic subcommittee that included some of their appointees, while the Nightingale Fund supplied donations and trained nurses.⁶⁹ On their insistence that district nursing be organized locally and not centrally, they also relented, albeit only following a special intervention by Queen Victoria, who assigned a public fund to support district nursing as part of her 1887 Jubilee celebrations. This resulted in the creation of the Queen Victoria's Jubilee Institute for Nurses in 1887 (QVJIN, later the Queen's Nursing Institute), supported by a £2,000 annual budget, with Rathbone as honorary secretary. As with the Nightingale Fund raised during the Crimean War to support the Nightingale Training School, the QVJIN's £70,000 capital was invested to generate annual returns, and this practice removed the need to contract nurses out to private houses to raise funds. The responsibility for boarding and maintaining the 'Queen's nurses' was, as before, borne locally.⁷⁰ Indeed, Rathbone and Nightingale worked to incorporate localised practice into the new national structure, helping to establish nine conditions that existing local district nursing associations needed to meet to officially affiliate with the QVJIN. The tiered organizational structure, with County Nursing Associations and District Nursing Associations operating relatively autonomously, retained some of the local character of previous schemes and included, as Carrie Howse argues, "overtones of *noblesse oblige*".⁷¹ The national network was by no means comprehensive: some associations, such as the Ranyard Mission in London, failed to meet the required standards of training; while others, such as the well-regarded Bristol District Nursing Society, preferred to retain their full independence.⁷² Nonetheless, consolidating most of the district nursing associations under one banner provided an early model of a largely publicly-funded system of healthcare. It was an amalgamation of old and new systems of home care, combining residual structures at the parish or district scale with a national structure.

69 Baly, *Queen's Nursing Institute*, 12–14.

70 *Ibid.*, 24.

71 Carrie Howse, "From Lady Bountiful to Lady Administrator: Women and the Administration of Rural District Nursing in England, 1880–1925," *Women's History Review*, 15 (2006): 423–441, 435.

72 Mary Stocks, *A Hundred Years of District Nursing* (London, 1960), 95.

3 Religious Vocations, State Registrations

One way to think about Nightingale's broader attitude to responsibility for care is to imagine a triangle drawn between three points, with these points representing, respectively: charity and philanthropy; the church and religious orders; and national or state institutions. In the second half of the nineteenth century, most debates around the future of healthcare took place within this conceptual space; it was commonly thought that optimal care provision would likely combine elements of each model. District nursing, which combined individual philanthropy with regional and national structures, and built on the religious impulse that had informed the charitable visiting of the district visiting societies, was one example. Another was the health missionaries' scheme on which Nightingale worked with her nephew, Frederick Verney, in 1890s Buckinghamshire. Trained to educate rural families on the tenets of health and domestic sanitation, health missionaries were quasi-religious figures supported by new county council grants for technical education.⁷³ Similarly, societies such as the Red Cross or the St John's Ambulance Association were national organizations in dialogue and co-operation with the state, but remaining apart from it, and also drew heavily on religious and philanthropic traditions. Nursing provision, too, combined charitable with national and religious elements. Hospital nurses were often provided by privately funded religious orders such as St John's House, which staffed the King's College and Charing Cross hospitals after 1856.⁷⁴ The British state encouraged the growth of nursing through the QVJIN and the Order of St Katherine (awarded to distinguished hospital nurses), but left the funding of nursing training to the charitable sector.

Nurse training institutions such as the Nightingale School borrowed a number of elements from religious orders, including blue uniforms designed for respectability, an on-site chaplain, and a structured daily routine with prayer schedules. Nursing school superintendents frequently looked for a sense of religious vocation in candidates. In Nightingale's eyes, the most important qualifications were moral, not technical; in an era before universal free schooling, a pure and dedicated character counted for more than book learning. Nursing was first and foremost a 'calling' – or rather, as Lynn McDonald argues, Nightingale was inconsistent in her use of the terms 'calling' and 'profession' because "she wanted nursing to be both, an opportunity for those who

73 See Crawford, Greenwood, Bates and Memel, *Florence Nightingale at Home*, 99–100.

74 See Carol Helmstadter, "Building a New Nursing Service: Respectability and Efficiency in Victorian England," *Albion: A Quarterly Journal Concerned with British Studies*, 35 (2003): 590–621.

experienced a 'calling' ... [to undertake] a lifelong commitment."⁷⁵ Nightingale herself had first felt what she described as a "call to God's service" during an influenza epidemic in 1837, when she cared for sick members of her household.⁷⁶ She experienced this 'call' several further times in her early life, and her relationship with God remained important to her throughout her career. Most of Nightingale's early colleagues and followers were also driven by a strong religious sense, notably Agnes Jones (1832–1868), a fervently evangelical Nightingale School graduate who led a nursing team into Liverpool workhouse infirmary (dying there of typhus), and Jane Shaw Stewart (1821–1905), who led the British army's female nursing service in the 1860s and spoke of having been "called to serve God in the painful way of official duty."⁷⁷ In 1869, Nightingale wrote that:

I do entirely and constantly believe that [the religious motive] is essential for the highest kind of nurse or teacher, especially for the highest kind of founder ... I do not believe any founder was ever carried through [obstacles and setbacks] except by feeling that she or he was called to the work by God, that it is a part of *His* work, that he or she is a fellow worker with God.⁷⁸

However, Nightingale thought that there were significant flaws with an exclusively religious model of care. She extolled Rathbone's Liverpool district nursing scheme as a Christian triumph – "an activity under the highest of all Masters, and from the highest of all motives" – but also emphasized its positive differences, in terms of its comprehensiveness of organization, from the almsgiving practices long associated with Christian charity.⁷⁹ Writing to Virginia Woolf's aunt Caroline Stephen (1834–1909) who was composing a book about religious sisterhoods, Nightingale explained that from her perspective, such organizations frequently had their priorities wrong.⁸⁰ Too often, religious organizations saw their nursing or charitable functions as secondary to the so-called 'higher motives' of saving souls or promoting particular

75 For example, Nightingale to Benjamin Jowett, May 1892, *Collected Works* 12, 549; Lynn McDonald, "Introduction" to *Collected Works* 12, 6.

76 Bostridge, *Florence Nightingale*, 51–55.

77 Anne Summers, "Ministering Angels: Victorian Ladies and Nursing Reform," in *Victorian Values*, ed. Gordon Marsden (London, 1998), 139–150.

78 Nightingale to Caroline Stephen, May 1869, *Collected Works* 8, 41–50, 47.

79 Nightingale, "Introduction," in Rathbone, *Organization*, 11.

80 Caroline Stephen, *The Service of the Poor: An Enquiry into the Reasons for and against the Establishment of Religious Sisterhoods for Charitable Purposes* (London, 1871).

religious practices. Proponents of religious charity, especially the ultramontanist version then progressing strongly in Catholic Europe, argued that the secularisation of care should be resisted because only religious charity incorporated “God’s blessing” and “sparked the soul”, opening the practitioner to higher, transcendent sensations.⁸¹ Nightingale rejected this as special pleading on behalf of ecclesiastical interests. For her, care work itself *was* the “higher motive”: “to take care of the sick, to educate the child, to de-pauperize the pauper, as well as it is possible to do it, and to strain body, soul, nerve and mind and strength to find out the best possible methods of doing it. And every other is not the ‘higher motive’ but the lower.”⁸² She had little time for nurses who primarily wanted to evangelise, arguing that “a nurse should be a nurse; not a tract giver”.⁸³ Doing God’s work, for Nightingale, meant nursing well, improving sanitation and public health, educating children, (and “reclaiming prostitutes”) – not increasing church attendance or taking vows and sacraments.⁸⁴ Regarding sisterhoods, by the 1860s, Nightingale thought the key question was whether “the sisterhood exists for the work, [or] the work for the sisterhood”. Her vision of nursing had shifted away from the sisterhood model – while remaining based on it in important respects as her work became more entwined with the British state and more secular opportunities presented themselves. She had also become disenchanted with the way in which the Daughters of Charity, in particular, had become a tool of right-wing French political currents.⁸⁵ She argued in 1868 that it had “ceased to be a *religious* order” – i.e., one characterised by a pure vocation to heal the sick and care for the poor, as in the time of Vincent de Paul – and that it had instead “become an *ecclesiastical* order”, subservient to the political machinations of the papacy.⁸⁶

Religious orders thus should not generally be given unfettered responsibility for healthcare; rather, Nightingale believed, they worked most effectively when in partnership with secular authorities. The Daughters of Charity did best when working with municipal authorities to distribute poor relief, rather

81 For more on the transcendental significance of charity in Catholic Europe, see Annelies van Heijst, *Models of Charitable Care: Catholic Nuns and Children in Their Care in Amsterdam, 1852–2002* (Leiden, 2008). Thanks to Peter Heyrman for this recommendation.

82 Nightingale to Caroline Stephen, May 1869, *Collected Works* 8, 43–44.

83 Nightingale to Harry Verney, 15 August 1870, *Collected Works* 15, 663.

84 Nightingale to Caroline Stephen, May 1869, *Collected Works* 8, 42.

85 Nightingale’s relationship to French politics will be tackled in a forthcoming article by Richard Bates for *European History Quarterly*, provisionally titled “Florence and the French: Nightingale’s Relationship to France and the Franco-Prussian War.”

86 Nightingale, note on religious orders, 4 August 1868, *Collected Works* 7, 755.

than when “solely under an ecclesiastical power”.⁸⁷ Nightingale was often in favour of the state assuming greater responsibility. In 1865, she proposed the reform of the Poor Law so as to separate its punitive function (workhouse incarceration of able-bodied paupers unable to support themselves through work) from the treatment of the poor sick and insane, for which she sought to create a centralised, universal, taxpayer-funded system of medical relief.⁸⁸ She also suggested, in an 1869 article for a popular magazine, that the state should “seize and educate the 100,000 homeless children running about the streets of London”, so that these children might develop into honest and productive citizens and not return as “paupers or as thieves upon the rates and the country”.⁸⁹ However, Nightingale was also enough of a *laissez-faire* liberal to argue, in the same piece, that the ultimate solution to unemployment-related poverty was an unfettered and efficient labour market freed from “the tyranny” of trade unions. Too much state involvement would lead to inefficiency and bureaucracy. Nightingale gave the example of the National Workshops (*Ateliers nationaux*) formed under the French Second Republic in 1848, which, in her view, guaranteed employment to workmen only at the expense of efficiency and productivity. Centralised models, she thought, were generally worse than small-scale initiatives tailored to local circumstances.

Nightingale’s wariness towards what she saw as unwarranted state involvement in healthcare was influentially manifested in her largely successful opposition, in the late 1880s and early 1890s, to the movement for the state registration of nurses in Britain. The British Nurses’ Association (BNA) was founded in 1887 by Ethel Bedford Fenwick (1857–1947) with the aim of creating a central, state-sanctioned register of nurses – in the hope of thereby elevating nursing’s social status, as the 1858 Medical Act had done for the medical profession. Many younger nurses of the 1880s and 1890s believed that state registration was a logical, forward-looking step that would establish nursing as a modern, middle-class, respectable profession, distancing it from associations with domestic service and religious self-sacrifice.

While Nightingale sympathised with this goal, she raised multiple objections to the registration idea. The BNA was naïve, she thought, to suppose that state certification would lead automatically to more gentlewomen entering the nursing profession. Rather, the requirement to pass a written examination would likely serve only to drive working-class women away, leading

87 Ibid., 757.

88 On Nightingale’s ideas for reforming workhouse infirmaries, see *Collected Works* 6, 223–490.

89 Florence Nightingale, “A Note on Pauperism,” *Fraser’s Magazine*, March 1869, 281–290, in *Collected Works* 5, 132–145, here 135–136.

to recruitment shortfalls.⁹⁰ In any case, the moral qualities such as “kindness, patience, trustworthiness, self-control, discretion” that Nightingale emphasized as central to a good nurse’s character were impossible to capture reliably or durably in an examination or register.⁹¹ Putting this into religious terms, she argued that “it is not knowing doctrine but bearing FRUIT that [God] desires of us, and the former is nothing in His eyes compared with the latter, which is so eminently true with regard to our nursing profession and art”.⁹² A nurse needed intangible domestic as well as measurable academic qualities, to understand “all that constitutes a good home” as well as “all that constitutes a good hospital”.⁹³ As she wrote in March 1888, “I am very much afraid of introducing or making prominent the *metallic* type of nurse, brilliant and confident in her accomplishments of brain and training, and of stamping out of the profession women of more homely attainments but whose sympathies instruct them to good purpose.”⁹⁴

The qualities required to furnish a home and homely care, then, were very much at the forefront of Nightingale’s mind in thinking about how nurses should be recruited, trained, and assessed. These homely qualities, coded as feminine, would be damaged by centralised bureaucratic control, implicitly understood as masculine. This gendered aspect of Nightingale’s opposition was reinforced by her sense that the BNA was becoming unduly influenced by medical men. Bedford Fenwick, who was married to a doctor, thought that medical support would enhance the BNA’s standing and help advance its aims. In exchange, she was prepared to allow doctors to influence the nursing curriculum and was supportive of their demands for docility and deference from nurses.⁹⁵ This was anathema to Nightingale, who had always been concerned to preserve nursing as an independent, female-led profession, and to deny medical men hiring and firing powers over nurses.

In practical terms, registration would most affect those nurses working freelance in private homes. Hospitals already kept their own registers, as did district nursing associations. A state register, Nightingale wrote in 1892, “therefore is only for private nurses”.⁹⁶ But Nightingale felt that it was not the state’s

90 See Carol Helmstadter, “Florence Nightingale’s Opposition to State Registration of Nurses,” *Nursing History Review*, 15 (2007): 155–165.

91 Nightingale, draft letter to Henry Acland, 1888 or 1889, *Collected Works* 12, 529.

92 Nightingale to Eva Lückes, 7 April 1889, *Collected Works* 12, 526.

93 Nightingale, draft letter to William Rathbone, ca. 26 February 1891, *Collected Works* 12, 539.

94 Nightingale, note of 6 March 1888, apparently quoting Angelique Pringle; see *Collected Works* 12, 524.

95 See Helmstadter, “Florence Nightingale’s Opposition,” 161.

96 Nightingale to Benjamin Jowett, May 1892, *Collected Works* 12, 548.

role to intervene in this private sphere. Anyone hiring a nurse to work in their home bore the responsibility of enquiring into her abilities and character, and certification could not substitute for such vetting. "If the public will not protect itself against bad nurses, how can a register protect it?", Nightingale asked.⁹⁷ Reformers aiming to improve private or domiciliary nursing should instead seek to emulate the character-oriented reforms undertaken by training centres like the Nightingale School, "namely, to make the hospital ... a home of moral and spiritual helps, physical comfort for health, proper accommodation for decency, good surroundings, careful and motherly superintendence, [and] good companions".⁹⁸ If private nurses continued to be of poor quality, this was because they lacked the homely base and *esprit de corps* provided by a good training institute. Rather than using registration to exclude these nurses from the profession, the answer was to provide them with the "moral and comfortable helps" that were needed to support and elevate their character.⁹⁹ If the state or the nation at large wanted to ensure higher nursing standards, it should focus on these homely aspects, rather than seeking illusory comfort in a chimerical standardization.

The campaign for nurse registration eventually succeeded in 1919, after Nightingale's death and more pertinently, after World War I had dramatically created an increased need for skilled nurses in a context in which oversight responsibility inescapably fell to the state. The increased complexity of twentieth-century medical procedures and thus of nurses' roles made it harder to maintain, as Nightingale had done, that homely qualities and moral character counted for more than book-based learning. The decline of rentier incomes and consequently of the servant class, and the concomitant growth of the welfare state, reduced the demand for private domiciliary nurses and confirmed hospitals as the pre-eminent site of nursing employment. The relationship between the three points of the 'care triangle' of the second half of the nineteenth century – charity, religion, and state – that Nightingale had sought to keep in a relatively even balance, thus shifted decisively towards the state. Nonetheless, the religious and vocational emphasis of the Nightingale-era nursing model persisted as significant considerations in the profession until at least the 1960s. The Nightingale School continued to be funded by charity and to structure its day around prayer schedules; nursing periodicals regularly published devotional articles, with nurses being exhorted to "carry that bedpan to

97 Nightingale to Henry Acland, 13 December 1887, *Collected Works* 12, 519.

98 Nightingale to Benjamin Jowett, May 1892, *Collected Works* 12, 548.

99 Ibid.

the glory of God".¹⁰⁰ Only in the later 1960s did the Royal College of Nursing mount a sustained campaign against the vocational model as an unwarranted justification for low pay and exploitation, and only with the 1972 Briggs Report did the British state move decisively away from the vocational ideal as a model for nursing.

4 Conclusion

Nightingale is an intriguing figure to consider in terms of this special issue's broader discussion of the balance in the responsibility for care between institutions, individuals, and communities, and between secular and religious models of charity and healthcare. Her career took her from the Lady-Bountiful style charity of her youth, to become the creator of secular public institutions – taking significant inspiration from religious organizations along the way. While seeing the potential of the state to provide funding and drive change on a much larger scale than that possible via private philanthropy, she resisted the accompanying tendency towards centralisation and standardisation. The secular institutions that she created, though often ambitious in scope, retained conscious echoes of older, smaller-scale charitable practices. Nightingale's ideal vision of care was one that combined the best aspects of the various models that she encountered: the attachment to, and understanding of, a local community present in the Lady Bountiful model; the sense of vocation possessed by the best religious sisters; and the ability of national organizations to mobilise funding and popular enthusiasm.

This article has shown how a complex network of considerations played out with respect to Nightingale's work on healthcare in the home in particular. As has been seen, the home was a pre-eminent location of care for Nightingale and one that she consistently emphasized throughout her writings and campaigns – especially the working-class home, which figured as a key site thought to require outside intervention in order to improve overall public health. Nightingale assigned the responsibility for this home-based care to different agents at different times, perhaps reflecting the confusions of an era which prized individual self-reliance but which tended to generate problems that fundamentally required collective solutions. In her early life, she took it on herself to do God's work by visiting the poor in person, but soon realised the inadequacy of this informal, individualised approach to meet the scale of

¹⁰⁰ Cited in Ann Bradshaw, "An historical perspective on the treatment of vocation in the Briggs Report (1972)," *Journal of Clinical Nursing*, 19 (2010), 3459–3467.

the challenges posed by industrial poverty. In writing *Notes on Nursing*, she seemed to subscribe to the self-help model in which responsibility lay on poor householders to improve their own environment, with appropriate guidance from their social and sanitarian betters. In creating district nursing systems, she implicitly assigned much more responsibility to the wider community to provide (or at least to fund) home-based care and sanitary advice – initially at a local level, but subsequently on a national scale. Yet, in resisting the state registration of private nurses, she threw some responsibility back onto householders to assure themselves that any nurse that entered their home possessed the requisite character and homely qualities, rather than relying on others to certify this. To look for consistency in Nightingale's approach over several decades, however, is probably to miss something essential about her: that she was characterised more by impatient pragmatism than by a desire for philosophical constancy. Healthcare and public health were everyone's problems, and they were urgent. Responsibility for these urgent concerns lay with anyone and everyone who was in a position to do something meaningful about them.

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