NURSING’S GREATEST LEADERS
A HISTORY OF ACTIVISM

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Nursing’s Greatest Leaders
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Nursing’s Greatest Leaders

A History of Activism

David Anthony Forrester, PhD, RN, ANEF, FAAN

Editor
This book is dedicated to my loving husband, Kevin, who makes me a better person, and to all nurses everywhere who choose to be leaders.

—DAF
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Foreword

In 2010, I served as study director for the Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011). The committee and I had spent months crafting a report that described the changes needed to prepare the nursing workforce to provide exceptional care in the 21st century. We poured our lifeblood into the report and we had great expectations. We wanted to galvanize nurses and other stakeholders to first understand how nurses could best be used to improve health and then take action to change the face of health and health care. We intended for the report to serve as a blueprint for the transformation of health and the health system.

To shape the future, I turned to the past—to Florence Nightingale, the inventor of modern nursing. The summer before the report was released, my husband, Bob, and I set off for London and Embley Park, England, and Scutari, Turkey, to literally follow in Florence Nightingale’s footsteps. I sought to learn all I could from the woman who shaped a movement to improve sanitation, improve quality patient care, and embark on large-scale prevention efforts. As early as 1894, Nightingale connected the importance of good childcare to building health. “Money would be better spent in maintaining health in infancy and childhood than in building hospitals to alleviate disease. It is much cheaper to promote health than to maintain people in sickness,” she wrote (Lundy, Janes, & Hartman, 2001, p. 4).

Retracing Florence Nightingale’s life changed me forever. It broadened the scope of what I thought was possible to inspire change for patients, families, and communities, and it gave me the courage to embark on a movement—The Future of Nursing: Campaign for Action, a joint initiative of the Robert Wood Johnson Foundation and AARP—that implements the IOM report recommendations. The campaign uses many of the skills that Nightingale perfected: a reliance on evidence, using networks and soliciting partners to elicit change, and speaking and writing often on the importance of using nursing to improve health.

But Florence Nightingale is just the first of many visionary nurse leaders who inspire me each day. Many of nursing’s heroes are included in *Nursing’s Greatest Leaders: A History of Activism*. I found myself captivated by the stories of the extraordinary women contained in these pages, from Clara Barton’s steadfastness in establishing the American Red Cross, to Edith Louisa Cavell’s courage in helping 200 Allied soldiers escape from German-occupied Belgium during World War I, for which she was executed.
This book is perfect for men and women who aspire to lead nursing and society into a better future. It will equally benefit undergraduate students enrolled in leadership courses, graduate students preparing for leadership roles, and nurses already established in leadership roles. *Nursing’s Greatest Leaders: A History of Activism* deepened my love for nursing and reinforced why nursing is repeatedly ranked the most trusted profession (Riffkin, 2014). I hope readers will be motivated, as I was, by these incredible nurse leaders, and that more nurses will follow in their footsteps.

*Susan B. Hassmiller, PhD, RN, FAAN*
Robert Wood Johnson Foundation, Senior Adviser for Nursing, and Director, Campaign for Action

**REFERENCES**


Preface

This book shares the life stories of some of the most revered leaders in nursing. It reports the distinguished history of nursing leadership, activism, and impact. First and foremost, this book is about leadership—nursing leadership. But it is also a book about history—nursing history within the context of an ever-evolving society.

This is a scholarly historical report with fidelity to the vision, intelligence, resourcefulness, and political awareness of nurse leaders committed to advancing the discipline and meeting the increasingly complex needs of society. In the aggregate, this is a compelling history not only of events and people within the context of their times but also of the contributions of so many visionary women who had the sheer courage, tenacity, and passion to move the nursing profession into the future—to the betterment of society around the world.

What is special about this book—why we wrote it—is that it provides an easily accessible one-stop reference on nursing leadership and nursing history. By telling the stories of some of the nursing discipline’s most prominent leaders, this book fills an educational gap for many nursing students and nurses regarding nursing, nursing leadership, nursing history, and nursing’s impact on society.

This book will be of interest to readers around the world, including anyone who has an interest in the leadership and history of nursing, medical/health-related professions, women’s studies, or an actual or potential interest in the nursing profession. This book will be of great benefit to undergraduate nursing students enrolled in leadership courses and to graduate nursing students (in both master’s and doctoral degree programs) who are preparing for leadership roles in nursing practice, advanced practice nursing, nursing administration, and nursing education and research. Finally, this book will benefit any nurse who is currently in a leadership position and wishes to increase her or his leadership capacity by learning more about the practices of exemplary nursing leadership, and how nurses might participate in leading the nursing profession and society into the future.

Although many of the fascinating life stories of the nurse leaders included in this volume were lived out long ago and far away, they are just as relevant today as when they occurred. These nurses’ stories tell of the evolution of nursing and society over the centuries and around the world. Their stories will facilitate an exploration of the very nature of leadership. Using the five practices of
exemplary leadership described by Kouzes and Posner (2012) as a framework, the contributing authors examine these nurse leaders’ behaviors in the following categories: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart.

The criteria used to select the nurse leaders for inclusion in this book were quite simple. Nurse leaders were chosen who have had a significant and enduring impact on the nursing profession, health, health care, and society. These nurses were selected because they exemplified courage, bravery, fearlessness, open-mindedness, and innovation. No judgments were made in placing one nurse leader’s story before or after another. The nurse leader biographies appear according to the exemplary leadership practice the contributing authors thought they best illustrated:

- **Modeling the Way**—Florence Nightingale (British; 1820–1910), considered to be the founder of “modern nursing.”
- **Inspiring a Shared Vision**—Mother Mary Aikenhead (Irish; 1787–1858), arguably the first visiting nurse in the world; and Clara Barton (American; 1821–1912), humanitarian and founder of the American Red Cross.
- **Challenging the Process**—Margaret Higgins Sanger (American; 1879–1966), who was a birth control activist and sex educator, opened the first birth control clinic in the United States, and established Planned Parenthood; Elizabeth Kenny (Australian; 1880–1952), who challenged conventional wisdom and promoted a controversial new treatment approach for poliomyelitis; and Clara Louise Maass (American; 1876–1901), who sacrificed her life in the fight against yellow fever.
- **Enabling Others to Act**—Dorothea Lynde Dix (American; 1802–1887), widely known as a pioneer crusader for the mentally ill; Lillian D. Wald (American; 1867–1940), who founded the Henry Street Settlement, which evolved into the Visiting Nurse Service of New York; and Mary Breckinridge (American; 1881–1965), who established the Frontier Nursing Service (FNS) to provide health care in the Appalachian Mountains of eastern Kentucky.
- **Encouraging the Heart**—Edith Louisa Cavell (British; 1865–1915), a World War I nurse heroine who faced a firing squad.

This book is intended to be an educational, entertaining series of biographies of some of nursing’s most important leaders as activist agents of change. It offers a comprehensive, interesting, and readable text, written with the purpose of educating and inspiring its readers to lead nursing, health, health care, and society into a better future.

*David Anthony (Tony) Forrester*

**REFERENCE**

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Nursing’s Greatest Leaders
TWO

Florence Nightingale: Where Most Work Is Wanted

Frances Ward

No sufficient medical preparations have been made for the proper care of the wounded. Not only are there no dressers and nurses—that might be a defect of system for which no one is to blame—but what will be said when it is known that there is not even linen to make bandages for the wounded? The greatest commiseration prevails for the unhappy inmates of Scutari, and every family is giving sheets and old garments to supply their want. But, why could not this clearly foreseen event have been supplied? (Royle, 1999, p. 247)

Thomas Chenery, a graduate of England’s Eton College and a diplomatic correspondent for London’s The Times, reported events of the Crimean War from his post in Istanbul. Often, he reported from the front lines. On October 12, 1854, he shocked Victorian England with his scathing criticism of the abysmal medical services provided to wounded soldiers at the British military hospital at Scutari, located on the edge of Constantinople. One of the first embedded reporters writing during wartime, he awoke the conscience of the British people. He also fueled national humiliation with his comparisons between the exceptionally poor care given to British heroes and the well-planned and executed care given to French soldiers, stating that “here the French are greatly our superiors.” Purposefully accentuating his point, Chenery lauded the French Sisters of Charity, who “accompanied the [French] expedition in incredible numbers. These devoted women are excellent nurses” (Royle, 1999, p. 247).

The Times’ readers responded, among them Florence Nightingale (1820–1910). A wealthy, educated, deeply rebellious individual frustrated by the Victorian ethos that shaped social customs and mores constraining contributions to society by women, Nightingale played on her countrymen’s indignation surrounding events at Scutari hospital. Capitalizing on her father’s relationship with Sidney Herbert, the British secretary of war, she requested that Elizabeth Herbert, his wife, influence her husband to support her proposal and to offer introductions for her party to the appropriate authorities at Constantinople. Using whatever means necessary to advance her goals, Nightingale was keenly aware that men held power and that power was the sine qua non for change and social reform.

Concurrently, and independent of Nightingale’s approach of Elizabeth Herbert, the secretary of war requested that Nightingale head an official party of nurses to Scutari as a government entourage. Recognizing this as an opportunity to model the way and lead change, Nightingale galvanized 38 women volunteer nurses she had trained, along with 15 Catholic nuns, and sailed to the maelstrom within the Ottoman Empire (Dossey, 1999). While at the military hospital for only a relatively short period—approximately 2 years—as the official superintendent of nurses charged to craft solutions to the debacle that was Scutari, Nightingale was credited with reducing the
obscenely high death rate to a much lower figure. Once at Scutari, Nightingale became a national heroine in her early 30s.

Nightingale’s launch to celebrity status was propelled by the British public’s acclaim for the outcomes of her work at Scutari: decreased death rate, stabilization of the nursing staff, environmental improvements by the Sanitary Commission, and increased order and discipline at the hospital, irrespective of the medical staff’s disdainful dismissiveness for the changes she instituted. Her administrative craftsmanship evolved from a complex web of values and behaviors antithetical to women in Victorian England. Significantly, Nightingale occasionally referred to herself as a male. As she noted in an imaginary conversation with her mother in 1851–1852, “I shall go out and look for work. . . . You must look upon me as your son. . . . You must consider me married or a son” (Woodham-Smith, 1983, p. 66).

Enraged at her culture’s dismissal of women as vehicles for reproduction and pleasure, Nightingale achieved great social reform, designed hospitals, created medical recording systems, developed statistical approaches for public health management (in wartime as in peacetime), and designed a standardized nursing curriculum eventually used in training schools internationally. Defying categories of gender, Nightingale’s public leadership was founded on her desire for a meaningful life, one lived in opposition to the oppressive social code of 19th-century England. In a private note dated March 1852, she wrote:

Why, oh my God, can I not be satisfied with the life that satisfies so many people? I am told that the conversation of all these clever men ought to be enough for me. Why am I so starving, desperate and diseased on it. . . . My God, what am I to do?

That same year, she wrote: “In my thirty first year I see nothing desirable but death” (Baly, 1991, p. 15). Denying death, yet aware of its presence, that which she did constitutes a leadership narrative of nursing’s dark angel.

RADICALIZATION

Florence Nightingale’s father, William Edward Shore, acquired great wealth from a relative, Peter Nightingale, on his mother’s side of the family, after which he changed his last name to Nightingale (Gill, 2004). Early in life, becoming quite learned by the teachings of her father, Florence was rankled by the purposeless lives expected for women. She had early exposure to influential thinkers and leaders of her era, including politicians, government officers, and educators. One such influence was Adolphe Quetelet, the Belgian statistician, mathematician, and astronomer who applied statistical methods in the social sciences (Diamond & Stone, 1981). Contrary to the upbringing
of her older sister, Florence’s education, through her father and the influence of those who frequented their home at Embley Park, radicalized her as a woman, providing her skills atypical of ladies of her time. A complex spiritual being, Nightingale was a religious eclectic, influenced primarily by her family’s Unitarian views as well as the tenets of the Church of England (Widerquist, 1992). Driven, Nightingale assumed the role of friendly visitor to neighbors requiring assistance (Whelan, 2001; Williamson, 1911, 1914/1999). Rescuing a baby owl, she named her Athena; the pet remained at her side until war broke out in the Crimea (Dossey, 1999). Nightingale’s Christian spirituality framed her behaviors toward those in need, shaping her singular focus on improving the care provided to others, including both direct care (nursing care) and indirect care (design of hospital structure, organizational models, medical documentation, and statistical reporting).

Tension between mother and daughter over marriage and work was intense for many years, particularly after Florence announced that God had called her in early 1837 to a life of service to others. She was 16 years old. Believing that service to God meant service to humanity, Nightingale searched for meaningful options. She wrote a friend, Christian von Bunsen, asking “What can an individual do, towards lifting the load of suffering from the helpless and the miserable?” (Calabria, 1997, p. 2). Bunsen advised Nightingale to visit the institution of the deaconesses in Kaiserswerth, Germany, to witness how care was given to ill patients. Forbidden by her mother to become a nurse, Nightingale turned to ill relatives to exercise her calling to care for people. In her early 20s, despondency overwhelmed Nightingale as she became desperately anxious to engage in a meaningful life of service. At a crisis point, she beseeched God to end her life:

Lord thou knowest the creature which thou has made. Thou knowest that I cannot live—forgive me, God & let me die—this day let me die. It is not for myself that I say this. Thou knowest that I am more afraid to die than to live . . . but I know that by living I shall only heap anxieties on other hearts, which will increase with time. (Calabria, 1997, p. 3)

Determined to live, Nightingale survived this crisis of spirit. Choosing the road less traveled by women in the early 19th century, Nightingale waited until 1844, when she was 24 years old, to announce her intent to become a nurse. Commonly considered as work generally undertaken by drunkards, prostitutes, or criminals in workhouse infirmaries for the indigent, nursing in Great Britain was embodied in Sairey Gamp, the infamous nurse-midwife character imagined by Charles Dickens in *Martin Chuzzlewit* (Dickens, 1844). Rapid growth of cities in the burgeoning modern era driven by exponential industrialization and capitalism, however, demanded a change from the unregulated friendly visiting to systematized care in hospitals. Such care demanded obedient, trained attendants.
Forever proud of his unusual, misfit daughter, William Nightingale supported her from her early childhood, eventually accepting her choice of nursing as a career. William shaped his daughter’s values for social reform through his own political career and views drawn from the Liberal wing of the Whig party. Although defeated in 1834 as the Whig candidate for a Parliament seat representing Andover in Hampshire, William Nightingale supported the 1832 Reform Act, legislation aimed at eliminating corruption in the electoral system in England (Gill, 2004). Growing up, Nightingale was immersed in British politics, conversing in her Embley Park drawing room with políticos over social reform. Her activities, successes, and national reputation as a social reformer both during and after her Crimean War efforts were highly correlated with her ability to speak directly with, and thus influence, her network of Parliament friends. Binding these influences to her alliances with popular press journalists, Nightingale succeeded in introducing social reform in England and India. As a woman, she could not hold a seat in Parliament, much to her frustration and chagrin. Nightingale thus labored harder and more painstakingly to use influence to model the way and lead change—a very exhausting process, fraught with political intrigue and lacking in objectivity. Through such processes, Nightingale focused objectively on her goals of social reform, first for British army and military health reform, and then for similar goals in India. When the Liberal wing of the Whig party lost power in Britain in the late 19th century, Nightingale retreated to her home, her bedroom, and continued political influence, albeit in a more indirect manner.

William Nightingale provided Florence with an annual annuity of 500 pounds in 1853, a sum that enabled her to move away from home, travel, and pursue her goals in rooms of her own (Dossey, 1999). Rejecting male suitors and marriage proposals, Nightingale had taken a vow of chastity at age 30, thus freeing herself from the constraints of Victorian life and liberating herself to pursue her goal to become a nurse. Husbandless, educated, and equipped with a generous annual annuity, Nightingale would undertake her own grand tour of Europe, exploring Greece, Germany, and Egypt, conducting medical and hospital tourism while documenting as much as possible about the structure, administration, functions, and personnel in these facilities. In Thebes, she claimed to have conversed with God, responding to his call for her to do good on his behalf, without public knowledge of her efforts (Nightingale, 1849–1850/1987).

When in Germany, Nightingale visited Kaiserswerth, where Theodor Fliedner, a Lutheran minister, had established a hospital and the Lutheran Deaconess Institute for the training of women in theology and nursing. Employing ideas borrowed from the Mennonites, Fliedner planned for young women to learn to care for the sick at the Institute. Nightingale joined the Institute as a student in July 1851; in October 1851, she finished her course of study (Dossey, 1999). Impressed by the steadfast devotion of the deaconesses, Nightingale’s German experiences framed her later work both in direct nursing care as well as in administration. In 1850, on return from her first
visit to the Institute and prior to her subsequent 4-month nursing training, Nightingale wrote a 32-page informational pamphlet at the request of Theodor Fliedner. Recognizing that the written word is a powerful tool for persuasion, Nightingale used the pamphlet—*The Institution of Kaiserswerth on the Rhine, for the Practical Training of Deaconesses under the Direction of Rev. Pastor Fliedner, Embracing the Support and Care of a Hospital, Infant and Industrial Schools, and a Female Penitentiary*—as a vehicle to dismiss a popular myth that nursing was a Catholic institution, one loyal to Rome (Nightingale, 1851). Nightingale reviewed the importance of deaconesses, or nurses, in all divisions of Christianity, existing free from vows prior to the existence of the Sisters of Mercy in the mid-17th century (O’Brien, 2010). By extension, Nightingale reasoned that women could have a professional nursing career in a nonreligious institution. Although Nightingale held a spiritual view that nurses served as handmaids of the Lord, she deeply appreciated the practical necessity of separating nursing from religion in England. If viewed as a by-product of Catholic monasticism, nursing in Protestant England would simply not thrive. Written anonymously, this pamphlet served as a vehicle for clarification of thought and realization of the power of publication. Florence keenly sensed this period as a pivotal point, as her life and her career became one.

Nightingale’s training at Kaiserswerth was more than, and quite different from, nursing care of sick patients. She induced best care practices from individual cases, documenting all the while. She also deduced patterns of effective administration, noting central administration methods driven down to hospital units. Voluminous reports on efficient hospital administration, staff motivation and delegation, controls for extraneous factors, and replicable quality care outcomes were compiled; descriptions of the nursing superintendent, a central control officer, were detailed in Nightingale’s reports. She was learning to turn personal observations onto the page, refine them, and offer them publically to her peers.

**MODELING THE WAY IN PRACTICE**

A Kaiserswerth graduate deaconess, Nightingale struggled with self-definition on her return to England. In a 3-volume, 829-page work entitled *Suggestions for Thought to the Searchers after Religious Truth* (1860), Nightingale undertook a self-exploration on true spiritual experience and the emancipation of women from the dull tyranny of mindless drawing rooms (Poovey, 1993). In her essay *Cassandra*, Nightingale passionately decries the imprisonment of women’s minds within trivial pursuits, stating that women needed meaningful employment or vocations, similar to men. “Why have women passion, intellect, moral activity—these three—and a place in society where no one of the three can be exercised?” (O’Malley, 1934, pp. 109–110).

In 1853, Nightingale assumed the role of superintendent of the Institution for the Care of Sick Gentlewomen in Distressed Circumstances in Upper
Harley Street, London. In response to her call from God, she was now free to execute her ideas for compassionate nursing care as well as efficient hospital administration. Equipped with powerful writing abilities, she was free to explore, implement, and publicize her ideas on health care administration and nursing care so carefully culled from her experiences in medical tourism trips throughout Europe, Greece, and Egypt. Respecting only her male role models throughout her life and maintaining what would become her lifelong disdain for women (whom she viewed as not as capable as men), Nightingale executed a plan, her plan, the only plan worthy of implementation.

Connections continued to provide opportunity. In the economically stressed years of the 1830s–1840s, there developed an oversupply of governesses. In the 1851 British census, governesses were known as “excess women,” with work conditions reflective of a near-slave lifestyle (Neff, 1929/2006). The Institution for the Care of Sick Gentlewomen in Distressed Circumstances managed large numbers of these severely debilitated, chronically ill governesses, an emotionally and physically complex group. As was common in this era of industrialization, urbanization, and poverty, women’s groups—usually wives of affluent families—managed care facilities for the poor. Social reform organizations, such as the National Association for the Promotion of Social Science and the International Congress for Charities, Correction, and Philanthropy, boosted women members and focused on solutions for public health, the penal system, and educational problems. At Nightingale’s request prior to her coming on board as superintendent, a committee of ladies managed the institution that relocated to No. 1 Upper Harley Street, London.

Consistent with other hospitals of the era, the Institution was very modest, housing only 27 beds in a three-floor building. Nightingale’s friend Elizabeth Herbert, the wife of Sidney Herbert, English statesman and the secretary of war from 1845 to 1846, 1852 to 1855, and 1859, had recommended Nightingale for the position of superintendent. In her April 29, 1853, acceptance letter to Lady Canning of the women’s committee, Nightingale requested that the committee consider the terms under which “volunteer Nursing Sisters shall be received into the institution, should any such offer themselves” (Dossey, 1999, p. 87). Three months and 2 weeks later—August 12, 1853—she began her career as nursing superintendent. Florence was 33 years old.

By the end of her first day as superintendent, Nightingale knew that she was no longer in Embley Park. With the building still undergoing renovation and chaos being the order of the day, Nightingale wrote to her friend Mary Clarke explaining her decision to leave her Embley Park home to live at Upper Harley Street, despite her mother’s and sister’s objections:

Clarkey dear, I will give you a plain answer. I have talked matters over (“made a clean breast,” as you express it) with Parthe [Nightingale’s sister], not once but thousands of times.
Years and years have been spent in doing so. It has been, therefore, with the deepest consideration and with the fullest advice that I have taken the step of leaving home, and it is a fait accompli. (Cook, 1914, pp. 138–139)

Chapter one of Nightingale’s freedom from home, her emancipation, had begun.

With incomplete renovations, an operating budget in the red, incompetent staff, and poor environmental conditions, Nightingale developed administrative knowledge from her own meager experiences in nursing, as well as from her past friendly visiting of ill neighbors and her experiences abroad. She reorganized patient spaces, insisted on sanitary room and patient conditions, developed nurse teams consisting of one or two probationary pupils to one nurse, fired drunken or unhygienic nurses and house staff, wrote job descriptions and daily work assignments, and maintained a clean kitchen with nutritious food and drink (Goldie, 1987). Air-filled, bright, quiet, and peaceful spaces conducive to mind and body recovery were mandatory in what was rapidly becoming Nightingale’s Institution.

A superb businesswoman, Nightingale brought change through political prowess. Her technique was self-effacement: Let the Institution’s governing committee and medical staff believe that the best ideas for change were theirs. Caring more for the success of her vision than for personal attribution, she worked tirelessly, earning respect from the staff. In a letter to her father, Nightingale wryly noted:

I perceive that I do all my business by intrigue. I propose in private to A, B, or C the resolution I think A, B, or C most capable of carrying in Com’tee & then leave it to them—& I always win. . . . The opinions of others concerning you depends not at all, or very little, upon what you are but upon what they are. Praise and blame are alike—indifferent to me as constituting an indication of what myself is, tho’ very precious as the indication of the other’s feeling. . . . My popularity is too great to last. (Dossey, 1999, p. 93)

Becoming accustomed to winning, she barreled through religious bias and swept the facility clean of prejudice when confronted by the committee of ladies who refused to admit Catholic patients. Risking dismissal, Nightingale scandalously claimed, “I might take in Jews and their Rabbis to attend them” (Cook, 1914, pp. 134–135). Her ploy was successful; all religious denominations were now allowed into the institution. Ever alert to the parodic power of language, she recalled this tense situation to her friend Mary Clark: “Amen. From Committee, Charity, and Schism—from the Church of England and all other deadly sins—from philanthropy and all the deceits of the Devil, Good Lord, deliver us” (Cook, 1914, p. 135).
Criticized in her early years as being incapable of successfully managing staff, Nightingale matured as a human resource manager with progressive experience (Goldie, 1987). In 1872, in an address to nurses and probationers at St. Thomas Hospital, Nightingale advised these novice students that the person in charge every one must see to be just and candid, looking at both sides, not moved by entreaties or, by likes and dislikes, but only by justice; and always reasonable, remembering and not forgetting the wants of those of whom she is in change. . . . In a Ward, too, where there is no order there can be no “authority”; there must be noise and dispute. (Nightingale, 1914, pp. 13–15)

On August 7, 1854, Nightingale completed her first year as the Institution’s nursing superintendent. She had not established a training school for nurses, but she summarized in her final quarterly report that “as to good order, good nursing, moral influence and economy, the result has been to me most satisfactory” (Dossey, 1999, p. 95).

In 1854, as Nightingale prepared to leave the Institution, a cholera outbreak occurred in London. Nightingale assumed the nursing superintendent position of cholera patients at Middlesex Hospital in London. There she worked with John Snow, a physician who provided detailed street maps of cholera deaths in 1854. His cholera street cartography pointed to one common source of contamination—the handle of the Broad Street water pump (Hempel, 2007). Nightingale’s working relationship with Snow taught her epidemiologic tools that were objective in their power to change health indices of whole populations. She retained this experience and used this new technique of medical disease mapping in future military health challenges during wartime.

MODELING THE WAY IN WAR

By March of 1854, Great Britain had entered the Crimean War. By November, eight Anglican Order sisters accompanied Nightingale to Scutari, including Sarah Anne Terrot. Sarah, a Sellonite sister of the Anglican Order, had cared for patients in a Plymouth cholera epidemic. She was thus considered a valuable, seasoned nurse. Five Catholic nuns were also in Nightingale’s nursing party; however, as they had only cared for orphan children in London, they were considered less useful in the care of complex cholera patients. A journal writer, Sarah documented her Scutari experiences, living in the Barrick Hospital alongside Nightingale (Richardson, 1977, p. 85):

These wards were in a miserable state; there was something more sad and depressing than any other part of the Hospital. The patients were mostly poor fellows whose constitutions had
early broken down under hardship; many had never reached the Crimea. Very few had seen the Battlefield; and they seemed to feel they were dying without glory. . . . Deaths were more frequent here than elsewhere; it seemed, indeed, as if our daily lives were spent in the valley of the shadow of death.

Sarah reported to Nightingale, a fact that pleased her, since she did not wish to report to a Catholic nun. Nightingale, a focused charge nurse, instructed Sarah and the other nurses to thoroughly clean their rooms, sew sacks of straw together to serve as beds for wounded soldiers, keep a healthy kitchen, and generally maintain a sanitary, uncluttered environment for healing. The filth was overwhelming; most of Nightingale’s party invariably fasted rather than become ill from poor, rotten food. Sarah was impressed by Nightingale, stating that while she looked tired, her appearance and manner “impressed me with a sense of goodness and wisdom, of high mental powers highly cultivated and devoted to highest ends” (Richardson, 1977, p. 66).

Nightingale was indeed fatigued, but perhaps as much from political maneuvering as from sickness. The physicians at Scutari did not want, nor had they sought, the services of Nightingale and her party. Despite clashes with medical authorities, Nightingale doggedly aligned with rank-and-file physicians, assisting them with their patients as needed. She also assumed firm control and command of her nursing party. As their advocate, Nightingale jockeyed resources to obtain materials for wound dressings, water basins, clean clothing, and food and fluids for soldiers—and for her nurses. Some nurses vehemently rankled at Nightingale’s spartan discipline, lamenting their original decision to join the party. Nightingale ordered nurses to enter wards only on the request of the medical officer of the day. As wounded soldiers increasingly poured into Scutari hospitals, Nightingale realized that deference to physicians—as a strategy to gain access to patients—would inevitably be successful. Nightingale weathered her nurses’ dislike of this policy in order to secure the physicians’ full capitulation to the obvious need for nurses. She encouraged surgeons to use chloroform as a surgical anesthetic, quite contrary to the orders of Dr. John Hall, inspector-general of hospitals, who preferred no anesthesia: “The smart of a knife is a powerful stimulant, and it is much better to hear a man bawl lustily than to see him sink into the grave” (House of Commons, 1854–1855, p. 56).

As the wounded grew exponentially, Nightingale documented relentlessly. She recorded individual patients’ wound status and care, death rates, types of diseases and symptoms managed, availability of supplies and lack of specific supplies, contaminated food and water, and organizational management. She was an early proponent of data-based decision making. Trends in data unveiled patterns, which, as evidence, could sway even the most recalcitrant of physicians or politicians. To effect large-scale change in military care practices, well-documented patterns of data must be thrust onto the
public stage, especially to the government. Given her experiences with documentation and Snow’s epidemiologic methods of mapping cases, Nightingale appreciated the large public health issues at play at Scutari, equal to her understanding of practical daily details of patient management. Sanitation, to Nightingale, was an obvious solution to the morbidity and mortality experienced at Scutari. Facilitating health by preventing contact with hazardous waste, human and otherwise, was the cornerstone of Nightingale’s action plan at Scutari. By November 14, 1854, Nightingale wrote to her friend Dr. William Bowman at the Institution at Upper Harley Street:

I hope in a few days we shall establish a little cleanliness.
But we have not a basin nor a towel nor a bit of soap nor a broom—I have ordered 300 scrubbing brushes. . . . But one half of the Barrack is so sadly out of repair that it is impossible to use a drop of water on the stone floors, which are all laid upon rotten wood, and would give our men fever in no time. (McDonald, 2010, pp. 63–64)

Nightingale dismissed the popular notion of contagion—the belief that disease is passed from one person to another by touch. Sanitation and hygiene were Nightingale’s essential pillars of public health. She and her nurses meticulously swept, scrubbed, laundered clothes, made bandages from clean cloth, and managed safe food supplies, as there was, as Snow had argued, no such thing as miasma. Understanding point of contact from Snow, Nightingale championed sanitation, particularly environmental control. As she wrote in Notes on Nursing: What It Is, and What It Is Not, Nightingale claimed that the “very first cannon of nursing . . . [is] to keep the air he [the patient] breathes as pure as the external air, without chilling him” (Nightingale, 1860/1969, p. 12).

Nightingale supervised sanitary measures at Scutari as well as the renovations of patient units for maximum light and airflow. Concurrently, she struggled to create a new order of military nurses, women professional in demeanor and skilled in caregiving to those entrusted to them—a radically different orientation from those who cared for ill, impoverished patients in English almshouse infirmaries. Through her efforts in Scutari’s military hospitals, Nightingale relentlessly, painstakingly staked out a nursing work culture. In peacetime, her task would have been difficult; in wartime, the spirit of patriotism fueled well-intentioned volunteers. She demanded women who could nurse well—ability, not birth, was her critical criterion. A competent nursing staff was equally essential to a sanitary environment; the former was responsible to ensure the latter.

Unrelenting, Nightingale concurrently nursed patients and administered the entire hospital enterprise. Nightingale’s efforts were widely published; she was a ministering angel, the heroine of Scutari. In 1855, Queen Victoria sent Nightingale a brooch designed by Prince Albert as a sign of her
appreciation. Depicting a St. George cross, the letters “VR,” and the royal cipher, the brooch was inscribed with the following on the back: “To Miss Florence Nightingale, as a mark of esteem and gratitude for her devotion toward the Queen’s brave soldiers—from Victoria R, 1855” (Gill, 2004, p. 401). The brooch became known as the Nightingale Jewel.

So popular was Nightingale that Henry Wadsworth Longfellow’s 1857 poem “Santa Filomena,” published in the Atlantic Monthly, referenced the Lady with the Lamp:

Lo! in that hour of misery
A lady with a lamp I see
Pass through the glimmering gloom,
And flit from room to room. (Longfellow, 1857, pp. 22–23)

In the winter of 1855, a confluence of factors catapulted Nightingale to fame in Britain. Already gifted by Queen Victoria and beloved as the “Lady with the Lamp,” a phrase first coined in London’s The Times to symbolize her practice of moving through rows of patients at the Scutari hospital at night with her lamp swaying at her side, she became known for exposing the government’s sluggish response to the inhumane care provided soldiers at the front line. In January 1855, the army numbered 11,000 soldiers; the sick and injured numbered 23,000. Determined to bring order to the hospital system, Nightingale devised a basic triage system for incoming wounded soldiers, demanding that they be thoroughly washed and wounds cleaned and dressed, with each soldier receiving fresh, new bandages. She set up a laundry system, contrary to the common practices on the wards—with resultant resentment from intransigent medical officers. She ordered food to be allocated according to patients’ needs, with the sickest receiving broths and extra fluids (Gill, 2004). “Nothing which the Times’ has said has been exaggerated of Hardship,” Nightingale wrote in her notes (Goldie, 1987, p. 130).

Maneuvering and influencing her political allies behind the scenes, she demanded a government response. Because of family connections, it was to come from the very highest level. Lord Palmerston, who retained a parliamentary seat largely due to the influence of Nightingale’s father and other family members, became prime minister in 1855. Noted as a shrewd manager of public opinion through skillful use of the press, Lord Palmerston’s first effort was to regain order in the Crimea—and accolades from his public.

First, Lord Palmerston constituted a royal Sanitary Commission, comprising two physicians and an engineer. The charge to this Commission, consistent with the nation’s growing embrace of sanitation and hygiene, was to immediately improve hospital conditions and thus save lives otherwise at high risk resulting from impure air and preventable sanitary problems. Nightingale applauded the work of the Sanitary Commission, whose flushing of water pipes, unclogging of sewer drains, improved airflow and ventilation in roofs, removal of debris, disinfection of walls, and other improvements cleared the
detritus symbolic of death in Scutari (Dossey, 1999). Mortality had begun to decline after Nightingale initiated her sanitary, dietary, and laundry measures; after the efforts of the Sanitary Commission, mortality continued to decline exponentially following aggressive sanitary public health action.

In 1855, Lord Palmerston also created the royal Commissariat Commission, a two-man team led by Sir John McNeill, a surgeon, and Colonel Alexander Tulloch, an army officer trained in law and internal affairs. Both men were passionate about sanitation and public health reform, with Tulloch an advocate of data collection of the health status of soldiers. The Commissariat report emulated Nightingale’s reports regarding problems with food, supplies, and hospital and other equipment (Dossey, 1999). Because Lord Palmerston authorized the two commissions with power to act, changes occurred quickly. Deliveries of fresh food began; processes for purchasing and storing of foods were established. For Nightingale, her many letters to her political friend Sidney Herbert and to the press had finally borne fruit—death from poor sanitation and poor hygiene was decreasing. The men in these two royal commissions and Nightingale remained colleagues for years, long after the commissions completed their work and the men involved suffered blocked professional advancement in their fields from jealous colleagues. Her association with these commissioners renewed Nightingale’s zeal and passion; she became increasingly determined to heal soldiers, and to do so well.

This same year Nightingale saw an opportunity in war to train a new breed of physicians who would elevate the role to a higher level as a result of improved knowledge to be gained from postmortem examinations and dissections, new therapeutics, and the collection of data and use of statistics. Nightingale saw opportunity for important secondary gains culled from war—new surgical techniques and increasingly intricate knowledge of human anatomy to be learned from the detritus of war. Nightingale appreciated that the morbidity and mortality associated with war offered opportunities to advance anesthetics and surgical techniques. Additionally, regular collection of data illustrated by statistics could provide evidence to document the need for change. Planning to use her own money to renovate a building in Scutari, Nightingale decided in 1855 to begin a medical school, given the large patient population and supply of corpses for dissection (Cook, 1914).

Easily able to separate emotion from objectivity, Nightingale was quick to appreciate secondary gains to be accrued from war.

Irrespective of these dramatic improvements, a cholera outbreak subsequently ravaged the hospital, its patients, physicians, and nursing staff. Nightingale fell ill with Crimean fever in May 1855 and only rallied after several months of rest. Encouraged to recuperate at home in Embley Park, Nightingale refused, preferring instead to stay in the Crimea with the soldiers. After several months, Nightingale returned to the bedside, to supervision of care, and documentation of the debacle symbolized by Scutari. She inundated government officials with information from the front, appreciating fully that public sentiment was on her side. Her adoring public lavished
Nightingale with gifts following her illness, as her political colleagues and confidantes in London schemed to create a more permanent testament of their devotion. In November 1855, high-ranking public officials met to create a voluntary national fund, to be called the Nightingale Fund, to support nurses’ training in England (Gill, 2004). The resolution drafted by the organizing committee paid tribute to Nightingale’s contributions to her country, for which the Fund would serve as a symbol of the public’s appreciation:

1. The noble exertions of Miss Nightingale in the hospitals of the East demand the grateful recognition of the British people.
2. That, while it is known that Miss Nightingale would decline any such recognition merely personal to herself, it is understood that she will accept it in a form that may enable her, on her return to England, to establish a permanent institution for the training, sustenance and protection of nurses to arrange for their proper instruction and employment . . . in hospitals. (Baly, 1986, pp. 8–9)

With flyers announcing it widely distributed throughout England, pledges for the Nightingale Fund poured in. At once, thousands of pounds sterling were received. Prior to the end of the Crimean War, a core endowment was now available to transform Nightingale’s dream of a training school for nurses into reality. Sultan Abdulmecid of Turkey also contributed to the Nightingale Fund in 1855, in addition to presenting her with a diamond and carnelian bracelet in appreciation of her services in Turkey (Dossey, 1999).

Believing that her poor health and fragility might hinder her personal oversight and administration of the Fund, Nightingale requested that it be entrusted to several of her male colleagues to make executive decisions on its appropriate use. By June 1856, there was approximately £44,000 in the Fund. Nightingale, financially savvy in banking and business, developed a deed of trust for the Fund for the investment of the contributions. Not willing to spend the money without careful planning, she allowed the funds to accumulate, and only in 1860 was a portion of the funds used to establish a training program for nurses (McDonald, 2009a). The Training School for Nurses at St. Thomas’ Hospital enrolled its first students on July 9, 1860, thus inspiring a shared vision for change and solidifying Nightingale’s sanitary public health reform values as standard for the education of nurses in England, and eventually in the United States (McDonald, 2009a).

MODELING THE WAY IN PEACE

Russian Czar Nicholas I died in March 1855. His death laid the foundation for peace. On March 30, 1856, the Crimean war ended with the signing of the Treaty of Paris. With the war over, Nightingale stayed until all soldiers
in Scutari either died or went home. Almost 4 months later, Nightingale returned to England, entering her family’s summer residence at Lea Hurst through the back door.

Considering her war mission a failure, given that no significant changes had been incorporated in the British Army’s Medical Department, Nightingale retreated. Awash with war memories of dead and dying soldiers neglected by the highest authorities in the Army, Nightingale once again saw nothing desirable but death. She wrote in her journal in 1857:

Father, I do not in the least care whether I die or live. I would wish to know which it is to be, that I may know what Thou wouldest have of me. I do not support that there will be any less work for us in any future state of existence (for us, the salt of the earth, at least, not till after many future states). Thou wilt send us where most work is wanted to be done. Lord, here I am, send me. Perhaps when I was sent into this world, it was for this, Crimea and all. (Vicinus & Nergaard, 1990, p. 395)

Another opportunity to lead presented itself in 1857 following an invitation by Queen Victoria and Prince Albert to meet them at Balmoral Castle in Scotland to hear what she had learned from her participation in the Crimean War. Nightingale rallied and gathered her support team—including the lead individuals from the Sanitary Commission and the Commissariat Commission, men she valued as essential to the changes instituted in Scutari during the war. Nightingale used her charisma, wit, public acclaim, and religious piety to embed her reform tenets into conversations with the queen and prince. She acted quickly, calmly, and decisively, to persuade the queen to constitute two royal commissions. She positioned her informal cabinet of male allies to support her efforts, with herself acting as core strategist and planner. Before the first commission was constituted, Nightingale was asked for a full report on the Crimean War. Energized by the possibility of making meaningful, permanent changes in the Army’s medical system, Nightingale worked tirelessly to produce an 830-page preliminary document—Notes on Matters Affecting the Health, Efficiency, and Hospital Administration of the British Army: Founded Chiefly on the Experience of the Late War—that framed the commission’s final report. Nightingale’s writing—robust with data, statistics, and succinct analyses on the conditions of soldiers and facilities at Scutari—persuaded Lord Panmure, secretary of state for war, to appoint the first commission. Nightingale picked the commissioners and delved into the status of the army in peacetime. Statistically skilled, Nightingale prepared data in pictorial form to impress her audience quickly and without question. Her coxcombs—rose diagrams similar to pie charts or John Snow’s earlier dot maps—illustrated death tolls from diseases to be more than the death toll from wounds in the Crimean War (Brasseur, 2005). Trusting only in objective
presentation based on data, Nightingale produced her finest work, documenting that the peacetime mortality of soldiers in the army was almost double that of civilians. Friended by physician and medical statistician William Farr, Nightingale learned of data on death and disease in England, information that framed her comparisons of peacetime versus wartime morbidity and mortality statistics.

Nightingale’s trusted ally, Sidney Herbert, chaired the royal commission, placing his signature on the final report to lend the male credibility that she thought necessary. Nightingale was the invisible scribe to the report that included proposals for army reform and medical reform, including a uniform system of medical statistics incorporating mortality (rates and causes of death), frequency and types of disease, and types of surgical operations. Nightingale considered statistical data critical to the evaluation of military hospitals’ sanitation effectiveness as well as medical–surgical outcomes. Other recommendations, consistent with Nightingale’s earlier suggestions, included aggressive sanitation protocols in army barracks, restructuring of the army medical department for efficiency, and establishment of an army medical school. The army medical school, located initially in Chatham, had an especially contentious beginning. The Lancet, a prestigious British medical journal founded in 1823, published letters unfavorable to the new medical school in 1858. Nightingale quickly galvanized her resources to avert negative opinions about the new school; on March 14, 1858, she wrote to Dr. William Farr, her physician colleague and medical statistician following the publication of negative letters appearing in The Lancet:

There are three letters in The Lancet yesterday against our Army Medical School. They are easily answered, but Mr. Herbert has also received remonstrances from Lord Naas and Lefroy, MP for Dublin. And we want to have the Lancet on our side. Would you ask the editor not to commit himself till he has heard our side of the question? You will find Sutherland here tomorrow at 6 o’clock and we will draw up a statement, which we depend upon you to father upon The Lancet and make them give a leading article in our favour. (McDonald, 2011, p. 368)

Ultimately, the new school flourished, changing location in 1863 and eventually becoming part of a joint medical school in Millbank, London, with a hospital constructed according to Nightingale’s own design specifications.

Once the Commission report was completed, Nightingale made sure the report’s recommendations hit the popular press—the British people, her court of public opinion. Accustomed to winning, Nightingale claimed that she would “eat straight through England” to achieve her goal of reforming the British army (Vicinus & Nergaard, 1990, p. 172). The people responded as she anticipated, with a public outcry that overwhelmed the War Office.
Instigating the War Office to change, Nightingale ceaselessly worked in the background to illuminate army medical problems and to propose solutions. Shortly thereafter, the British army medical department was restructured, an army medical school was established, an army statistical department was developed, and military barracks and hospital buildings were redesigned, according to sanitary reforms. Always one to “bite on a fact,” Nightingale found statistics “more enlivening than a novel” (Boyd, 1982, p. 209). Nightingale’s statistical prowess was rewarded by the Royal Statistical Society—one of the oldest statistical societies in the world—in 1858, when she was elected as the first woman member of the Society (McDonald, 1998).

THE END OF EMPIRE

As Nightingale, Sidney Herbert, and the royal commission on army and military medical reform revolutionized the British Army and military health system using their report as ammunition, India, a key British colony, mutinied. Hundreds were massacred in the bloody 1857 Great Mutiny—the Sepoy Rebellion—in India, the flash point that heralded an end to British paternalism and the beginning of Indian patriotism. The end of the British Raj was within view on the horizon, with the oppressed hungry for control, participation in government, and increasing independence. Although Britain regained control after the Great Mutiny, it had lost credibility and entered a new era of watchfulness. In August 1858, Britain passed the Government of India Act, adding a new member to the British cabinet, the secretary of state for India, who received advice and guidance on internal Indian affairs from the Council of India, with headquarters in Calcutta (Dossey, 1999).

Lord Stanley served as Britain’s first secretary of state for India, a man who had dined with Nightingale a year earlier at an introductory meeting arranged by Nightingale’s former suitor. Lord Stanley, a contributor to the Nightingale Fund in 1855, deeply understood the need for reform in India; he was also keenly knowledgeable of the many and complex barriers to reform in that British colony. Nightingale, well versed in army and military health issues in India, soon began lobbying Lord Stanley for sanitary reforms in India. Specifically, Nightingale demanded the constitution of the India Sanitary Commission; the goal was sanitation of the army and civilian populations (Dossey, 1999; Gill, 2004).

The royal Sanitation Commission of India was constituted in 1859 with three sanitarians, a statistician, and two members of the India Council. Lord Stanley transferred this Commission to the War Office, given its recent changes aimed at improving overall performance as well as health status of troops. Forever an advocate for timely reform, Nightingale did what she did best, prior to the Commission’s establishment. She collected data. Without firsthand knowledge of the health of British soldiers in India or the sanitary state of military bases and the country as a whole, however, Nightingale
was incapable of knowing what problems existed in India, and therefore, she was unable to design strategies for improvements. She abhorred stories, narratives of individuals aimed at evoking sympathy. Such stories made her impatient and only fueled her demands for objective data. Having designed a “circular of inquiry”—a questionnaire—to be sent to all military posts in India, Nightingale began to gather baseline data. Data, she knew, was needed to sway opinions of powerful politicians—her target group. She tabulated enough completed questionnaires to fill a room in her house. Additionally, she received copies of regulations regarding sanitation and administration from several hundred military posts throughout the country. Working collaboratively with her colleague, Dr. William Farr, the medical statistician on the Commission, Nightingale completed a commission report that also included an addendum—“Observations by Miss Nightingale.” The final report, a two-volume treatise with over 2,000 pages, was published in 1863 (Dossey, 1999).

The report from the Royal India Sanitation Commission report findings paralleled those of the Royal Sanitation Commission (of the British army in England), only with shockingly worse findings. This report documented that the overwhelming majority of British troops in India died from causes associated with poor sanitation. Nightingale publicized the reality that death among British military troops in India was due to preventable illnesses, at an astonishing cost to the Crown. As in the Crimea, morbidity and mortality were correlated with polluted environments. She announced to all who would listen that the three things that decimated the British army in the Crimea were “ignorance, incapacity, and useless rules” (Gill, 2004, p. 420). Her persistence, as well as her influence among powerful political connections, was rewarded. The India Sanitation Commission made broad recommendations for reform, including demanding that British-controlled provinces constitute individual military sanitary commissions. In addition, the previously constituted sanitary commission was expanded to include Indian representatives as full voting members.

Once completed, the report of the Royal India Sanitary Commission was hijacked by a low-level bureaucrat in England, who eliminated all of Nightingale’s statistical analyses and other observations—the majority of data required to substantiate the recommendations advocated—and replaced her material with his own executive summary, or “Précis of Evidence” (Dossey, 1999). Nightingale’s observations included in the original report were bound in red cloth, becoming referred to as her “little red book.” She became enraged at this bureaucratic sabotage. She took immediate action, informing members of Parliament to secure the full report at the appropriate office. Additionally, she offered to use her own financial resources to ensure that the full report would wind its way to her ultimate target audience—the Indian Civil Service. Ultimately, the full report was distributed in 1863, with pressure coming from readers again enraged by articles published in London’s
The Times stressing the need for sanitary reform in India. As she had done so often in the past, Nightingale challenged the status quo, and using her influence among both politicians and the public, Nightingale unabashedly deployed all of her available resources to meet her goals. When the secretary of state for war died in April 1863, Nightingale lobbied a journalist for the Daily News to “agitate, agitate” for a replacement sympathetic to sanitary reform (Cook, 1914, p. 30). The journalist complied; Nightingale’s choice was ultimately named as successor.

For nearly four decades, Nightingale pushed for multiple reform efforts in India, despite the fact that she never visited the country. Her first initiatives in India evolved logically from her successful sanitary reform efforts in the British army. Sanitation was a thread for Nightingale that was woven through all of her Indian efforts. It was her core concept, extending from public health efforts, to engineering work, and to the individual patient cared for by a nurse at the bedside. Her efforts to improve farm irrigation, to curb poverty and famine by introducing land policy, and to extend formal education to women were all accomplished through finding facts, data analysis, and conversations with eminent politicians, members of the royal family, and ordinary people. Once she had the data, she framed the key problems and conceptualized solutions that she documented meticulously—and then distributed to people with powerful influence primarily in politics and the press. While not all of her reforms were instituted, Nightingale remained immersed in Indian sanitary reform for decades; it became, in fact, a lifelong effort (Gourlay, 2003).

Nightingale’s efforts in India demonstrate her ability to lead—first, her focus on values that drove her guiding principles, enabling her to model the way for a social reform era within an age of empire. This singular emphasis galvanized her colleagues, parliamentary men in positions of authority, to align with her goals. Nightingale’s exemplary ability to reject status quo in favor of doing the right thing facilitated dramatic challenges to processes contrary to her values. She captivated both leaders and the public with her passion and behaviors to further her causes, empowering them to act rather than to be passive spectators. While tenacious in efforts to meet her goals, Nightingale’s demeanor, charisma, and drive for excellence softened and warmed the hearts of the British public, endearing them to her work (Kouzes & Posner, 2011). Nightingale led without fanfare, following a road less traveled for women in Victorian England.

Beyond Great Britain and India, Nightingale’s technocratic advice—specifically, definition of the urgent problem, preparation of solutions based on data, and efficient implementation—for the management of military hospital design and services extended to the United States and other countries. In fact, at the beginning of the American Civil War, the Union Army used Nightingale’s war materials while the Confederate Army reissued her book on field cooking (McDonald, 2001). Two decades later, Nightingale wrote
that the Egyptian–Sudan campaign, or the Anglo–Egyptian war of 1882, was a great opportunity to pilot test new ways of implementing nursing services to demonstrate the outcomes of a well-prepared nursing unit on morbidity and mortality among soldiers (McDonald, 2001).

Although shy, almost a recluse in her daily life, Nightingale was never reticent to provide advice regarding military hospital management. Her idealistic admiration for the courage of soldiers, combined with her confidence that sanitary improvements would decrease their morbidity and mortality both in war and in peacetime, framed Nightingale’s view that it was her responsibility to inform others—individuals, armies, and nations—of her plan for military health management. Nightingale’s sanitation data was undeniable.

AN IMPROVING WOMAN

Between her early idea of instituting a training school for nurses at the Institution for the Care of Sick Gentlewomen in Distressed Circumstances in 1854 and the completion of commission reports in 1858 and 1863, Nightingale had reinvented herself. No longer a woman searching for work meaningful to herself and her God, Nightingale had transformed herself into a highly visible, politically influential social reformer targeting sanitary change, both for wartime as well as peacetime efforts. The darling of Queen Victoria, Nightingale moved offstage as the winds of political change shifted from social reform to a political and social climate of conservatism.

In a changed political environment, Nightingale focused attention on nursing, which she equated with sanitary knowledge. In her immediate post-Scutari life, Nightingale wrote Notes on Nursing (Nightingale, 1860/1969). In her preface, Nightingale is stunningly clear that the knowledge of nursing is a knowledge that every woman needed:

Every woman . . . has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid,—in other words, every woman is a nurse. 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 will have no disease, or that it can recover from disease, takes a higher place. . . . If, then, every woman must at some time or another of her life, become a nurse . . . how valuable . . . if every woman should think how to nurse. (Nightingale, 1860/1969, p. 3)

Nightingale used the word nurse for “want of a better [word]” (Nightingale, 1860/1969, p. 8). She advocated for a new vision of nursing, one that looked beyond dependently following physicians’ orders for patients’ medications and treatments. A strikingly independent woman reformist,
Nightingale structured nursing care as an essential tool for the sanitary management of patients. She stressed that nursing “ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet” (Nightingale, 1860/1969, p. 8). Nurses, to Nightingale, were primarily sanitarians, with interventions emanating from the knowledge of sound sanitary practices extending from the individual to the general public. Nurses, physicians, sanitary engineers, and hospital designers and architects—all were necessary public health equipment. Nursing care complemented medical care, with all care dependent on good sanitary practices consistent with Nightingale’s—and those of the Liberal wing of the Whig Party—social reform ideals. Nurses needed good, disciplined training to serve well as one component of the sanitary team improving the morbidity and mortality statistics of Britain—and of India.

With renewed interest, Nightingale turned again to the Nightingale Fund begun with much public fanfare, adoration, and acclaim in late 1855. At the time instituted, the Fund was nothing more than a mere distraction, a metaphoric gift from well-wishers unable—possibly unwilling?—to appreciate her true reform goals. In July 1860, the Nightingale School of Nursing opened its doors at St. Thomas Hospital in London. She handpicked her students—Nightingale nurses—who were trained in a 1-year program. Ultimately, graduates of the Nightingale School of Nursing, all unmarried and thus untethered to fulfilling the needs of husbands and children, became missionaries. Graduates were dispatched to serve in hospitals in England, Europe, and elsewhere in order to proselytize the knowledge of efficient sanitary principles of good nursing across much of the world. Nightingale was exceptionally clear that graduates of her school had not been trained merely to meet the workforce needs of St. Thomas Hospital. Eight years after the school was established, Queen Victoria presided over groundbreaking ceremonies for the construction of a new St. Thomas Hospital, in view of the Houses of Parliament (Dossey, 1999; Nelson & Rafferty, 2010).

For the fledgling school, 1872 was a pivotal year. Nightingale learned from probationers that classes were poorly delivered, if delivered at all. When a chief administrator at the school objected to her strong discipline and high ideals, Nightingale secured a new administrator, one willing to provide probationers’ instruction according to her demands (Dossey, 1999).

Nightingale nurses were to be exemplary emissaries valuing discipline, moral character, and sanitary principles; to be less so meant dismissal from the school. In her May 1872 graduation address at the school of nursing, Nightingale appealed to the graduates to remain fresh, to avoid stagnation:

What we can do depends so much upon what we are. To be a good nurse one must be a good woman; or one is nothing but a tinkling bell. To be a good woman at all, one must be an improving woman; for stagnant waters sooner or later, and
stagnant air as we know ourselves, always grow corrupt and unfit for use. Is any one of us a stagnant woman? Let it not have to be said by any one of us: I left this Home a worse woman than I came into it. (Nightingale, 1914, p. 5)

Nightingale School of Nursing, founded on her goal to improve morbidity and mortality through sanitary reform interventions, was a purposeful, self-conscious initiative to forcibly create standardized nursing training to diffuse sanitary health reform both nationally and internationally. In creating a school of nursing grounded in her guiding principles and values, Nightingale modeled the way for the profession of nursing for decades into the future. The sheer strength of her values influenced women to become pupil nurses—probationers—who shared Nightingale’s vision of sanitation and social reform. Her sustained drive for excellence in sanitary, gentle nursing care provided in safe and clean environments captivated both the minds and the hearts of enrollees, empowering them to bravely nurse their patients. Her demand for self-discipline and accountability among nurses provided the foundation for strong, capable women to transform the public image of the Sairey Gamp midwife to that of a modern-era professional. Whether reviewing Nightingale’s sanitary reforms, nursing school establishment, or hospital redesign, one common theme emerges—her strength of leadership.

Nightingale’s somewhat strident confidence in her belief that the hospital environment was simply a mirror image of the society sponsoring it, coupled with her indefatigable energy and sustained attention placed on poor outcomes associated with hospitals, stimulated hospital reform. Nightingale again turned her attention to writing to promote her views on both hospital design and nursing care.

In 1863, Nightingale’s Notes on Hospitals was published, deeply influencing hospital design and construction for decades into the 20th century (Rosenberg, 1989). Her Notes were basic instructions to hospital architects to improve sanitary conditions in hospitals by conforming to the various principles of construction she outlined in her book. Statistics served as her primary tool of persuasion. Turning to the mortality rates of three groups of hospitals—24 London hospitals, 12 provincial town hospitals, and 25 county hospitals—in the year 1861, Nightingale noted that the death rate was highest in London hospitals and lowest in county hospitals. “Here we have at once,” Nightingale wrote, “a hospital problem demanding a solution” (Rosenberg, 1989, p. 4). Based on her experience, Nightingale stated, “a great deal of the suffering, and some at least of the mortality, in these establishments is avoidable” (McDonald, 2012, p. 50). Nightingale identified several ideals for construction essential to the health of hospitals. These ideals were elementary, including fresh air, light, ample space, and subdivision of the sick into separate buildings or pavilions. Subsumed in these principles are the additional realities of assuring effective sewage drainage and
water flow, washable floors for disinfection, efficient kitchens and laundries, acceptable furniture for both patients and nurses, and appropriate accommodations for nurses residing at hospitals (Rosenberg, 1989). If hospitals were to be constructed to also support medical schools, then Nightingale advocated quite adamantly for her design—a design that would allow medical students to monitor patients recovering from sickness.

Several core concepts are intermeshed in Nightingale’s *Notes on Nursing* (Nightingale, 1860/1969) and *Notes on Hospitals* (1863/1989), all operating under the umbrella theme of reform—social, public health, and management reform. Sanitation, central in Nightingale’s efforts, underscored much of the nursing care services described in *Notes on Nursing* (Nightingale, 1860/1969), the first such effort to outline the essentials of nursing. In her construction of a nursing school program, organizational lines of authority and delegation were as central to predicting a quality school as the teaching materials. Viewing all people as equals in God’s eyes, Nightingale advocated for improved conditions in workhouse infirmaries. Nightingale led efforts in nursing education and social reform that laid the groundwork for both public welfare reform and national health care reform in Great Britain. As Virginia Dunbar wrote in her foreword to the 1969 edition of *Notes on Nursing*, Nightingale lamented in 1860 that “bad sanitary, bad architectural, and the bad administrative arrangements [in hospitals] often make it impossible to nurse” (Nightingale, 1969, p. xiii).

Nightingale’s prescient insistence on placing a trained woman nursing superintendent—called matron—in charge of nursing pupils and the training program itself revolutionized nursing services by centralizing the control of nursing to nurses (McDonald, 2013). The nursing superintendent position was thus upgraded, with defined authority and accountability. Power was diffused among men—physicians and hospital administrators—and women—nursing superintendents. Instead of serving as domestic servants, nurses now assumed status as operators of a separate field. Although battles between the genders ensued, nurses now were empowered to battle. Nightingale was firmly of the opinion that nursing was a service that opened doors of opportunity for women rather than serving as a vocation, as noted in her 1866 correspondence to her statistician-physician colleague, William Farr:

I would rather than establish a religious order open a career highly paid. My principle has always been that we should give the best training we could to any women of any class, of any sect, paid or unpaid who had the requisite qualifications moral, intellectual and physical for the vocation of Nurse. Unquestionably the educated will be more likely to rise to the post of Superintendent, but not because they are ladies but because they are educated. (Baly, 1991, p. 75)
The nursing school program was one of “every day sanitary knowledge,” as Nightingale wrote in her preface to Notes on Nursing (Nightingale, 1860/1969). Her Notes on Hospitals (1863/1989) and Notes on Nursing followed a common theme—sanitary reform, one from the perspective of hospital design and the second from that of direct patient care. These two volumes had different target audiences with themes remaining consistent. Her nursing care descriptions focused on ventilation and warming, health of houses, noise, diet, bed and bedding, light, cleanliness of houses and hospitals, personal cleanliness, observation of the sick, and documentation of the patient’s status and care. Discipline, predictable care routines, and pride in one’s work were prerequisites of being a Nightingale pupil nurse.

As these values began to permeate training schools of nursing in Great Britain, Nightingale turned her attention to the status of workhouse infirmaries, facilities established as a social welfare effort through the Poor Law Amendment of 1834. (Englander, 1998). Workhouse infirmaries had troubled Nightingale for many years. Therefore, when sought for advice on how to improve conditions in the Liverpool Workhouse Infirmary, Nightingale leaped at the opportunity. Twelve of Nightingale’s graduates—“Nightingale nurses”—began working in the Liverpool Workhouse Infirmary in May 1865, shifting the workforce from Dickensonian Sairey Gamps to disciplined nurses well versed in the Nightingale curriculum (Dossey, 1999). The Liverpool Infirmary stands as a symbol of Nightingale’s activism in public welfare reform. More interested in large-scale policy change than simply local, facility-based change, the success of reforms in the Liverpool Infirmary energized Nightingale to more aggressive activism, culminating in her “ABCs” for legislative amendments to the Poor Law. Nightingale’s 1866 “ABCs” called for reforms in the infirmary system to include separation of the sick from the well pauper population, establishment of a single central administration, and placement of the entire system under responsible administration reporting to Parliament (McDonald, 2004). The “ABCs,” although not fully implemented because of shifting political agendas, succeeded in informing subsequent legislation, particularly the Metropolitan Poor Act of 1867. Nightingale’s efforts in social reform were part of an unrelenting, remorseless agenda that steamrolled through Britain, positioning the United Kingdom to embrace a national health care system years later.

As industrialization and subsequent urbanization accelerated in the latter half of the 19th century, the burgeoning hospital enterprise fundamentally changed Britain’s basic ontology of health. With the hospitalization of the country, the locus of care now shifted from home to hospital while the focus gradually morphed from prevention and return to wellness to management of illness. Likewise, friendly visiting also changed, as might be predicted in cities where ladies’ committees, often eager to participate in social reform movements and to demonstrate their talents at organization, sought tangible projects for engagement. Some ladies’ groups supported programs
for home nursing for the poor by providing basic care by untrained women (McDonald, 2009b). As this program of home care enterprise took hold, spreading in multiple neighborhoods in England, Nightingale noticed and was unnerved. Untrained individuals providing care in the homes of fragile, at-risk poor was a daunting development for Nightingale. Even as she orchestrated the training of nurses in hospitals consistent with the tenets of sanitary knowledge, Nightingale’s basic assumption was that such trained nurses would deliver care to ill people in their homes. For her, hospitals existed for acute care management only.

Nightingale, once again, took action in the 1870s. With her mantra—only trained nurses can safely provide effective sanitary care—driving her actions, Nightingale turned her attention to district nursing. Collecting data on district nursing, Nightingale revealed that the majority of district nursing programs did not employ trained nurses. Outraged, she approached the Metropolitan and National Association for Providing Trained Nurses for the Sick and Poor, an organization established by her male colleagues William Rathbone, Henry Carter, and others, in 1875 to ensure at least basic care for poor residents (Baly, 1986; Dossey, 1999). Employing her oft-used strategy of influencing those in official power with undeniable data, Nightingale’s report of existing district nursing programs stimulated the establishment of a central home for district nurses by the Metropolitan and National Association. Pupil nurses lived in the nurses’ quarters of hospital training schools, which provided them structure and discipline under the authority of the nursing superintendent. Nightingale demanded similar arrangements for district nurses. Passionate that training was needed to meet the requirements of patients’ needs, Nightingale bundled aspects of training specifically relevant to home care for nurse probationers in district training programs. District nursing programs in Britain, similar to private duty registries in the United States, evolved for the delivery of parceled nursing services through organized visiting nursing associations. Here was an emphasis on home, care, and wellness. As medicine advanced and hospitals flourished, this emphasis waned in Britain, as nurses assumed increasingly dependent roles to physicians and as hospitals began to be symbolic of health care. Nightingale’s ontology of sanitation and public health conflicted with the public’s idolization of technical advances, physicians, and specialization in health care. Regardless, nurses’ training programs became standardized and accepted as a salaried career path for women, despite Nightingale’s disdain for the unexpected twist in the road—the unpalatable shift in focus from caring for patients to caring for physicians.

As Nightingale turned 73, British and American nurse leaders planned to participate in the International Congress of Charities, Correction, and Philanthropy held in Chicago in June 1893, during the Chicago World’s Fair. Nightingale served as advisor to those who orchestrated the first Nurses’ Congress. During this historic World’s Fair, American nurse leaders formed
the American Society of Superintendents of Training Schools for Nurses, endorsing standard nurse training programs in hospitals (Ward, 2009). As hospital training schools flourished, unpaid pupil nurses became an indispensable intact workforce, a phenomenon contrary to Nightingale’s personal ethos. She advocated for meaningful, paid work for women, not for work under conditions akin to slavery. In June 1867, Nightingale had written a friend “The ultimate destination of all nursing is the nursing of the sick in their own homes. I look to the abolition of all hospitals and workhouse infirmaries. But it is no use to talk about the year 2000” (Dossey, 1999, p. 298).

DEMYSTIFICATION

In 1907, 3 years before her death at age 90, Florence Nightingale was awarded the Order of Merit from King Edward VII, son of Queen Victoria. Nightingale was the first woman to receive this accolade, one that acknowledges those who have demonstrated exemplary service in the armed forces, distinguished themselves in science, or who promote art. At age 35, Nightingale’s image as leader beloved to the British people was solidified through her work in the Crimea; at 90, she was a national icon. A complex confluence of factors shaped Nightingale’s ability to lead. These factors are worthy of explication and demystification.

Although Jeffry A. Frieden (2006) is correct in noting that mercantilism was in decline by the time of the Napoleonic Wars, it is also true that the influence of the colonial mentality of command and control continued to exist as Victoria took the throne in 1838 and Nightingale arrived in Scutari. The managerial frame of reference that accompanied forced foreign trade was intractable, and advocates of reform would continue to face substantial opposition until the manufacturers of the early 19th century won the day by eliminating barriers to trade. A predecessor to our own global environment, the new manufacturing economy required another type of leader. Nightingale was part of that new brand of leaders.

To see the significance of her leadership in our own time, it is useful to reflect on the principles of leadership identified by Kouzes and Posner in 2011. Nightingale’s behavior, as described in this chapter, emulates the principles of modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart as explicated by Kouzes and Posner. In 2013, Paul J. H. Schoemaker, Steve Krupp, and Samantha Howland identified abilities similar to those outlined by Kouzes and Posner that are needed in unpredictable environments such as the one in which Nightingale lived. Because uncertainty builds leaders, skills are needed in anticipation of opportunity, interpretation of complexity, extended inquiry, alignment toward common ground, acceptance of challenge, and commitment to decisive action. Even across a great distance, it is not too difficult to see Nightingale as our contemporary.
The simple fact of Nightingale’s birth within an affluent British family was critically important to her development of leadership characteristics. Expected to become a pampered, tinkling bell of a wife to a well-chosen suitor, Nightingale pricked. Given that work was not demanded of her during her early life, and that she was exposed to influential figures conducting business with her father in their drawing room, Nightingale had time to study and be mentored by politicians, statisticians, policy experts, and others concerned with issues of social justice. Whirling within this salon of influential people, wealth, and education, Nightingale concretized the five attributes essential to leading as identified by Kouzes and Posner. She did not want a life of boredom. Provided an annuity by her indulgent father as a young woman, she was freed from the common financial constraints of daily life, allowing her absorption in topics that interested her: hospitals, nursing, theology, and literature. Disdainful of the paths that Victorian women chose, Nightingale emulated behaviors of men that she thought worthy and productive in the social reform political culture within which she was embedded. Had she been born a man, she may have groomed herself to serve as Britain’s prime minister in the late 19th century. As she increasingly gained perspective on her intense desire to have a useful purpose in life, Nightingale became confident of herself, achieving the hubris that was reserved for men. In essence, she learned to anticipate threats to her progressive vision and strategically target opportunities to promote reform.

To synthesize the information she gathered, she learned to interpret complex streams of information. An elegant writer, she realized that style, tone, and content must vary for both the audience and the goals to be achieved. With a clear understanding of the religious values framing her actions, Nightingale honed her skills in writing—particularly writing for persuasion—as well as in interpersonal communication, artful manipulation of men in positions of influence, and goal-directed focus. To conduct extended inquiry, Nightingale wrote. She shared her opinions in bellettistic language, inciting the British populace to outrage at crimes against soldiers, the poor, the sick, workhouse inhabitants, and anyone powerless in need of assistance. Faithful to her vow to do good for its own sake without the benefit of advancing her own reputation, she often allowed attribution to male colleagues in order to advance reform. A master at aligning her vision with the common ground of reformers in power and the British people, she knew how to target her reports and she was fearless in launching them. Nightingale exemplifies the practices of leadership as described by Kouzes and Posner. She always did her homework, identifying political support as trump cards to institute the changes she petitioned. In 21st-century terms, Nightingale conducted internal and external environmental scans prior to pushing her political agenda to colleagues in Parliament. Passionate on the page, she was never cited for lack of information to support her causes. Analyzing her visual rhetoric in the rose diagrams, Lee Brasseur (2005) praised Nightingale’s understanding
of making complex data clear to potentially resistant audiences. Along with Charles Joseph Minnard, who designed a visual of mortality in the Napoleonic Russian Campaign, Nightingale is cited as a leader in what is often termed the “Golden Age of Data Graphics” (Friendly, 2008, p. 509).

Born during the age of empire, Nightingale welcomed challenges on a grand scale. Given her predilection for sanitation, public health, and social reform, Nightingale framed all actions within that empirical mantra. Highly focused and very disciplined, when she realized that a problem existed, she employed her skills in statistics to determine the root cause. Subjective stories and emotional responses were rejected as useless; objective data derived scientifically was embraced. She deliberately moved as far away as possible from the stereotypical feminine attributes and behaviors of her time. Given that she functioned as a highly acclaimed social reform activist within the constraints existent in Victorian culture, Nightingale led remarkable change through her skills at exerting influence among those in power and through her prolific writing. She was economical in her friendships—all friends must have utility to further her causes. Ultimately, Nightingale became neutral toward her father, seeing him as lacking in tenacity as he refused to continue in politics once he lost an election. For Florence, commitment trumped empathy.

Nightingale never lost focus on sanitation, public health, and social reform. A decisive leader committed to action, her thoughts never scattered. From friendly visiting of ill friends and family members to the design of military hospitals, Nightingale walked a narrow path, becoming highly versed in all nuances of sanitary problems and associated morbidity and mortality. She was an expert in her field of sanitary knowledge, which she equated with nursing knowledge. Nurses, physicians, engineers, and others were all tools for sanitary improvement. She drove change in this field by meticulously collecting relevant data, analyzing data to identify patterns and trends, and subsequently disseminating her findings to individuals with the authority and power to make policy and to amend law. Her very passion also framed a certain intolerance of mediocre or poor performance. Far more decisive than the benign lady with the lamp, Nightingale was more likely to dismiss inept individuals than attempt to remediate them. Impatient and solitary, she sought guidance from divinity and her male colleagues. She kept one or two popular female press reporters in her inner circle, but only for specific purposes. Securing and retaining influential connections was critical to Nightingale. She believed in herself, in her own plans. She possessed confidence in her cause and her knowledge, never going off track to follow the causes of others. In fact, although she believed that women should have the right to vote, she believed more in advocating for women’s utility and productivity. If a feminist at all, then she can best be labeled a reluctant one.

With keenly anticipatory vision for opportunity, superior interpretative communication ability, passionate inquiry through empirical methods, alignment toward common ground, unabashed willingness to accept grand
challenges, and remorselessly decisive action, Nightingale led. The dark angel of nursing, she proclaimed in 1856 that she would eat straight through England to achieve her goals. She did just that.

**TIMELINE**

- May 12, 1820—Florence Nightingale is born Grand Duchy of Tuscany at Villa La Columbaia in Florence, Italy, to a wealthy British family; the family moves to Lea Hurst estate in Derbyshire, England; Florence has one older sister, Parthenope.
- February 7, 1837—First experiences a “Christian calling” to become a nurse while living at Embley Park in Wellow, Hampshire, England.
- 1844—Begins to visit hospitals.
- December 1844—Becomes the leading advocate for improved medical care in the infirmaries through the reform of the “Poor Laws.”
- 1845—Declares her intention to become a nurse; she visits the convent of the Saint Vincent de Paul sisters, where she learns nursing theory.
- 1850–1855—Keeps a pet owl, Athena, as her constant companion, now mounted and on display in the Nightingale Museum.
- 1850—Makes her first visit to Protestant Deaconess at Kaiserwerth, where care was provided for the poor and which later became a training school for nurses and teachers.
- 1851—Spends 3 months training as a sick nurse at Kaiserwerth.
- August 22, 1853—Accepts the post of superintendent at the Institute for the Care of Sick Gentlewomen in Upper Harley Street, London.
- October 21, 1854—Sent to the Ottoman Empire.
- November 4, 1854—Arrives in Turkey with 38 nurses and is stationed at Selimiye Barracks in Scutari (Istanbul) to nurse British soldiers fighting the Crimean War.
- 1855—Nurses British soldiers through outbreaks of cholera and typhus.
- November 25 or 29, 1855—A public meeting to give recognition for her work during the war leads to the establishment of the Nightingale Fund for training nurses.
- August 7, 1856—After every patient has returned to Britain, she follows, meets with Queen Victoria at Balmoral and tells her about the defects in military hospitals and the need for nursing reforms; Nightingale plays a central role in the establishment of the Royal Commission on the Health of the Army.
- August 1857—After collapsing, Nightingale is sent to Malvern, a health care resort, where she is put on bed rest for exhaustion.
- 1858—In her report, *Notes on Matters Affecting the Health of the British Army*, Nightingale creates statistical charts to show the number of men who died from the conditions in the hospitals compared to those who died from battle wounds.
• 1859—Publishes her 136-page introduction to nursing, titled *Notes on Nursing: What It Is and What It Is Not.*
• 1860—Nightingale’s attention turns to the morbidity and mortality rates of the British troops and citizens in India; she gathers statistics and recommends sanitation reforms; is elected the first female member of the Royal Statistical Society and becomes an honorary member of the American Statistical Association.
• August 7, 1860—Nightingale Fund is used to establish the Nightingale Training School at St. Thomas Hospital, London.
• May 16, 1865—The first Nightingale nurses begin working in the Liverpool Workhouse Infirmary.
• 1869—Dr. Elizabeth Blackwell and Nightingale open the Women’s Medical College.
• 1883—Awarded the Royal Red Cross by Queen Victoria.
• 1892—With the assistance of the County Council Technical Instruction Committee, Nightingale organizes a health crusade in Buckinghamshire.
• 1896—Nightingale becomes bedridden but continues working on hospital plans.
• 1907—First woman to be awarded the Order of Merit from King Edward VII.
• August 13, 1910—Nightingale dies peacefully in her sleep (aged 90), 10 South Street, Mayfair, London; she is buried in the graveyard at St. Margaret Church in East Wellow, Hampshire, England.
• 1975–1992—Apart from Queen Elizabeth II, Nightingale becomes the only woman to be featured on a Bank of England note (at the beginning of this chapter); her portrait appears on the back of £10 Series D notes accompanied by a scene showing her tending wounded soldiers in Scutari; first issued in 1975, it ceased to be legal tender in 1994.
• 1989—Nightingale Museum is established on the site of the first Nightingale Training School at St. Thomas Hospital, London; remodeled and reopened in 2010.

QUESTIONS FOR DISCUSSION
1. Florence Nightingale, a wealthy and educated woman frustrated by the cultural ethos that constrained women’s contributions to society in Victorian England, was awarded the Order of Merit from King Edward VII in 1907, 3 years before her death. She was the first woman to receive this prestigious award, generally reserved for distinguished service in the armed forces, science, or art. A reluctant feminist, if one at all, Nightingale led in an era marked by the oppression of women. What were Nightingale’s attributes and behaviors that propelled her to successful leadership in *modeling the way* within this Victorian context?
2. Florence Nightingale promoted improved sanitation, public health, and social reform in Victorian England using statistics as the major driving
tool for change. Nightingale was elected to the Royal Statistical Society in 1858, the first woman ever elected to membership in this prestigious academy. An early evidence-based researcher, Nightingale’s work led to reform within Britain’s medical military services, the establishment of an army medical school and an army statistical department, and redesign of hospitals. Can you comment on Nightingale’s statistical strategies, her data-collection and data-dissemination techniques, and her political acumen to ensure sustained incorporation of sanitary reform in her nation’s health care system?

3. Leaders galvanize resources to effect change; Florence Nightingale did so in Victorian England, an era marked by the rejection of women in leadership roles. Nightingale deeply appreciated that power was the sine qua non for initiating change and social reform—she also knew that men held power. What resources did Nightingale employ in modeling the way to lead change? Consider Nightingale’s use of family influence, family wealth, use of public press—particularly popular newspapers—and male politicians sympathetic to her social causes as you explore her use of resources to create change in this era of the British Empire.

4. Florence Nightingale has been referred to as the “mother of modern nursing,” having established a school of nursing at St. Thomas Hospital in London in 1860 that incorporated principles of sanitary reform. For Nightingale, nurses were essential “public health equipment,” members of a disciplined sanitary team improving the morbidity and mortality statistics of Great Britain and India. Explore the contrasting themes of Nightingale’s career—the Lady with the Lamp during the Crimean War versus the Dark Angel of England who said she would “eat straight through England” to achieve her goal of reforming the British army. For Nightingale, the grand challenge was remorseless public reform. Was sanitary nursing care a tool for, or a stimulus for, such reform?

REFERENCES


2 FLORENCE NIGHTINGALE: WHERE MOST WORK IS WANTED


FURTHER READING


54   II  MODELING THE WAY


You must never so much as think whether you like it or not, whether it is bearable or not; you must never think of anything except the need, and how to meet it.

—Clara Barton
Clara Barton (1821–1912) was born in North Oxford, Massachusetts, on Christmas Day in 1821. She was the youngest of the five children born to Stephen and Sarah Barton. The family had deep roots in New England. Her father was descended from Samuel Barton, who came to the Massachusetts colony in 1640. Her grandfather fought in the American Revolution, while her father fought under General Anthony Wayne during the War of 1812.

Clara’s siblings were responsible for much of her early education. By the age of 5, her brother David had taught her to ride a horse, and in a short time, her equestrian skills surpassed those of many men. When Clara was 11, David suffered a serious accident that left him an invalid for the next 2 years. During this time, Clara was responsible for providing the majority of his care, which included both basic comfort measures and the application of leeches. This experience may have helped to prepare Clara for the roles she would play later in her life.

The Barton family belonged to the Universalist Church and faithfully attended Sunday services. The Universalist Church was a sect that had split from the strict Puritan doctrine of human depravity, and instead, embraced the tenet of salvation for all, not just Christians. This belief system might have contributed to Barton’s later willingness to extend her humanitarian efforts to all persons afflicted by disaster rather than only to those considered to be “deserving” (C. Barton, 1907; Jones, 2013).

As Clara grew older, she became increasingly shy and sensitive. She was short in stature, prone to obesity, and plagued by insomnia. The persistence of these traits caused her parents anxiety about a future course of action for their “difficult” daughter. They consulted L. N. Fowler, a lecturer visiting their town who specialized in phrenology, a forerunner of modern psychology. Following his assessment, Fowler predicted, “The sensitive nature will always remain. She will never assert herself for herself. She will suffer wrong first, but for others she will be perfectly fearless. She has all the qualities of a teacher” (C. Barton, 1907, pp. 112–115). Years later, Clara often repeated this story, stating she believed Fowler’s words were prophetic.

At the age of 15, Barton began a course in education at a New Jersey seminary for women, passed a teacher qualification examination with a high score, and began a career in teaching that continued for the next 15 years. Barton taught in a variety of private schools in Massachusetts and New Jersey, and then settled in Bordentown, New Jersey. There she founded a free public school, one of the first in New Jersey. In 1 year, the school grew in size from 6 to 600 students. This growth required the town’s citizens to secure a new school building at the cost of $4,000. Unfortunately, when the school was enlarged, Barton was replaced as principal by someone less qualified, a male teacher who had been born and educated abroad. Although Barton was well liked by her students, she was firm and held high standards for them. She corresponded with some of her former students for many years (Bacon-Foster, 1918).
In search of employment, Barton traveled to Washington, DC, to ask her Congressman and distant cousin, Alexander DeWitt, for help in her pursuit of a position as a governess. Instead, he recommended her to the commissioner of patents for a position as a government patent clerk (Pryor, 1987, pp. 60–61). In her appointment as one of the first female patent clerks, Clara Barton reputedly suffered much harassment from her male colleagues in the form of negative remarks, showers of spittle, and attempts to trip her as she approached her work space. At times, her managers required her to work at home in a small and dimly lit room in a boarding house to avoid the disruptions her presence in the workplace engendered. Barton’s perfect handwriting and hours spent copying legal documents by hand, however, led to a promotion and increase in salary after only 1 year (Jones, 2013). According to a close friend and daughter of Clara Barton’s immediate superior, the chief clerk of the patent office praised Barton as “the best clerk we have ever had in this office” (Bacon-Foster, 1918, p. 284).

In 1856, when James Buchanan, who was sympathetic toward the continuance of slavery, was elected president, Clara Barton, who had been vocal in her opposition to slavery, lost her patronage position. She returned to Massachusetts and resumed her study of French and art with the hope of securing another teaching position. While in her home state, she resumed correspondence with some of her former students, writing to one that she hoped to secure a teaching position in the South, preferably in Mobile, Alabama (Bacon-Foster, 1918). In view of her strong abolitionist views and later work, this seems to be an unusual choice; however, it is indicative of her quest for new and challenging experiences. In 1860, when the newly formed Republican party came to power, Clara Barton was recalled to Washington and reappointed to her prior position, forsaking a suitor of many years who had recently proposed marriage. Enthralled by the promise of change that followed the election of President Lincoln, Barton gave her full support to the antislavery movement. The years that she worked in Washington seemed to give Clara the strength she would need for her future endeavors. During those years, she developed skills in organizational management, became confident in her abilities, and developed a sense of political activism.

Clara Barton was in Washington, DC, in April 1861, and witnessed the beginning of the Civil War, and foresaw the suffering the war would entail. Later that month, the Massachusetts Sixth Regiment, while en route to Washington, was attacked by rebels while marching through Baltimore. As the wounded volunteers streamed into Washington, Barton left her desk and rushed to their aid. Among the wounded, she recognized many as her former neighbors, classmates, and students. This early experience led her to bond with the ill and wounded soldiers she cared for throughout the war, often referring to them as “my boys” (Oates, 1994, p. 17).

At the beginning of the war, little thought had been given to the casualties of the war, the ill and wounded soldiers who would require medical
and nursing care, as well as food, hospitals, and medical supplies to aid in their recovery. Dorothea Dix (see Chapter 8), who before the war had gained renown for her efforts to reform asylums and improve the care of persons with mental illness, was appointed superintendent of nurses for the Union Army. In this capacity, she was responsible for the recruitment of suitable women to serve as nurses for the Union Army and the coordination of the activities of these “nurses.” At the time of the Civil War, no schools for the education of nurses had yet been established in the United States. Volunteers recruited by Dix had only a rudimentary knowledge of nursing care, gleaned primarily from personal experiences caring for sick family members. In addition, the U.S. Sanitary Commission, established by the government but supported by donations from citizens of the Northern states, raised money, gathered food and supplies, and mobilized resources to aid the sick and wounded soldiers. It took some time, however, before these efforts were sufficiently organized and functional to yield any demonstrable outcomes.

EARLY EFFORTS TO INSPIRE A SHARED VISION

Some women volunteers for the war effort eschewed the efforts of Dix and the U.S. Sanitary Commission, preferring instead to mount their own efforts. Included in this group of volunteers was Clara Barton. As sick and injured soldiers continued to stream into Washington, Clara Barton, acting independently, solicited clothing, food, and medical supplies from friends and relatives and distributed them to regiments in need. Her goal was to provide care to soldiers within days, or even hours, of their affliction. During the first years of the war, Clara Barton distinguished herself among fellow relief workers by her willingness to travel to battlefields and provide care on the front lines of the fray. She began to provide care on fields of battle in August 1862 during the Second Battle of Bull Run. But this was possible only after she had gathered personal warehouses of supplies, secured an army wagon and teamster for transportation, and persuaded reluctant army officers to issue her the passes necessary to travel to the front lines of battle.

A decade later, in a series of lecture tours, Clara Barton delighted in describing her Civil War service. It is believed, however, that many of her heroic exploits benefitted from a certain amount of personal embellishment. For example, in a tale often related, during the Battle of Antietam, as Clara Barton reached to the ground to offer a drink of water to a weary soldier, a bullet tore a hole in the sleeve of her dress, mortally wounding her patient. As the battle continued, she made repeated trips to the front to care for the wounded and comfort the dying soldiers. At a makeshift hospital, she assisted surgeons with sedation and restraint of patients, as well as with provision of lanterns so that care of the wounded could continue through the night (Oates, 1994).
Clara Barton launched similar initiatives later in 1862 during the battles of Cedar Mountain, Chantilly, Harpers Ferry, and Fredericksburg. Her work in these battles is considered to be the most significant of her service in the Civil War. Through her independent efforts, she was able to gather supplies, distribute them to sick and wounded soldiers, and provide nursing care to those in need. Her ability to provide aid quickly during these emergency situations helped thousands of soldiers whose needs could not be met by the poorly organized, government-sponsored mechanisms. These efforts also formed the framework for Barton’s lifelong work.

By 1863, the efforts of the U.S. Sanitary Commission and army medical services had matured and become better systematized. As a result, Clara Barton found that the services she offered were increasingly marginalized. This proved to be a time, however, when Barton developed personal relationships that would influence her later life and work. In April of that year, Clara Barton joined her brother David in Hilton Head, South Carolina, where he had been appointed quartermaster. From this post, she witnessed the 8-month-long siege of Charleston, as well as the siege of Fort Wagner by the Massachusetts 54th Regiment, a unit composed entirely of African American troops. It was also at this time that Clara Barton had a brief romantic affair with Lieutenant Colonel John Elwell of Cleveland, Ohio, a married man who was an officer in the Quartermaster Corps. Before the war, Elwell had practiced both medicine and law and had served a term in the Ohio legislature. When they first met, he was a patient who had sustained a broken leg in a fall from a horse. He later wrote about his injury, “Two boys of the 62nd Ohio found me and carried me to our . . . hospital. . . . Clara Barton was there, an angel of mercy doing all in her mortal power to assuage the miseries of the unfortunate soldiers” (W. E. Barton, 1922, Vol. 1, pp. 251–252). During his recovery from the injury, Elwell also contracted yellow fever. But through his difficulties, Clara remained his nurse and constant companion. The couple found they shared many interests, including horseback riding and lively conversations, and spent increasing amounts of time together. Although Barton ended the relationship when she learned that Elwell’s wife planned to visit South Carolina, there is evidence that, following the war, she continued to correspond with Elwell by mail, sharing fond memories of their time together and seeking his advice about matters of importance in her life (Oates, 1994; Pryor, 1987).

During the 4 years of the war, Clara Barton was present on 16 battlefields, in addition to the 8 months she spent in South Carolina during the siege of Charleston. A contemporary described her as “always calm, cheerful and well poised, and philosophical, but strict, firm, and unflinching in maintaining authority” (Harper, 1912, p. 703).

Jones (2013) asserts that Clara Barton’s work on the battlefields of the Civil War developed in her the sense of humanitarianism that would be a force that drove her efforts for the rest of her life. She transferred the
traditional Victorian virtue of “women as care givers” from the home to the battlefields and in the process demonstrated remarkable courage, a virtue not usually attributed to women of the era. Her work was based on her firm belief that the pain of wounded soldiers must be relieved as soon as possible. Thus, she expressed human sentiment, or concern for the welfare of others, blended with a rational call to action.

During the last months of the war, Barton became involved in a new venture, called by historians as “the search for the missing men,” which would impact her later work. Of the Union soldiers known to be dead or imprisoned in the South, more than half were unidentified. More than 80,000 were listed on the government rolls only as “missing.” Letters from distressed relatives flooded the office of the War Department, but because no information was available, the letters remained unanswered. Clara Barton, feeling a deep sense of injustice at the lack of response to these inquiries, personally asked President Abraham Lincoln if this correspondence might be routed to her and if she might officially respond to these letters. The President responded with the notice to the public, “To the friends of missing persons; Miss Clara Barton has kindly offered to search for the missing prisoners of war. Please address her at Annapolis, Maryland, giving name, regiment, and company of any missing prisoner” (Bacon-Foster, 1918, p. 296).

Because of the high mortality rates from disease and injury, many soldiers who died were quickly buried in unmarked graves. Although at the end of the war there were 315,555 known graves of Union soldiers, 143,155 of these were unmarked. In addition, 44,000 had been recorded, with no site of burial given. Over the next 4 years, Clara Barton answered more than 63,000 letters and identified more than 22,000 missing soldiers (Somervill, 2007, p. 59).

Clara Barton also established a Bureau of Correspondence for Friends of Paroled Prisoners, which carefully compiled lists of soldiers’ names from hospital and prison rolls. Of particular concern was the Confederate prison in Andersonville, Georgia, where 13,000 Union soldiers were reported to have died in 1 year. During the summer of 1865, Barton supervised the disinterment, identification, and reburial of the bodies in graves with individual name markers. In addition, the graves of 4,000 Confederate dead were carefully marked. This work led to the establishment of Andersonville as one of the first national cemeteries in the United States.

Initially, Clara Barton financed this project using her own funds and spent over $8,000 to pay for maintenance of an office staff of 12. When her private funds were nearly exhausted, she appealed to Congress for funding to continue the work. In 1866, Congress appropriated $15,000 to reimburse Barton for the money that she, as a private citizen, had spent for a public cause. Although these funds enabled her to pay many of the bills she had accrued, they provided no salary for her work on this project.
DEVELOPING THE TOOLS TO INSPIRE A SHARED VISION

In 1866, Clara Barton, now almost insolvent after her search for missing soldiers, sought a means to support herself. During the Civil War, her fame had become so widespread that admirers across the country were eager to hear about her work during the war years. During this era, lectures by noteworthy persons were a popular form of entertainment. When she was first invited to give public lectures about her wartime experiences, Clara was overwhelmed at the thought and focused on what she perceived to be her deficiencies. In her childhood, she was thought to be painfully shy and sensitive. But motivated by her need for personal income, she signed a contract with a lecture bureau that charged from $75 to $100 per lecture. She traveled around the country, speaking to thousands of people. Clara Barton emerged as a gifted speaker with a soft and mellow voice, who captivated audiences with her descriptions of her wartime exploits. Newspaper accounts described her presentations as “animated, instructive, and enjoyable” (Oates, 1994). Barton distinguished herself from other persons on the lecture circuit through her use of stories to remind her listeners about the human costs of war (Jones, 2013). She proved to be one of the most highly paid lecturers of that time and was able to save $25,000 to use for her later work (Harper, 1912). Through her experiences on the lecture circuit, Barton was able to overcome the shyness that had haunted her during her earlier life. Further, she was able to develop persuasive skills that would benefit her in her later activities.

Clara Barton found the lecture circuit to be tiring. In 1869, she was scheduled to give a lecture but found herself before an audience, unable to speak. Throughout her life, Clara had experienced recurrent episodes of depression. It seems that the exhaustion of the travel involved in her work, coupled with the depressing effects of the constant repetition of her war memories, contributed to her physical and mental exhaustion. She consulted several physicians who advised her to spend some time in Switzerland to recover her strength. Her sojourn to Europe lasted until 1873 and introduced her to new ways of channeling her energies for her humanitarian efforts.

ROLE MODELS FOR INSPIRING A SHARED VISION—CLARA BARTON IN EUROPE

During her visit to Switzerland, Clara Barton was able to stay with friends. Charles Upton and his wife, whom she had known in both Massachusetts and Washington, were now engaged in diplomatic service for the United States in the Swiss city of Geneva. Clara was also invited to spend part of her visit with the family of Jules Golay, a Swiss citizen who had served in the Union Army and for whom Barton had provided care.

Soon after her arrival in Geneva, an event occurred that would influence the remainder of her life’s work. Because news of Clara Barton’s record
of charitable activities had spread abroad, she was visited by members of the International Convention of Geneva, more commonly known as the Red Cross, a group with whom she was only vaguely familiar. The group, led by Dr. Louis Appia, inquired why the government of the United States had refused to give its consent to the Geneva Convention, also called the Treaty of Geneva, an international agreement of which she had no prior knowledge. These questions left Barton so surprised and perplexed that she asked her visitors for more information (Pryor, 1987). She was fascinated with the story that unfolded.

In 1859, Red Cross founder Henri Dunant was a Swiss businessman en route from his home in Geneva to the town of Soferino, who came upon a ferocious battle involving troops from France, Sardinia, and Austria. The battle, which would prove to be significant in the Wars of Italian Independence, had left 40,000 wounded soldiers to languish unattended on the field of battle. Dunant mobilized local residents to provide food, water, and bandages to aid the casualties of the battle and assembled makeshift hospitals in nearby villages. Over the succeeding years, Dunant was haunted by the memory of the men in agony, dying because they lacked the most basic care. He became convinced that similar tragedies should not be allowed to occur in the future. In 1862, he published, *Un Souvenir de Solferino* (A Memory of Solferino), which offered vivid accounts of the battle and its human costs. The book was so well received across the European continent that it garnered the attention of leading physicians and generals who agreed that some action must be taken. In 1863, the Convention of Geneva, a conference attended by representatives from 16 nations, was called to discuss the treatment of those wounded in battle. The following year, the Treaty of Geneva was written and signed by 11 countries. By the time Clara Barton first learned about the treaty, 32 countries had agreed to its terms. The Treaty of Geneva contained several key points: (a) In time of battle, ambulances and field hospitals, as well as the personnel staffing them, both volunteers and professionals, should be treated as neutral parties; (b) authorized workers should be able to enter the field of battle to distribute supplies and provide care; (c) casualties are entitled to care whether they were wounded in their own or in hostile territory; (d) seriously wounded soldiers should not be taken as prisoners of war but instead should be sent back to their own army for care; and (e) neutral workers caring for the wounded would be distinguished by a badge of a red cross on a white background (Pryor, 1987).

Clara Barton was both surprised and disheartened to learn that the U.S. government had been requested three times to sign the treaty but had refused on each occasion. In truth, there are a number of possible reasons for the government’s refusal. At the time the Geneva Convention was called, the United States was embroiled in the Civil War and had little interest in international events. During the years that immediately followed, the United States was concerned with the process of reconstruction and recovery from
the lasting effects of the war. Finally, the proceedings of the Geneva Convention were sent to the United States in French, and, thus without translation, could not be published in local newspapers. In 1866, Dr. Henry Bellows, the head of the Sanitary Commission during the Civil War, tried to interest government officials in the Treaty of Geneva but received the response that there probably would never be another war, and, if one occurred, a society such as the Sanitary Commission could be established to coordinate relief efforts (Harper, 1912).

Clara Barton was in Berne in 1870 when France declared war on Prussia (presently a part of Germany), launching the Franco–Prussian War. Although she was ostensibly in Switzerland for rest, Barton nevertheless convinced leaders of the Swiss Red Cross to travel to the battlefields of France to aid in the relief efforts. Antoinette Margot, a young Swiss woman who was fluent in English and French and who also aspired to be a battlefield nurse, was assigned to accompany her. At this time Princess Louise, Grand Duchess of Baden, only daughter of Kaiser Wilhelm of Prussia, visited Clara. She had read about Clara Barton’s work during the Civil War and now came to ask for her guidance and assistance in the relief efforts. They eventually became lifelong friends. The city of Strasbourg in France had been defeated by troops led by Louise’s husband, the Grand Duke, and the Duchess now asked Clara Barton to aid the citizens who had been harmed in the battle. Barton and her companion left for Strasbourg on August 6, 1870, stopping en route to observe field hospitals that had been set up to care for wounded soldiers who had been evacuated from the front lines. Clara longed to again provide nursing care on the battlefields as she had done during the Civil War. She repeatedly found, however, that her colleagues in the International Red Cross were unwilling to allow this.

When the women reached Strasbourg, they encountered members of the Swiss Red Cross who were providing aid to citizens of the city who had the greatest needs. The Swiss assigned Clara Barton to work with those persons who had been evacuated from the city during the battle and who had lost their homes and possessions. Barton developed a model of care that deviated markedly from the Red Cross members’ traditional provision of care only to wounded combatants. She advocated for citizens who had been affected by the war to now be participants in the relief efforts aimed at helping in their recovery. Thus, she began a small business that involved the citizens of Strasbourg in sewing clothing. The garments produced aided those who had lost all of their possessions and also aided those without work. The relief efforts in Strasbourg were among the first attempts to involve citizens who had been affected by a disaster, a population whose needs had not been considered in the Treaty of Geneva (Jones, 2013). Barton continued to use this model when she organized relief efforts in the French cities of Metz, Montbéliard, Belfort, and later, in Paris. From that time forward, the main focus of her work would be provision of aid to citizens affected by war.
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and other disasters (Bacon-Foster, 1918). Clara Barton also came to understand the effectiveness of Red Cross workers in their care of combatants and resolved to secure U.S. support for the Treaty of Geneva. She observed that the Red Cross workers were more efficient and better prepared than had been the Sanitary Commission workers during the American Civil War. After her 2 years of work with the French, Swiss, Prussian, and British Red Cross Societies, Barton promised her colleagues that she would devote the rest of her life, if necessary, to the introduction of the Red Cross movement in the United States (W. E. Barton, 1922). In turn, Clara Barton was praised by European dignitaries for the aid she had provided during the Franco-Prussian War. Kaiser Wilhelm presented her with the Iron Cross, the German government’s highest honor, which had never before and has never since been awarded to a woman (Jones, 2013).

Unfortunately, Clara Barton’s early attempts to inspire a shared vision, although effective, ultimately came at a cost to her credibility. Although her diary and accounts from her companion, Antoinette Margot, clearly indicate that both women never served on an actual field of battle in France, Barton nevertheless related that they had been personally involved in combat. It seems she embellished her accounts both to entertain her admirers and to enlist their financial support for her cause. She believed that necessary support could best be engendered through the use of strong words and the presentation of the events as both dreadful and in need of immediate attention (Pryor, 1987).

Unfortunately, Clara’s work in Europe had taken a toll on her health. In 1873, she suffered another bout of exhaustion and depression, which caused her to return to the United States and to seek treatment in a sanatorium in Danville, New York. As she recovered her strength, she began to write newspaper articles about the work of the Red Cross in an attempt to gain public support. In 1887, when she had fully recovered her strength, she renewed her correspondence with Gustave Moynier, the president of the International Committee of the Red Cross (ICRC) and Dr. Louis Appia, a colleague of Moynier who had visited Barton when she first arrived in Switzerland. Both proved to be wise mentors to Clara Barton as she began her new endeavor. First, they cautioned her that under the rules of the ICRC, a country’s national Red Cross would not be recognized until its government had signed the Treaty of Geneva. Barton’s first action, therefore, should be to convince the U.S. government to agree to the terms of the Treaty of Geneva. Further, they warned that because the United States did not consider itself a military power and because the danger of war did not seem imminent, the government would be unlikely to see this action as a high priority. Historically, the United States had adhered to the warning of George Washington as he left office and avoided “entanglements” with foreign powers and had signed treaties with foreign governments only to bring an end to wars.
Dr. Appia sent Clara Barton a detailed plan for the establishment of a Red Cross Society in the United States: (a) seek publicity, (b) achieve government approval of the Treaty of Geneva, (c) found a national Red Cross Society, and (d) collect funds to support the national Red Cross. He further advised her to “surround yourself with a little body of persons full of goodwill and capacity, docile to your directions” (W. E. Barton, 1922, p. 128). Moynier appointed Clara Barton the agent of the ICRC and sent her a letter of introduction to present to Rutherford B. Hayes, the president of the United States, strongly encouraging him to accept the Articles of the Convention of Geneva. Unfortunately, during the years that Clara Barton was abroad, she had lost many of her prior contacts with persons of influence in the nation’s capital. Those who remained had little power in the Hayes administration. Barton visited President Hayes at the White House and was warmly received. However, the letter of introduction was referred to the Assistant to the Secretary of State Frederick Seward, who had no interest in the proposal. During the 1860s, Henry Bellows and members of the Sanitary Commission had proposed the idea of a Red Cross Society to Seward, who remembered his refusal of their request, referred her to the record of this refusal, and regarded the matter as decided. Clara Barton later wrote,

I saw that it was all made to depend on one man, and that man regarded it as settled. I had nothing to hope for then, but did not press the matter to a third refusal. It waited, and so did I.
(C. Barton, 1922, Vol. 2, p. 146)

Clara Barton had learned much from her colleagues and mentors in Europe. She now needed to develop strategies that would appeal to the sentiments of the people of the United States, as well as to U.S. elected officials. To win acceptance, the idea of a Red Cross had to speak to the hearts of Americans.

INSPIRING A SHARED VISION—DEVELOPING NEW STRATEGIES

Because Clara Barton realized that she was unlikely to have any success in further appeals to members of the Hayes administration, she decided to wait until the election of a different president before making further attempts to secure approval of the treaty. As she waited, Barton embarked on a strategy to educate the American public about the value of a Red Cross Society. She gathered a group of friends, including the Swiss counsel-general, Switzerland’s official representative to the United States, to form a “Society of the Red Cross.” This committee aimed to bring public attention to the work of the Red Cross and to arouse public sentiment in favor of approval of the Treaty of Geneva. In 1878, the committee members published and circulated
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a pamphlet, *The Red Cross of the Geneva Convention: What It Is*, authored by Barton. In this publication, she presented the Red Cross as a national relief organization that would function during times of peace to “afford ready succor and assistance to sufferers in times of national widespread calamities, such as plague, yellow fever, and the like, devastating fires or floods, rail disasters, [or] mining catastrophes” (C. Barton, 1878, pp. 5–6).

Clara Barton expanded the idea of a Red Cross Society beyond that envisioned by Dunant. European Red Cross Societies had been formed to provide rapid relief to those injured in battle and actually had been cautioned by Moynier to limit resources expended in national relief efforts. But Clara Barton realized that in the United States, memory of the Civil War was fading and that the idea of provision of relief during “national calamities” would better speak to the concerns of the American public. She wrote,

> Our Southern coasts are periodically visited by the scourge of Yellow Fever; the valleys of the Mississippi are subjected to destructive inundations. . . . to gather and dispense the profuse liberality of our people, without waste of time or material, requires the wisdom that comes of experiences and permanent organization. (C. Barton, 1878, pp. 7–8)

Thus, Clara Barton and her committee members became the first in the international Red Cross movement to make disaster relief the central focus of its mission (Jones, 2013). Efforts to educate the American public and to win the support of persons of influence continued throughout the remainder of the Hayes administration.

Soon after the inauguration of President James Garfield in 1881, Barton renewed her efforts to secure government approval of the Treaty of Geneva. The new president was receptive to the idea. He urged its approval to Secretary of State James Blaine, who began correspondence with the ICRC and began arrangements to organize a branch of the Red Cross in the United States. In 1881, the original small committee was reorganized and incorporated as the Society of the Red Cross. President Garfield nominated Clara Barton to be its president, a position she held for the next 22 years. That summer, President Garfield was assassinated, a blow to the nation, but especially to the members of the newly formed Red Cross Society. However, his successor, Chester A. Arthur, proved to be equally supportive and recommended approval of the treaty in his inaugural address. The Treaty of Geneva was accepted by Congress and was signed by President Arthur on March 1, 1882.

President Moynier of the ICRC wrote to Clara Barton, “You must feel happy and proud at last to have attained your object, thanks to a perseverance and zeal which surmounted every obstacle” (Harper, 1912, p. 708). Bonfires were lit in Geneva in celebration of the acceptance of the treaty by the United States. In a proclamation of its mission, the stationery of the society
read, “The American Society of the Red Cross organized under the Treaty of
Geneva for the Relief of Sufferings of War, Pestilence, Famine, Fires, Floods,
and other National Calamities” (Bacon-Foster, 1918, p. 307). The primary
mission of the ICRC, however, was the provision of relief to casualties of
battle, and the charter of the American Society required ratification by the
nations of the ICRC. Using her well-honed skills in diplomacy, Clara Barton
presented the case that because many disasters of various forms occur an-
nually in the United States, for the American Society to be able to justify its
existence, it should have the power to offer its aid in any national calamity.
The nations of the ICRC accepted Barton’s proposal, calling it the “American
Amendment” (Harper, 1912).

For the first 10 years of its existence, the American Society of the Red
Cross operated under the charter it had been granted by the District of
Columbia. Barton and her colleagues realized, however, that for the Society
to have the power and standing it required, a federal charter would be neces-
sary. This could only be secured through congressional legislation. Although
this would seem to have been a simple matter, Clara Barton spent several
years lobbying members of Congress who were quite indifferent to her cause.
During this time, Clara learned the important skill of political action, which
is necessary for the inspiration of a shared vision.

In 1893, when Clara Barton’s lobbying efforts were successful and a
federal charter was granted, the Society was reincorporated as the American
National Red Cross. Full recognition from Congress would not be attained
until 1900. Congress failed, however, to allocate financial support for main-
tenance of the Red Cross, although the government of every other coun-
try in the Red Cross movement had established a mechanism to fund its
national society. Thus, for 23 years, the cost of the Red Cross headquarters in
Washington, DC, was borne entirely by Clara Barton. No salaries were paid
to her staff except for a few temporary employees who provided fieldwork
or secretarial services.

INSPIRING A SHARED VISION ON A LOCAL LEVEL

In August 1881, the first local branch of the American Red Cross, called a
Red Cross Auxiliary Society, was established in Dansville, New York, Clara
Barton’s home during the years of her illness. In only a few weeks, other
local branches were established in Syracuse and Rochester, New York. The
value of the Society was soon proven in its rapid response to forest fires that
swept across Michigan, leaving many families homeless and destitute. The
local branches collected money and supplies, which were distributed by
Dr. J. B. Hubbell, the chief field agent for the Red Cross and Clara Barton’s
personal assistant (Bacon-Foster, 1918).

Dr. Hubbell served as Clara Barton’s assistant from 1881 until 1904. He
took charge when she was away from headquarters and was sent to direct
aid missions when she was unable to be away from the office. Barton met Hubbell when he served as a professor of science and principal of the Dansville Hygienic Seminary. He became interested in Barton’s work and pledged to help her in the establishment of the American Red Cross. When he asked how he could best help the fledgling Society, Clara Barton asked him to attend medical school, in the belief that the presence of an educated medical doctor on her staff would add to the organization’s credibility. Hubbell studied at the University of Michigan and received his medical degree in 1883. At many points in his education, however, he was called away to aid in various Red Cross relief efforts.

The first real test of the effectiveness of the Red Cross was its response to flooding in the Ohio and Mississippi river valleys in 1882, 1883, and 1884. The American Red Cross collected $175,000 in money and donations for the relief effort. Clara Barton rented a steamship, loaded it with supplies, and journeyed along the Ohio River, distributing supplies to those in need. When the flooding spread to the lower Mississippi River valley, the American Red Cross chartered another ship in St. Louis, stocked the ship with provisions, and traveled as far as the Mississippi Delta, bringing aid to many afflicted persons in areas too remote to have been reached through the government’s relief efforts. The relief efforts of the American Red Cross were unique in that Barton collected and distributed clothing, seeds to replace lost crops, coal for heating homes, and feed for animals—all items needed for survival, which were not considered in government-sponsored relief efforts. Following the approach she had used during the Civil War, Barton traveled to the site of a disaster and personally comforted those in need.

Through her personal contact with disaster victims, Clara Barton strove to *inspire a shared vision* through collecting and sharing with the press personal stories of those who had been afflicted by the disaster. For example, a family of six children in Pennsylvania who had heard about the devastation caused by the flood staged a variety show to aid the victims and sent Clara Barton the $51.25 they collected. As Barton traveled along the flooded Ohio River, in Shawneetown, Illinois, she encountered a widow with six children who had been driven from their home by the flood. Clara used the funds from Pennsylvania to aid the family and notified the donors about the recipients of their generosity. The children in Pennsylvania responded, “Some time again when you want money to help you in your good work, call upon the ‘Little Six’” (Jones, 2013, p. 41). Clara Barton sent the story to be published in the *Erie Dispatch*, the local newspaper of Erie, Pennsylvania. She then ordered 1,000 copies of the article, which she sent to other newspapers and included in the notes of thanks she sent to many of her donors. Thus, she was able to *inspire a shared vision* through astute use of the media, coupled with the establishment of a personal connection to her donors.

Later, in 1884, soon after Clara Barton returned from her flood relief efforts, the secretary of state appointed her to represent the United States
at the International Conference of the Red Cross, which would be held in Geneva in September. At this conference, she was the only woman among the representatives from 32 nations. Her work was applauded through a resolution introduced by the representative from Italy, “This conference declares that in obtaining the accession of the United States of America to the Convention of Geneva Miss Clara Barton has well merited the gratitude of the world” (Bacon-Foster, 1918, p. 310).

In 1888, the American Red Cross aided victims of a yellow fever epidemic in Jacksonville, Florida. In addition to the Red Cross, many other agencies provided aid, including the U.S. Public Health Service and the U.S. Marine Hospital Service. When Clara Barton appealed to local Red Cross units around the country, the onetime leader of the New Orleans Red Cross responded by sending nurses to aid in the relief effort. Unfortunately, some of the nurses recruited for this effort proved to be less than professional and were accused of drinking to excess, theft, and general incompetence. In contrast, a group of educated nurses from Bellevue Hospital in New York City who joined the relief effort demonstrated the application of scientific principles such as attention to nutrition, hydration, environmental regulation, and treatment protocols in the care of the victims of yellow fever (D’Antonio & Whelan, 2004). Fortunately, a small group of the New Orleans Red Cross nurses performed valiantly through their establishment of a hospital and maintenance of quarantine in the severely afflicted town of McClenny, a short distance from Jacksonville. From this experience, Barton realized the importance of close supervision and guidance of local Red Cross chapters as well as the persons sent as nurses to disaster areas.

On the afternoon of May 31, 1889, a dam built by the exclusive South Fork Fishing and Hunting Club gave way, flooding the town of Johnstown, Pennsylvania, which lay in the valley below. In the wake of the disaster, 2,209 people were killed. Debris littered the town, thousands of residents were homeless, and parts of the city were covered with up to 30 feet of water. The club’s members, who included industrialists such as Andrew Carnegie and Henry Clay Frick, had given little attention to either the maintenance of the dam or the threat it posed to the residents of Johnstown. The Philadelphia local Red Cross Auxiliary sent doctors and educated nurses who went door to door to locate sick and injured persons in need of medical attention. The medical and nursing staff further implemented sanitation mechanisms to prevent the outbreak and spread of waterborne diseases, such as typhoid fever. Clara Barton took charge of the distribution of food, clothing, and supplies to the flood victims. The Red Cross used donated lumber to construct temporary hotels that housed nearly one hundred families. Her goal was to provide care and comfort to those who were psychologically distraught as a result of the disaster. When the Red Cross’s relief efforts ended in late October, Clara Barton was recognized in an editorial in the Johnstown Daily Tribune with the words, “The first to come and the last to go, she has indeed
been an elder sister to us—nursing, soothing, and tending for the stricken ones” (C. Barton, 1898, p. 168).

In August 1893, a hurricane ravaged the South Carolina coast. Most affected were the Sea Islands along the coast, which were pounded by a 20-foot tidal wave. One of the greatest achievements of the American Red Cross was the aid it provided to the 30,000 residents who were affected by the storm and its aftermath. In 1890, 92% of the residents in the area most affected were African Americans. Many of these were descendants of former slaves who had labored in the rice plantations along the coast and retained many African traditions. Little media attention was given to this disaster, and because the nation was in the throes of an economic depression, little help was offered. Thus, the American Red Cross acted independently in its provision of relief and often was subjected to intense criticism. Complaints included that the African American victims of the storm were unworthy of aid and that any assistance provided would make them lazy and discouraged. Further, the argument was put forth that a disproportionate amount of aid was provided to the African American island residents, with little aid offered to the predominantly white residents along the coast. Thus, Clara Barton maintained the moral imperative of treating all victims of disaster equitably, regardless of race or ethnicity.

INSPIRING A SHARED VISION ABROAD—INTERNATIONAL RELIEF EFFORTS

During the 1890s, Clara Barton sought to expand the influence of the American Red Cross beyond the borders of the United States through involvement in crises abroad that demanded humanitarian aid. During the decade that followed its founding, the efforts of the American Red Cross had been confined to the United States. As the 19th century drew to a close, however, the spread of colonialism, improved communications and travel among nations, and an increase in missionary activities gave rise to the belief that more advanced nations had a responsibility to aid developing nations. Actually, international involvement seems to have been Clara Barton’s vision as early as 1878, because in her pamphlet, *The Red Cross of the Geneva Convention*, she referred to “the misfortunes of other nations” (C. Barton, 1878, pp. 7–8).

Throughout this decade, opportunities for overseas involvement arose, the most significant of which were a famine in Russia from 1889 until 1892, a massacre of Christian Armenians in Ottoman Turkey, in 1895; and a Cuban struggle for independence from Spain from 1895 until 1898. Through these international relief efforts that were necessary to deliver aid to those in need, Clara Barton learned to balance her involvement with foreign governments with the need for the American Red Cross to maintain its neutrality.

Clara Barton was only partially successful in efforts to send corn, grain, and potatoes to Russia. Midwestern farmers quickly identified with the
plight of starving peasants and willingly sent produce for shipment abroad. Barton had great difficulty, however, in raising the funds needed to ship the donations abroad. Further, she had difficulty coordinating the efforts of the American Red Cross with a rival, the Russian Famine Committee of the United States, which had been organized by American farmers who were weary of the delays Barton encountered in her attempts to ship contributions abroad. By the time the shipments reached the Russian peasants, they had endured the famine for nearly a year, and relief programs from their own government were beginning to show positive results. Americans, however, believed the relief effort mounted by Clara Barton had been a success. *The Christian Herald* proclaimed enthusiastically, “We have saved the lives of 125,000 Russians” (Jones, 2013, p. 68).

During the summer of 1895, reports were sent by missionaries and travelers abroad that Muslim Turks and Kurds had committed atrocities against the predominantly Christian Armenians. The ire of Americans was further raised by reports that schools and buildings that had been erected by American missionaries to bring “civilization” to the Armenians had been burned and razed. Because the nation of Turkey had ratified the Treaty of Geneva, Clara Barton, the president and representative of the American Red Cross, seemed the logical person to intervene in the crisis. Although she was 74 years old, Barton felt it was her responsibility to undertake this project, despite the knowledge that she would, once again, be venturing into potentially dangerous situations. When she was introduced to Tewfik Pasha, the prime minister of Turkey, by A. W. Terrell the U.S. ambassador to the country, both Clara Barton and Terrell presented their goals in strict humanitarian terms, stressing their concern for the welfare of both the survivors of the massacres and the missionaries attempting to provide aid. When asked to state her plans for the proposed relief effort, Barton later recalled saying,

> Our object would be to use [our] funds ourselves among those needing it, wherever they were found, in helping them to resume their former positions and avocations, thus relieving them from continued distress, the State from the burden of providing for them, and other nations and people from a torrent of sympathy. (C. Barton, 1898, p. 279)

The prime minister agreed to the relief effort and provided guards to escort Barton and her assistants on the four expeditions they made into the interior of the country. The group traveled hundreds of miles, bringing to the distraught Armenians medicine and supplies valued at $116,000. Both Clara Barton and Dr. Hubbell remained in Constantinople for 6 months, administering the distribution of aid.

In recognition of her work in Turkey, Prince Guy de Lusignan, Patriarch of Armenia, awarded Clara Barton the Brevet of Chevalier of the Royal Order
of Melusine, which was conferred for her humanitarian services to the Armenian nation. Likewise, the Sultan of Turkey awarded Barton the decoration of Shefaket, also awarded for her humanitarian work. Despite the good that was accomplished by this mission, Barton was criticized by some Americans of Armenian descent for failure to prevent further massacres. Reportedly, 6,000 Armenians were slaughtered in the span of 2 days, only a few weeks after the American Red Cross team departed from Constantinople. Critics further claimed that Clara Barton had developed relationships with the Turkish prime minister and Sultan that were too cordial and that prevented her acknowledgment of the atrocities committed by Turkish officials.

In her work in Turkey, Clara Barton did much to extend the vision of Dunant, the founder of the International Red Cross. In this vision, the society aimed to provide immediate relief to the afflicted, rather than to prevent future crises. Further, in her mission to Turkey, Clara Barton demonstrated leadership through her maintenance of both religious and political neutrality. To successfully accomplish her aims, it was imperative that she refrain from actions that could be misperceived as sympathy to either the Muslim Turks or the Christian Armenians. Her success in this matter is evidenced by the awards she received from both sides in the conflict. When their steamship arrived in New York harbor, a member of her entourage told reporters, “It was not our work to investigate causes. We found the sufferers and did what we could for them” (Jones, 2013, p. 79).

INSPIRING A SHARED VISION—IN TIME OF WAR

During the summer of 1897, amid a growing number of reports of starvation among the peasant population of Cuba, concerned Americans repeatedly requested Clara Barton to send aid. Cuban revolutionary leaders were embroiled in a revolution against the government of Spain, which had ruled the island nation for over four hundred years. Early in 1896, the Spanish government removed peasants from their land and relocated them to detention camps. The peasants, called reconcentrados, now faced disease and death. Although President McKinley initially was opposed to U.S. involvement in the Cuban revolutionary efforts, he eventually agreed to a policy of provision of aid to the citizens of Cuba. In cooperation with Clara Barton and the secretary of state, President McKinley formed the Central Cuban Relief Committee to raise funds and collect supplies to aid the reconcentrados. Although Clara Barton was 76 years old, she agreed to the president’s request that she lead the relief effort. She arrived in Cuba only 3 days after her meeting with the president, inspected the “dirt and filth” of the camps, and began to establish Red Cross distribution centers (Pryor, 1987).

In her efforts to aid the Cuban peasants, Clara Barton worked with General Ramon Blanco y Erenas, the commander of the Spanish armed forces in Cuba. Because Spain had been one of the first countries to sign the Treaty
of Geneva and because he expressed compassion for the condition of the Cuban people, she sought to work with him as a colleague in the provision of aid. When she was later criticized for this alliance, Clara Barton defended her actions, stating she met with the Spaniards “as the head of the Red Cross of one country greeting Red Cross men of another.” She continued that she did not “speak for America as an American, but from the Red Cross for humanity” (C. Barton, 1899, p. 546).

On February 15, 1898, the U.S. battleship Maine exploded and sank while it was moored in Havana Harbor, killing 250 persons. The ship had been sent to Cuba to protect U.S. citizens and their interests during the Cuban fight for independence from Spain. Although recent investigations have concluded that the explosion was caused by spontaneous combustion of the coal stored in the ship’s hull, the American public accused the Spanish government of plotting the disaster (Maroldu, 2001). In April 1898, the Spanish government announced an armistice with the rebel forces and enacted a program to grant Cuba increased self-government. The U.S. Congress responded with resolutions that demanded full independence for Cuba and removal of Spanish forces from the island. Further, the U.S. Congress voted to allow President McKinley to send U.S. troops to ensure the removal of Spanish forces from Cuba. In response, on April 24, Spain declared war on the United States. This was followed by a U.S. declaration of war on Spain, which was made retroactive to April 21. With the outbreak of war, Barton bid farewell to General Blanco y Erenas and his staff and relocated the Red Cross headquarters to Tampa, Florida.

Only days before the start of hostilities, the State of Texas, a ship that had been commissioned by Clara Barton to deliver Red Cross supplies to the reconcentrados departed from New York, bound for Key West, Florida. Barton met the ship there and implored Admiral Sampson, the U.S. naval commander responsible for the enactment of a naval blockade that surrounded Cuba to allow the supplies to pass through the barrier. He responded that it was his responsibility to prevent aid from reaching Cuba despite Clara Barton’s pleas that the responsibility of the Red Cross was to deliver immediate aid to combatants, regardless of their cause. But her resentment of the barriers to her mission that had been imposed by the U.S. military forces led to her choice to function independently, rather than in unison with the efforts of the army and navy.

Unable to begin the work she planned, Clara Barton remained in Tampa, the point of departure for U.S. troops leaving for Cuba. Her attention remained focused on the delivery of supplies and food to Cuban civilians, with little regard for the needs of the U.S. troops that were being assembled for the invasion of Cuba. Many of these troops languished in camps that lacked appropriate sanitation and soon fell victim to typhoid fever and malaria. To aid these troops, many relief groups, such as the American National Red Cross Relief Committee, were organized by concerned community leaders.
from all regions of the United States. These “auxiliary” Red Cross organizations were committed to raising funds to aid the army and navy in their efforts to provide medical and hospital care. These groups had been formed, however, without the knowledge or consent of Clara Barton—a fact she only later recognized as a threat to her leadership (Jones, 2013).

As hostilities on the island increased, Clara Barton, functioning in accord with the Red Cross mission to provide immediate relief, followed Theodore Roosevelt and his troops to Cuba. There, she once again encountered resistance from army medical personnel who opposed the presence of female nurses in military field hospitals. She noted in her diary, “All seemed interested in the Red Cross, but none thought a woman nurse would be in place in a soldier’s hospital” (C. Barton, 1899, p. 557). On a battlefield in Siboney in Cuba, Clara Barton was dismayed to find wounded men with high fevers, lying on the coarse grass with no blankets under them. Her attempts to provide aid were rebuffed by U.S. Army surgeons who stated they were dealing adequately with the situation. The U.S. and Cuban field hospitals had been arranged in immediate proximity. Clara Barton and her staff then redirected their attention to the care of patients in the Cuban field hospital. When the American medics realized that the Cuban patients were clean, well nourished, and the recipients of excellent care, they changed their minds and requested the services of the Red Cross (Pryor, 1987).

In her memoir of the war, Clara Barton related an incident in which a young U.S. Army officer, who had been forbidden to ask for aid from the Red Cross in adherence with the U.S. Army’s original policy, approached her with a request to purchase needed supplies for his men. Clara replied that she would not sell supplies to him, even if he offered her a million dollars. In desperation, he asked what he could do to obtain the supplies, to which she replied, “Just ask for them.” With that, the officer gathered the supplies he needed and, with a bulging sack thrown over his shoulder, trudged back into the jungle to return to his troops. The young officer was Theodore Roosevelt who would soon be elected president of the United States (C. Barton, 1899).

During the Battle of El Caney, which was fought on July 1, 1889, victims were transported to Siboney for care. Nurses prepared gruel and a drink made from dried apples and prunes, which was nicknamed “Red Cross Cider.” In her published memoir, Barton related that, dressed in a calico skirt and white apron, she worked from 16 to 18 hours each day, cooking and caring for sick and wounded soldiers. In addition, many soldiers and Red Cross staff members had contracted yellow fever, which required specialized treatment such as applications of ice.

Following the Battle of San Juan, Clara Barton heard that wounded men on the battlefield required care. In actions reminiscent of her work during the American Civil War, Barton loaded supplies into the only two wagons that were available and drove through tropical jungles to bring aid to
the afflicted. Following the battle, military surgeons performed more than 400 operations in 2 days. Clara found the recovering patients, lying on the ground in pools of water, in conditions she assessed as much worse than any she had seen in her earlier work. She was welcomed by the more able patients with the cry, “There is Clara Barton. Now we’ll get something to eat” (C. Barton, 1899, p. 649).

The work of Clara Barton and her associates was further recognized in Major Louis LeGarde’s annual report to the U.S. War Department in 1898, for the “Base Hospital” at Siboney, Cuba. It states,

As the wounded crowded upon us in numbers beyond anything we had any reason to anticipate, they came forward with cots, blankets, and other necessities. . . . For such help at a moment of supreme need, coming from people in no way connected with the military services, the deep sense of gratitude . . . cannot be conveyed by words. (Bacon-Foster, 1918, p. 341)

Ironically, for her work in Cuba, Clara Barton chose as her chief assistant, J. K. Elwell, the nephew of J. J. Elwell, the married officer with whom she had been romantically involved during the Civil War. In his memoir, J. K. Elwell wrote that he had met Clara Barton through his uncle, “who had been intimately acquainted with her during the Civil War” (Bacon-Foster, 1918, p. 330). He added that Clara Barton personally recommended him to President McKinley and that prior to the outbreak of hostilities, he had been appointed by the State Department to work with the U.S. consul general in Havana.

Hostilities ended on July 17, 1898, with the surrender of Spanish military forces to General William Shafter. In the Treaty of Paris, which was signed on December 10, 1898, Spain granted independence to Cuba, ceded Guam and Puerto Rico to the United States, and transferred its sovereignty over the Philippines to the United States for a payment of $20 million. At the conclusion of the war, the Spanish government presented Clara Barton with the “Diploma of Gratitude,” a plaque engraved with a testimonial from the Red Cross of Spain for the aid she provided to Spanish soldiers (Harper, 1912). The people of Santiago, Cuba, erected a statue of Clara Barton on the town square (Frantz, 1998).

Clara Barton received criticism, however, for many of her actions in Cuba. Questions were raised about the aid she provided to Spanish troops during a time of war, her need to work independently with a concomitant inability to coordinate her efforts with other groups providing aid, and her decision to work on the battlefields rather than attend to administrative responsibilities in the Red Cross headquarters. This criticism would increase dramatically during the years that followed. Although her work during the Spanish–American War facilitated Clara Barton’s efforts to inspire a shared
vision, she neglected to consider a corollary of this leadership principle—the importance of coordinating efforts with others, sharing of intermediate goals, and delegation of work to others to make progress toward attainment of the vision.

ATTAINMENT OF THE VISION

On September 8, 1900, a devastating hurricane struck Galveston Island, off the coast of Texas, with winds of more than 125 miles per hour. Still ranked as the worst natural disaster in the history of the United States, the storm left 8,000 people dead and more than 25,000 homeless (D’Antonio & Whelan, 2004). Although Clara Barton was 78 years old and in poor health, she nevertheless traveled to Texas to aid in the relief effort. Although confined to a bed for over a week, she insisted on directing the clothing and food distribution efforts. She remained in Galveston for over 2 months, procuring lumber and planning the construction of houses on frail stilts, which were named Red Cross houses by locals. In her memoirs, she described fires that were kept burning for weeks to control the spread of disease from decaying corpses.

Following the disaster, her work was acclaimed in a resolution that was introduced in the Texas State Legislature on February 1, 1901, “especially does the Legislature thank Miss Clara Barton, President of the Society for her visit to the State and her personal supervision and direction of relief to those who were in need and distress” (Bacon-Foster, 1918, p. 347). This was to be Clara Barton’s last relief effort.

Not everyone continued to be so enamored of Barton’s work. The American National Red Cross Society had grown in both membership and in the scope of its activities. Many members believed that Clara Barton continued to work too independently without consulting with others, especially in regard to the collection of donations and the use of the Society funds.

In May 1900, the U.S. Congress approved an official federal charter for the Red Cross, to recognize the American Red Cross as the society responsible for fulfilling the obligations that the United States had agreed to through its acceptance of the terms of the Treaty of Geneva. Although the U.S. Congress had signed the treaty in 1882 and had approved a federal charter in 1893, it had never formally recognized the American Red Cross as its official agent. The charter specified that the American Red Cross would be responsible for the provision of aid to the sick wounded in times of war and would work with military officials to maintain communication between active service members and their families at home. Further, the Society was charged with maintenance of a system of national and international relief in times of peace to aid those afflicted by natural disasters. As an important addition, through this legislation, more power was given to the Society’s executive committee, and a board of control was established.
Clara Barton had persistently sought to achieve this recognition for the American Red Cross, repeatedly lobbying members of Congress. Having achieved this goal, she decided to retire and submitted her resignation as president of the American Red Cross to the newly formed board of control at its meeting in July 1900. The board, however, refused to accept her resignation and praised her as “a greater heroine than Florence Nightingale” (Jones, 2013, p. 94).

Unlike the informal group of advisors that had loosely governed the American Red Cross since its founding in 1882, the new board of control was required to submit an annual report to Congress, which would need to include detailed information about contributions to the Society and funds expended in relief efforts. Throughout the years of her presidency, Clara Barton had developed her own unique method of fiscal management that was now exposed to the scrutiny of board members. Although many members of the board of control, including her nephew William Barton, were long-time supporters of Barton, some were detractors who believed the American Red Cross was in need of new leadership. These members, led by the socially prominent Mabel Boardman, called for a congressional investigation of the financial operations of the Society.

Unfortunately, through these new demands for fiscal transparency, serious flaws were detected in Clara Barton’s methods of accounting. For example, Barton’s approach was to wait for a new disaster to occur in order to secure the contributions needed to pay the debts the Red Cross had accrued from its involvement in a prior calamity. When Barton was asked to submit the American Red Cross account books for an audit by the U.S. Treasury Department, she brought an assortment of trunks, suitcases, hatboxes, and wooden boxes, which she had used to file these records. In addition, two of her most trusted employees were found to have embezzled funds from the Society; the Red Cross had issued no public financial statements until it was required to do so in 1900, and funds collected for the Society’s relief efforts had been sent directly to Clara Barton, rather than being channeled through the Society’s treasurer.

Clara Barton, who had always been sensitive to criticism, was distraught that she should be the subject of a congressional investigation. She wrote in February 1903, “All of this kind of life is so distasteful to me that I cannot carry it much longer . . . so humiliating that I can scarcely take it in or bear it” (Bacon-Foster, 1918, p. 352). Her only answer to the criticism she received was, “Let my life and work speak for themselves” (Harper, 1912, p. 711).

Although the congressional committee that conducted the investigation found that Clara Barton had done nothing wrong, it nevertheless questioned the accounting system for the Red Cross and the Society’s distribution of funds. In 1904, at the age of 83, Barton resigned as president for the last time. In her letter of resignation, she wrote, “It is a pride as well as a pleasure
to hand you an organization perfectly formed, thoroughly officered, with no debts and a sum of from $12,000 to $14,000, available to our treasury as a working fund” (Bacon-Foster, 1918, p. 354). This comment was undoubtedly a response to the board’s expressed concerns about the financial status of the American Red Cross. Clara Barton had garnered these funds through sale of some of the Society’s assets, including vacant lots in Washington, DC, that had recently increased in value.

For the final 15 years of her life, Clara Barton resided in her home in Glen Echo, Maryland. Originally built in 1891 as a warehouse for Red Cross relief supplies, Barton moved there in 1897, making it both her home and the headquarters for the American Red Cross. This may have indicated that she made little distinction between her personal life and her work. In her Christmas letter to friends that year, she outlined a plan for what she called “My Later Work.” She wrote that now that the work of the Red Cross had, in her opinion, been totally taken over by the government, it was a “finished effort.” She added, however, “You have never known me without work; while able you never will. It has always been a part of the best religion I have had.” She now planned to initiate a program to provide “organized first aid to the injured” (Harper, 1912, p. 711).

In 1903, Clara Barton met with Edward Howe and recruited him to be superintendent for a new first aid department for the American Red Cross. Howe had been affiliated with a similar program, the St. John Ambulance Association, which had been initiated in Great Britain. He was now eager to bring the idea to the United States, and Barton was in full agreement. They envisioned an educational program that Red Cross auxiliaries could operate between relief missions. The program would provide training for school personnel, firefighters, police officers, and factory employees to enable them to provide rapid treatment for accidents they encountered in their work. Further, training would be provided to housewives to enable them to deal with family accidents and emergencies. The program could also provide a source of revenue for the auxiliaries through the sale of first aid kits and supplies and fees charged for classes. By the end of 1903, the governors of 24 states and territories, as well as the presidents of 19 state medical societies had voiced their support of the plan (Jones, 1913). This plan provides evidence that although Clara Barton was of an advanced age and showed frailty in many aspects of her life, she was nevertheless able to devise a creative plan for the expansion of the influence of the American Red Cross.

Although Clara Barton had planned to implement the first aid program in her retirement and the idea proved to be successful, the American Red Cross brought suit against her to own and direct the program. The Society argued that because Clara Barton had developed the idea for the program while she was president of the American Red Cross, it belonged to the Society. A weary Clara Barton decided not to engage in a battle for control of the program (Pryor, 1987).
During her final years of life, Clara Barton spent the majority of her time at her beloved Glen Echo, making frequent visits to a second home she purchased in Oxford, Massachusetts. In 1904, she wrote the book, *A Story of the Red Cross*, which although intended to be a history of the American Red Cross, was autobiographical in much of its content. In 1907, in response to a request from a young admirer, she wrote a book about her early life, *The Story of My Childhood*. Through her final years, Clara Barton continued to experience the episodes of depression that had haunted her through much of her life. She wrote, “The longer I live, the worse it gets, until now the menacing spirits hover about my poor beset pathway. . . . There have been no successes in my life, only attempts at success and no realization” (W. E. Barton, Vol. 2, 1922, p. 146).

In August 1911, Clara Barton made a final visit to her home in Oxford, Massachusetts, to visit family members. While there, she contracted pneumonia, which lingered for several months. Her health seemed to improve as she celebrated her 90th birthday on Christmas Day, 1911. As the winter wore on, however, her health continued to deteriorate. She died at Glen Echo on April 12, 1912. Friends held a memorial service for her there, and a burial followed in Oxford, Massachusetts, her birthplace and childhood home.

**CLARA BARTON’S LEADERSHIP LEGACY**

Kouzes and Posner (2012) describe *inspiring a shared vision* as a two-part process. A leader first envisions a future for the organization that is both exciting and desirable. The leader must have confidence the envisioned future is attainable and that he or she has, or can develop, the skills to bring the vision to reality.

Clara Barton envisioned a future for the provision of immediate care for those in need, for victims of both military actions and natural disasters. This vision was forged through her battlefield experiences nursing sick and wounded soldiers during the Civil War. Her ability to provide aid quickly during these emergency situations aided thousands of people whose needs could not be met by the existing, poorly organized, government-sponsored mechanisms. These efforts also formed the framework for Barton’s lifelong work.

Jones (2013) asserts that Clara Barton’s work on the battlefields of the Civil War developed in her the sense of humanitarianism that would be a driving force for her efforts for the rest of her life. Her work was based on her firm belief that suffering must be relieved as soon as possible. Thus, she expressed human sentiment, or concern for the welfare of others, blended with a rational call to action.

The possession of a vision is not enough. A leader must have the confidence to believe that he or she has the skills necessary to move the vision forward. Since her childhood, Clara Barton had been described as rather
shy and lacking in social skills. Through her experiences on the lecture circuit, Barton was able to overcome the shyness that had haunted her during her earlier life. She was able to develop persuasive skills that would benefit her in her later activities. There is evidence, however, that her attempts to develop skills in persuasion sometimes worked to her detriment. At times, she embellished her accounts of her battlefield experiences, both to entertain her admirers and to enlist their financial support. She believed that support could best be engendered through the presentation of the events as both dreadful and in need of immediate attention, even if this involved a bit of exaggeration (Pryor, 1987).

In the second part of the process of *inspiring a shared vision*, the leader enlists others in the pursuit of the envisioned future. The process involves an ongoing dialogue with others in which the leader conveys an understanding of the hopes, aspirations, and values of others and presents the vision as one aimed at the common good.

Although Clara Barton had learned much from her colleagues and mentors on the International Red Cross Committee, upon her return to the United States she realized she would need to develop strategies that would appeal to the sentiments of her fellow citizens. To win acceptance, the idea of a Red Cross had to capture the imaginations of her fellow Americans. Because she realized that the memory of the U.S. Civil War was fading and that many Americans believed that the United States would never again be involved in a war, an idea of a Red Cross Society beyond that envisioned by Dunant would be necessary. Thus, the idea of provision of relief during “national calamities” would better speak to the concerns of the American public. Clara Barton wrote,

> Our Southern coasts are periodically visited by the scourge of yellow fever; the valleys of the Mississippi are subjected to destructive inundations. . . . to gather and dispense the profuse liberality of our people, without waste of time or material, requires the wisdom that comes of experiences and permanent organization. (C. Barton, 1878, pp. 7–8)

Her descriptions of the types of natural disasters that many Americans had actually experienced resonated with her audience and augmented her appeals for the support of a movement that would aid the “common good.”

Efforts to educate the American public about the value of a Red Cross Society also formed an important strategy in Barton’s attempts to enlist others in the pursuit of her envisioned future.

For example, Clara Barton authored a pamphlet, *The Red Cross of the Geneva Convention*, which presented the Red Cross as a national relief organization that would function during times of peace to “afford ready succor and assistance to sufferers in times of national widespread calamities, such
as plague, yellow fever, and the like, devastating fires or floods, rail disasters, [or] mining catastrophes” (C. Barton, 1878, pp. 5–6).

Attempts to educate the public were most successful when they also appealed to the emotions of the audience. An example was Clara Barton’s use of her personal contact with disaster victims to collect the stories of those who had been afflicted by the disaster. She then shared these experiences with the press. The example of the “Little Six” from Pennsylvania demonstrated her use of this strategy. Barton’s use of local newspapers and the education of her donors through the use of newspaper articles further aided in her efforts to enlist others in the pursuit of her vision.

When Clara Barton’s first attempts to secure congressional approval for the Treaty of Geneva were unsuccessful, she developed skills in lobbying members of Congress, the president of the United States, and members of his administration. These skills were also beneficial when Clara and her colleagues worked for congressional approval of a federal charter for the American Red Cross.

Perhaps Clara Barton’s greatest aid in her efforts to enlist others in the pursuit of her vision was her adherence to the advice given to her by Dr. Appia. Barton took steps to surround herself “with a little body of persons full of good-will and capacity, docile to [her] directions” (W. E. Barton, 1922, Vol. 2, p. 128). To her advisory board and staff, she appointed people of unwavering loyalty, including William Barton, her devoted nephew; J. Elwell, the nephew of her former romantic interest; and Dr. Hubbell, who had pledged to help her in the establishment of the American Red Cross and, at her request, to aid the cause by earning a medical degree. Many of her supporters had been drawn to Clara because of the appeal of her humanitarian mission. They were impressed with her treatment of all victims of disaster equally, regardless of race or ethnicity. One of her contemporaries stated, “Clara Barton had one pronounced failing; she was never able to resist a plea for assistance” (Bacon-Foster, 1918, p. 350). In fact, during the congressional investigation Clara Barton endured, one of her detractors stated, “Nobody would testify against her—not even all our friends and relations in New England” (Jones, 2013, p. 111).

In her attempts to inspire a shared vision, Clara Barton was often the recipient of criticism; some of it perhaps well deserved. Leaders in the developing profession of nursing were sometimes harsh in their comments. Educated professional nurses did not emerge until the 1870s, when the first hospital-based schools of nursing, based on the Nightingale model, were established in New York, Boston, New Haven, and Philadelphia. While Clara Barton was single-handedly delivering care to soldiers in the jungles of Cuba, in the manner that she had during the American Civil War, a new movement was under way. In response to the horrendous conditions military personnel encountered in Cuba, the army set criteria for the selection of nurses who would serve there. All nurses were required to be graduates of a school of
nursing and were required to furnish recommendations that addressed their health and character.

Leaders in the emerging profession of nursing had observed that Clara Barton was unwilling to work with government agencies that were organized to provide relief. For example, as late as 1864, when Barton was asked why she continued to work independently of the Sanitary Commission, she replied that she began her work before the Sanitary Commission was formed and had acquired so much skill in her work through practice that she might not be able to “work as efficiently” or “labor as happily” under the direction of those with less experience (W. E. Barton, Vol. 1, 1922). They had also experienced Barton’s unwillingness to work with the educated nurses who had been sent by Red Cross auxiliary agencies to aid in relief efforts for victims of the Johnstown Flood, the Florida yellow fever epidemic, the conflict in Cuba, and other disasters’ aid efforts in which she had participated.

Nurse leader Anna Maxwell, who in 1910 participated in the formation of the Army Nurse Corps, criticized Clara Barton stating,

She resented having others take up and carry on . . . what she as one human being could not accomplish. . . . Professional nursing did not receive from her proper recognition. . . . Consequently, she was not willing that women prominent in the nursing profession who volunteered their service should be allowed their opportunity. (Maxwell, 1923, p. 619)

Nurse leader, Lavinia Dock, in her book, A Short History of Nursing, criticized Clara Barton for her failure to “identify herself with the growing movement to reform nursing,” adding that Clara Barton was “rarely benevolent in spirit” (Dock, 1934, p. 150).

Psychiatrist and medical historian G. D. Evans (2003), in his analysis of Clara Barton’s leadership, offers praise for her energy, creativity, and courage. As a psychiatrist retrospectively viewing behaviors that she consistently displayed over the course of her life as well as her family history, Evans asserts that she probably was afflicted by manic-depressive illness. This diagnosis is consistent with her episodes of disabling fatigue, interspersed with episodes of boundless energy and creativity. Evans uses this diagnosis as a partial explanation for the weaknesses Clara Barton displayed rather than as a denigration of her accomplishments and leadership abilities. Evans cites Clara Barton’s greatest weakness as her “inability to manage a large number of people working toward a common goal” (Evans, 2003, p. 81). This opinion is similar to that held by other contemporaries.

Biographer Elizabeth Pryor (1987) also raised questions about mental health issues that may have plagued Clara Barton. She noted in particular the blind loyalty that Clara Barton demanded of her associates as well as her ruthless use of personal influence to achieve her goals. Historian Stephen Oates (1994) expressed concern about Clara Barton’s paranoid tendencies in
questioning the motives of those who criticized her work. A summary of these comments and criticisms indicates that Clara Barton had difficulty in the coordination of her efforts with those working toward a common goal. The key word in *inspiring a shared vision* seems to be “shared.” A leader must be willing to share with others the tasks required for continued progress toward the attainment of the vision.

Robert Giffin (2000), a past president of the American Red Cross, pointed out that at the time Clara Barton founded the American Red Cross, it was a rather small operation. He quickly added that, in his opinion, Clara Barton lacked any sense of organization, stating, “There were numerous Red Cross movements, but they paid no attention to Clara Barton,” (Giffin, 2000, p. 145). He further asserted that the Red Cross was able to grow only when Mabel Boardman, who succeeded Clara Barton in 1904, assumed control, stating that Boardman understood the importance of strong management and well-educated staff members. Anna Maxwell (1923) echoed these sentiments, stating that in Clara Barton’s later years, the financial responsibilities in the management of a growing association proved to be too much for one who had always been accustomed to acting alone.

These weaknesses should not, however, diminish Clara Barton’s leadership legacy. In fact, there is much to be learned by reflecting on her life and situation. Consider these:

- Clara Barton modeled a single-mindedness of purpose that is rare, yet required of leadership. She worked tirelessly, choosing to “go it alone” rather than being “side tracked” by the issues of other organizations/agendas. Clearly, while she may have been affected by the criticisms of others, she stayed the course. This demonstrates, again, her passionate commitment to humanitarian efforts. For example, was her refusal to commit energy to the formation of professional nursing intentional in order to husband her strength for her own mission? She demonstrated excellence in political strategy but made choices along the way. Good leaders must be careful stewards of their actions and energies.

- Our society strives to respect individual differences related to disability. This was certainly not the case in Ms. Barton’s lifetime. Yet, despite her struggles with mental disability, she formulated a leadership style and work ethic to achieve her goals. She leveraged her strengths to her advantage and produced successful outcomes of her interventions that could not be disputed. She would have benefited from our current emphasis on teamwork and team building, perhaps bringing together teams of individuals who could complement her weaknesses, thus avoiding her struggles with organization and finance in her later years.

- Consider the political expertise necessary for an individual to achieve an international sphere of influence such as Barton’s. Politics do not come naturally to nurses. This aspect of leadership is often overlooked. It is often ignored in leadership development programs and formal nursing
educational programs. Most often, it is an “acquired taste” achieved through mentorship. Political action requires insight, excellent interpersonal skills, the ability to read and interpret behavior, group dynamics, and risk taking. Clara Barton certainly possessed this skill set. She serves as an inspiration to those who aspire to this level of change and sustainability. What would it be like to sit at the knee of a master, such as Barton, and be regaled with her analysis on navigating bureaucracy to meet the needs of individuals? Her story gives us just an inkling of this great talent.

Clara Barton was a true humanitarian. She showed great courage and worked tirelessly for the cause to which she had devoted her life: to bring humanitarian aid to those in need. She was repeatedly described as a person who was patient, diplomatic, calm, persistent, independent, proud, and determined to accomplish her goals. In spite of her weaknesses, her life exemplifies a triumph of the human spirit—the ability to overcome obstacles in the achievement of one’s goals.

TIMELINE

- December 25, 1821—Clara Barton is born in North Oxford, Massachusetts, the youngest of the five children born to Stephen and Sarah Barton.
- May 1838—Secures first teaching position.
- 1850—Begins studies in the Clinton Liberal Institute in New York to further her education by studying writing and language.
- 1852—Founds a public school in Bordentown, New Jersey, which begins with six students, but enrollment soon grows to 600 students.
- 1854—Moves to Washington, DC, and secures a position as a clerk, one of the first women to hold a position with the U.S. government; she receives the same salary as the male clerks.
- 1856—Loses her position in the U.S. Patent Office because of a change in administration; returns to Massachusetts and resumes study of French and art with the hope of securing another teaching position.
- 1861—Returns to prior position in the U.S. Patent Office.
- April 1861—U.S. Civil War begins; the Massachusetts Sixth Regiment, while en route to Washington, is attacked by rebels while marching through Baltimore; among the wounded she recognizes many as her former neighbors, classmates, and students.
- August 1862–March 1865—Aids ill and wounded soldiers in the battles of Second Bull Run, Harpers Ferry, Antietam, Petersburg, Fredericksburg, and the Wilderness; earns the name “Angel of the Battlefield.”
- March 1865—Abraham Lincoln appoints her general correspondent for inquiries about soldiers listed as “missing”; establishes a Bureau of Correspondence for Friends of Paroled Prisoners.
• Summer 1865—Attempts to identify the remains of those Union soldiers who perished while held at the Confederate prison at Andersonville, Georgia; this leads to the establishment of one of the first national cemeteries in the United States.
• 1869—Upon the recommendation of physicians, travels to Geneva, Switzerland, for recovery from fatigue.
• 1870—Works with members of the International Red Cross during the Franco-Prussian War.
• 1873–1877—Returns to the United States; suffers an episode of overwhelming fatigue for which she seeks treatment at a sanatorium in Dansville, New York.
• May 2, 1881—Founder and president of the American Association of the Red Cross; organizes the first branch of the American Red Cross.
• 1882—Treaty of Geneva is ratified by the Congress of the United States; the American Red Cross is chartered by President Chester A. Arthur and joins the International Red Cross.
• August 1888—Aids in relief efforts for victims of a yellow fever epidemic in Jacksonville, Florida.
• 1889—Aids in relief efforts for victims of a devastating flood in Johnstown, Pennsylvania.
• 1893—Aids in relief efforts for victims of a hurricane that brought widespread destruction to the Sea Islands, Georgia, North Carolina, and South Carolina; engendered criticism for assistance provided to African American residents of the Sea Islands.
• 1895—Travels to Turkey to provide aid to survivors of the Armenian Massacre.
• 1898—Works in Cuba during the Spanish–American War; publishes the book, *The Red Cross: A History of this Remarkable International Movement in the Interest of Humanity*.
• 1899—Publishes the book, *The Red Cross in Peace and War*.
• 1900—Aids victims of a hurricane that destroyed Galveston, Texas.
• 1904—Publishes the book, *A Story of the Red Cross: Glimpses of Field Work*; resigns as president of the American Red Cross in the wake of allegations of incompetence, inability to deal with expansion of the association, and fiscal mismanagement.
• 1906—Establishes the National First Aid Association of America.
• 1907—Publishes the book, *The Story of My Childhood*.
• April 12, 1912—Clara Barton dies at her home in Glen Echo, Maryland; she is buried in the family plot in Oxford, Massachusetts.
• 1921—The Women’s National Missionary Association of the Universalist Church purchases Clara Barton’s birthplace home with support from the Legion of Loyal Women, the Clara Barton Memorial Association, and members of the Barton extended family; they open the Clara Barton Birthplace Museum.
• 1948—The U.S. Post Office issues a commemorative postage stamp honoring Clara Barton (see the beginning of this chapter).
• 1974—Clara Barton’s home, for the last 15 years of her life, in Glen Echo, Maryland, is established as the Clara Barton Historical Site by the National Park Service; it is the first National Park Service site dedicated to the accomplishments of a woman.
• 1995—The U.S. Post Office issues a second commemorative postage stamp honoring Clara Barton (see the beginning of this chapter).

QUESTIONS FOR DISCUSSION

1. Clara Barton’s exemplary leadership led to a change in international policy and the eventual U.S. ratification of the Geneva Convention. Her leadership impact as an activist agent of change is still important today because the Treaty of Geneva still prescribes rules of humane treatment in times of war. Further, she and her colleagues became the first in the international Red Cross movement to make disaster relief the central focus of its mission; an action referred to as the “American Amendment” to the Treaty of Geneva. List current international challenges related to health promotion and health maintenance, as well to nursing and health care delivery. How can today’s exemplary nurse leaders collaborate with others to inspire a shared vision and lead change in international policy in these areas of need?

2. In her youth, Clara Barton was often described as “shy,” “sensitive,” and even “difficult.” What approaches did she use to move beyond these traits and establish herself as an innovator and leader of the American Red Cross? How can aspiring nurse leaders use similar methods to develop the ability to inspire others?

3. Clara Barton skillfully used the media (newspapers of the time) to share stories that demonstrated the value of the work of the Red Cross in relief efforts and inspired others to support her work. How can modern nurse leaders best make use of the media to engender support for nursing through sharing stories about nurses’ work and its effects?

4. Although Clara Barton supposedly traveled to Switzerland for rest, she soon became involved in efforts to relieve the suffering of French citizens who had been devastated by the Franco–Prussian War. To be effective in this situation, it was necessary for her to develop sensitivity to the culture of the French people. What mechanisms did Clara Barton use to develop the cultural sensitivity required for her work? Through her life’s work, what other groups did she encounter for whom culturally sensitive approaches were necessary? Describe situations in which a modern nurse leader is required to use culturally appropriate techniques.

5. Clara Barton had difficulty with delegation and might have benefitted from skills that team members could have provided. If Clara Barton had...
been better able to work collaboratively with others, as she embarked on the formation and expansion of the work of the American Red Cross, what skills might she have sought in members she hoped to recruit to strengthen her “team”? What skill sets did Clara Barton lack that would have enabled the American Red Cross to function more effectively in its relief efforts?

6. An “accident of history,” the American Civil War changed the life and vision of Clara Barton. For her entire adult life, she endeavored to inspire a shared vision of humane treatment of combatants in time of war. What are some of the national and international human rights challenges we face today and how can nurse leaders impact how they are addressed?

7. Clara Barton’s international travels broadened her worldview and inspired her to collaborate with many others to address the health challenges of her day. Where have you traveled or where would you like to travel to see, firsthand, the health challenges confronting other people of the world? How might nurse leaders collaborate with others to meet these challenges? Who would be good partners to collaborate with in addressing these challenges and why?

8. Mentors were very important to Clara Barton in shaping and clarifying her vision. What mentors would you, or have you, identified who inspire and shape your vision of your preferred future of nursing, health care, and society? How have you, or will you, seek them out and pursue your vision of a preferred future?

9. As an exemplary nurse leader, Clara Barton modeled the way by tirelessly persevering in her pursuit of national and international change. How important are the characteristics of tenacity and perseverance in achieving a nurse leader’s vision?

REFERENCES


**FURTHER READING**


