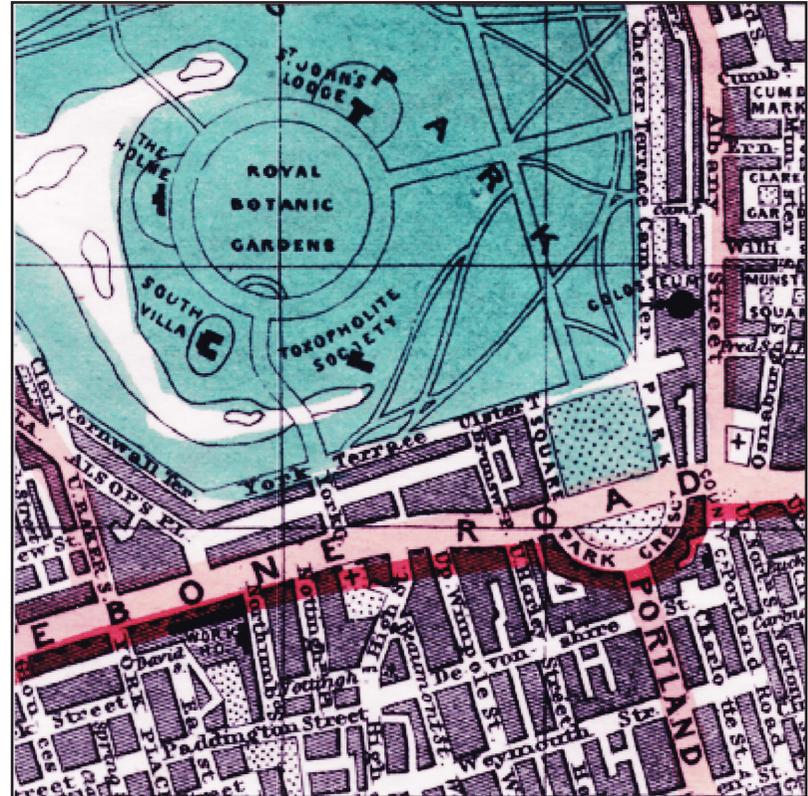


## Florence Nightingale's Sojourn at Middlesex Hospital. An experiment in historical narration

Establishment for Gentlewomen during Illness  
1 Upper Harley Street,  
the corner house at Weymouth Street  
St. Marylebone Parish, Greater London

Thursday afternoon, 31 August 1854



John would soon be knocking to say the cab was waiting. She sensed her irritation mounting, but she had no intention of rising to this bait. Eventually the Matron stopped kvetching.

After a few more moments, the Superintendent began speaking calmly to Mrs. Clarke. Everything is sorted. Lady Canning knows which patients will be ready for discharge after their two months in the institution and will present their names to the Committee when it meets on Fridays and Mondays. The Quarterly Report

is in the Committee's hands. They have been informed that you want to return to Yorkshire, so the search for a new Matron will be set in motion when summer holidays are over.

The three nurses have also been informed that they will receive daily instructions from the Matron for a fortnight or so. They should be able to manage the patients on their respective floors without assistance. The lift from the kitchen is working fine. Good that the boiler in the attic was repaired so that hot water is again available on

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each floor. Saves steps for the nurses and the under-housemaids. In case of medical emergencies, send for Mr. Bowman or Dr. Bence Jones.

There are no additions to the Matron's duties. Trips to Covent Garden for vegetables? The cook will do that. Under-housemaids, cook, and porter, household accounts and disbursement from petty cash remain under the Matron's direction, as always. Send a messenger if something unexpected occurs. The hospital is close by, less than a kilometer from the institute.

John Strachin begged their pardon for the interruption; the hansom had arrived. The Superintendent wasn't ready to leave quite yet. Have the cabbie take her traveling-bag to Middlesex Hospital and deposit it with the day porter. She'd walk.

The Superintendent spoke awhile longer with Mrs. Clarke, who resigned herself to the situation when her superior promised to drop by the institution on a regular basis. Noise from the dining room next door meant that supper was being prepared for the ambulatory patients. It was time to end the conversation so the Matron could supervise preparations.

When Mrs. Clarke was gone the Superintendent took stock of her room, set a few things to rights, closed the window, selected a white shawl from the coat-tree, and stepped into the ground floor foyer, locking the door behind her. Several strides brought her to the front door, then out of the house onto Upper Harley Street.

A warm afternoon. Won't need the shawl for long. Two quick left turns and she was east-bound on Weymouth Street.

She didn't look back.

\* \* \*

Mary Jarrow untied the string around the hospital's blue-gray folder containing papers about the young woman in the black silk dress sitting across from her. She gave her a quick glance: Seems very relaxed, self-absorbed even. No matter. This was no interview. Everything was already arranged. She opened the flap of folder and extracted the contents.

It was a thin file. Topmost lay a generic circular sent to all metropolitan hospitals at the end of 1853, requesting information about the organization of nursing services, spiritual instruction and lodging offered the nurses, and annual income of nurses at all levels of experience. Jarrow remembered it well. She unfolded a foolscap copy of the report prepared largely by herself, gave it a rapid scan, refolded it, and turned to the next item.

Jarrow carefully re-read a letter of reference in which hospital administrators were



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requested to send Miss Florence Nightingale the desired details and permit her to make personal inquiries thereafter. Hers was by no means an official or governmental investigation of private hospitals. The purpose is solely to collect data on the current state of nursing training and services which she will analyze in advance of preparing a report that may include recommendations for improved nursing care and education. Findings about individual hospitals will remain confidential; any policy recommendations will be made solely on the basis of aggregate data.

The letter underscored Miss Nightingale's qualifications to undertake such a study. It had taken her less than six months after appointment as Superintendent of the Establishment for Gentlewomen during Illness in Upper Harley Street to revamp the institution into a small private infirmary with a matron and small nursing staff who provide efficient and sanitary medical care. She had supervised the remodeling of new premises according to a rational plan of her own devising: a nursing station on each of the three floors; bells from each patient room to this station to alert the nurse when assistance was required; and two time-and-energy saving conveniences – a mechanical lift to convey meals to each floor, and hot-water outlets on each floor, gravity-fed by a boiler in the attic. Moreover, she held the nurses under her supervision to high standards. Her assumption is that each is a Sister in training.

Miss Nightingale had developed her no-

tions of effective nursing over many years. In 1847 she had undertaken a systematic study of Parliamentary Blue Books on public health, the two Reports of the Health of Towns Commission, as well as those by various sanitary commissions and annual reports from municipal hospitals throughout the United Kingdom and the Continent. Previous to her superintendence at Upper Harley Street, she had visited the Institution for Practical Training of Deaconesses at Kaiserswerth on the Rhine, written a pamphlet to introduce the Kaiserswerth model to English women interested in nursing, and spent several months there as a trainee herself. In addition, Miss Nightingale had made investigative visits to the major hospitals in Berlin and nearly every hospital in Paris, including the Salpêtrière and the one managed by the Sisters of Charity.

The letter concluded with a few biographical particulars of note: Born 12 May 1820 – that would make her 34 now; Father, William Edward Nightingale, gentleman, of Embley Park, Hampshire, and proprietor of the manor and lead mines at Lea Hurst, near Matlock, in Derbyshire; Mother, Fanny Nightingale, née Smith, daughter of William Smith, Member of Parliament for forty-six years; privately tutored in mathematics and the classics, mainly by her father.

Florence Nightingale sat patiently whilst the Matron re-familiarized herself with the person who had volunteered to substitute as a Sister to

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superintend nurses on one of the hospital wards. This Matron was thorough and conscientious – characteristically so, as Nightingale recalled from her investigations at Middlesex Hospital in the spring. She had memorized the Matron's personal particulars: born 1811 in St. Andrews, Scotland; service at Morningside Lunatic Asylum in Edinburgh before coming to London and the Middlesex.

Nightingale was there that afternoon only because she had decided to hedge her bets if an administrative job at King's College Hospital did not materialize to her liking. In June she had been thrilled when Mr. Bowman recommended her for the position of Matron/Superintendent of Nursing in that hospital's projected re-organization plans. Nightingale heard nothing until July, however, when she was asked to submit her conditions of employment. She minced no words: re-training of currently employed nurses, including spiritual instruction; a school to train novices; sleeping quarters for all nurses on their assigned wards; substantial meals for nurses on duty; and augmented salaries so her nurses would not have to keep body and soul together by taking in needlework or prostituting themselves. Then came dispiriting interviews with senior medical doctors and surgical misters; disgusting displays of jockeying for power interleaved with meaningless compliments about her Sanatorium for sick governesses; rifts and intrigue amongst these leading men of King's, some, like Mr. Bowman,

who wanted a nursing superintendent with teeth, others a business-as-usual matron with minimal ward responsibilities. But Bowman was only an assistant-surgeon. They simply didn't see that sub-standard nursing care would undo all the wonders they wrought in the surgical theatres and on the medical wards. Did they want King's to become like Barts – a horrific place to work if a nurse, a virtual death sentence if a patient, for all its storied past?

Nightingale had stiffened her spine. She was simply not going to compromise on a nurses training school. If King's won't promise at least that, another London hospital surely would at some point in the near future. Perhaps the Middlesex, which had scored the highest amongst English hospitals in her recent survey of nursing services. A few weeks as Head Ward Nurse would prove that pudding, one way or another. If Middlesex Hospital fell short of expectations, then Westminster Hospital or St. Thomas' were worth another look.

Nightingale was in no hurry. The notice she had sent the Ladies' Committee permitted her to remain at Upper Harley Street through January, if she so desired. Any longer was unthinkable. Truth be told, she had known her Sanatorium would fall short of expectations when the Ladies' Committee had dismissed her suggestion to relocate to the wing of a major hospital or the new hotel opposite Paddington station, where the patients would lie on bona fide wards. The

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house in Upper Harley Street they were now using had been a private residence, so patients were in single or double rooms. This situation was completely unsuitable for training Sisters since major hospitals were organized on a ward basis. Nightingale's contractual year was over. High time to move on to something that approximated here vision.

She didn't have to kowtow to anyone, ever again. An allowance of £500 per annum from her father made her an independent woman.



Female Medical Ward,  
Middlesex Hospital  
Charles and Berners Streets  
St. Marylebone Parish, Greater London

Thursday afternoon, 31 August 1854

He didn't recognize the sister accompanying the Matron. Another *locum tenens*, most likely. There'd be more of them; the silly-season lasted until the end of September, when all summer vacations would be over.

Matron made the introductions. Miss Nightingale, substituting as head ward nurse, met Alexander Stewart, M.D., Assistant-Physician to the hospital. He normally took late afternoon and evening rounds on the medical wards. Miss Nightingale would meet Dr. Hawkins, one of the

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hospital Physicians, in the morning. She would do as either bid.

Most of the dozen or so beds were occupied. Standing at the sister's station at the end of the ward, Stewart began a preliminary overview: hooping cough and scarlatina in several infants and young girls.

Nightingale nodded. She had observed childhood diseases among cottagers at her father's summer estate in Derbyshire and at the orphan asylum run by the Kaiserswerth Institute in Rhenish Prussia.

Advanced typhus, both the Irish fever and typhoid varieties.

She had seen this as well.

Two cases of choleraic diarrhea, three with well-marked cholera.

Nightingale puzzled the distinction.

Stewart took notice and came to the rescue. Based on collective experience with Asiatic cholera since the first London epidemic in 1832, this hospital's medical staff believes that ordinary diarrhea rarely progresses to full-blown, malignant cholera, even during the height of a major epidemic such as this one. Diarrhea is one of the body's natural responses to temporary disequilibrium of the constitution. The offending cause could be morbid cholera matter, of course. But it's more often due to other causes, such as eating meat that has gone off; intemperance; fear; or a host of constitutional indispositions that settle in

the alimentary canal. It's best not to over-react or over-treat. In most instances the body eliminates whatever is untoward and the natural equilibrium of the bodily economy is restored without outside intervention.

Of course, in epidemic times people assume, for good reason, at the earliest signs of diarrhea that they have come down with cholera. For diarrhea is frequently the first symptom of Asiatic cholera. They should seek competent medical advice. Hundreds of people have visited the hospital dispensary with complaints of diarrhea since the current cholera epidemic began the second week of July. Many receive emetics or cathartics designed to encourage the body's natural eliminative processes, and successfully so in most instances. Many more are exposed to the morbid matter of cholera than predisposed to suffer its ravages in full measure.

It must be acknowledged, however, that sometimes the drugs dispensed do not operate as hoped, or the administration of them at home was improper, or patients delayed too long in seeking medical advice, or the initial disequilibrium was too extreme to be managed on an out-patient basis. In such cases where the duration and severity of the diarrhea increases rather than abates, it is quite possible that the bodily economy is being pushed into cholera. Choleraic diarrhea is the hospital's term for an indeterminate condition that is worse than simple diarrhea

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but short of rice-water discharges, a definitive expression of Asiatic cholera. As a precautionary measure, patients presenting symptoms of choleraic diarrhea are admitted to hospital, as is anyone with indisputable cholera, rather than treated on an out-patient basis in the dispensary. During an epidemic, everyone is treated, regardless of station or means.

In normal times, what kinds of patients are admitted to this hospital?

Respectable artisans in Marylebone, and their families, who cannot be nursed at home and come to the dispensary with a letter of recommendation from a hospital subscriber or governor may be placed on a medical ward. In addition, this is the nearest hospital for many residents of St. James, Westminster south of Oxford Street; medical wards are available to them on the same terms. Admissions to the surgical wards depend entirely on circumstance and need during the immediate post-operative period; no letters are required unless patients wish to be transferred to a medical ward at a later point. Currently, the surgical wards are nearly empty since elective surgeries are postponed until early October when the fall medical school session commences and ward-walking students are available. A few students from the summer session are still about, and they are recruited to assist in the operating theatres for emergency surgeries. They are also kept in reserve for service on the medical wards if

there is a spike in cholera admissions.

Isn't that highly unlikely? The weekly reports from the Registrar-General's Office indicate that there is little cholera north of the Thames compared with low-lying districts to the south.

True enough. The five northern districts were little visited during the first phase of the epidemic last year and the same so far this summer. A similar pattern occurred in the two previous epidemics of 1832 and 1849. Fortuitously, the northern districts are situated at an elevation well above the high-tide mark of the Thames, so miasmatic emanations rarely reach the parishes served by Middlesex Hospital. But there are many other sources of putrefaction in this part of the metropolis than the River Thames. Stagnant water and marshes harbor miasmata, rotting flesh and excrement emit effluvial poisons, all of which disperse aerially with local variations in concentration related to shifting weather patterns, especially the wind. If inhaled, these morbid compounds disrupt blood physiology, circulate through the body, and cause fever. The precise manifestation depends on local contingent factors such as dosage, individual susceptibility, diet, habits, cleanliness, as well as each disease's epidemic constitution.

Epidemic constitution?

Particular seasons and atmospheric conditions are conducive to specific fevers, some of which take on an epidemic form. English cholera

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is often active every summer, occasionally lasting into early autumn; the meteorological excitors are still unknown. It finds synergistic partners in miasmata which, if inhaled, may result in a fever peculiar to that disease that eventually produces derangement of the stomach and bowels. Projectile vomiting or explosive purging is the earliest symptom. Signature characteristics of epidemic cholera are well established: pervasive, but outbreaks are locally limited by prevailing winds; when outbreaks do occur, they are seemingly instantaneous with the greatest number of victims in the first few days; and such outbreaks are not traceable to human contact. There is currently an epidemic of summer cholera in Marylebone and St. James, Westminster. It began the middle of July and has accelerated this month. Two to three hundred cases of diarrhea treated per week in the hospital dispensary. Usually not worrisome, but since there is concurrently Asiatic cholera in the metropolis, one must take seriously the possibility that an annual and medically unremarkable epidemic of summer cholera may take a malignant turn.

Is Asiatic cholera contagious?

Not as an ordinary contagion such as smallpox, which is spread by touch and fomites. But it may develop infectious properties within the bodies of cholera victims who inhabit confined and filthy rooms in sub-standard housing. There are many such fever nests north of the Thames,

where mostly impoverished laboring families live in unsanitary, overcrowded, and poorly ventilated rooms. Few in such circumstances can afford to call for a medical man when they develop diarrhea. Instead, they swallow an inexpensive binding medication such as arrowroot, which has the inadvertent consequence of impeding rather than assisting natural eliminative processes. Or they dose themselves with a proprietary cholera preventive, often with disastrous results. Add unwholesome diets to the mix, and it's inevitable that, under a propitious epidemic constitution when Asiatic cholera is about, some cases of diarrhea due to harmless summer cholera will be pushed into its severer form. Earlier today, an unemployed Irish farrier died in hospital of malignant cholera. Mr. Sibley, the hospital registrar, just visited the address given on admission, a dank mews in Ogle Street a few blocks from the hospital. The farrier lived with his family in unmitigated poverty in an over-crowded house next to a cow shed. He was in the collapse stage of cholera on admission, which means that if the cholera had become infectious within his body, the unventilated room in which he lay would be suffused with *virus*. Family members and visitors would now be at risk from cholera that had become contagious.

But he was admitted to a ward, where infection is also possible.

Theoretically, yes; practically, no. Mid-

## Florence Nightingale's Sojourn at Middlesex Hospital. An experiment in historical narration

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dlesex Hospital wards have high ceilings and many windows; the ventilation is excellent. Beds are kept far apart. Wards are kept scrupulously clean. Patients are bathed regularly, receive a wholesome diet and fresh, pure water. The density of *virus* particles required for infectious communication should not occur in these wards, and experience to date bears this out. Nineteen patients with cholera, roughly equal numbers of men and women, have been admitted to Middlesex Hospital since the third week of July. Most were already in a state of collapse when first seen by a medical man in the dispensary. Yet, nine of them recovered after constant attention and treatment. Sisters and nurses are well-fed and follow hygienic principles of cleanliness. So far, no hospital staff have been infected by vapors emanating from cholera patients who may have become contagious, despite close contact. Nor have any patients with other maladies housed in the same wards.

Some dispensaries in the metropolis, however, aren't as fortunate. There the slightly indisposed sit cheek by jowl with the very sick, often in dank waiting rooms little better than fever-nest housing. Infection is highly likely under such circumstances. A few days ago, Mr. Tilly, a surgeon at the Westminster General Dispensary, died of Asiatic cholera contracted in that institution or whilst visiting patients in St. Anne's rookeries.

The tenements south of Soho Square?

Yes. An outbreak of summer cholera began there ten days ago. Hundreds with diarrhea besieged the charity dispensary in Gerrard Street. Although most of them present simple, treatable diarrhea, the St. James Vestry has yet to initiate house-to-house visitation by medical men to insure that outbreak does not progress to malignant cholera. Mr. Tilly undertook home visitations, on his own volition and without remuneration from the vestry, and died from Asiatic cholera. So the infectious form is most assuredly present north of the Thames. Only time will tell if the mischief peters out for lack of fresh victims or finds a new source from which to spread to others.

**Florence Nightingale's Sojourn at Middlesex Hospital.**  
**An experiment in historical narration**

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Female Medical Ward,  
Middlesex Hospital

Late-morning, Friday 1 September 1854

The Sister from the neighboring medical ward approached Nightingale.

Had she heard the commotion next door?

Dr. Hawkins was discharging all but a few patients to make beds available for an unexpected influx of new admissions from the outpatient hall.

Why so many clanks and thumps?

Oh, some porters are bringing in metal tubs for washing the patients before we put them to bed, others are replenishing the woodpile by the fireplace for heating water.

Isn't that normally done in the hospital wash-houses?

Yes, but the staff there is overwhelmed. It seems that a severe visitation of cholera has occurred south of Oxford Street. Hospital protocol requires us to put all cholera patients in a warm

bath immediately after administering an emetic. When the vomiting ceases, patients generally feel chilled.

Will Dr. Hawkins be emptying this ward as well?

Perhaps. All depends on how quickly the surgical wards fill up. They were nearly empty because only emergency surgeries are performed until the medical students return in October. He's sent for Dr. Stewart and Dr. Seth Thompson to help in out-patients. One of them will come by before dinner-time with additional instructions.

\* \* \*

Early afternoon

Nightingale emptied the bowl of vomit into the metal pail under the bed. The mustard emetic had produced the expected results. She eased the exhausted woman into a large wash tub, fetched more warm water to raise the bath temperature, and washed her gently.

Nightingale let her soak for several minutes as she reviewed Dr. Stewart's case notes. The patient was a widow, 44 years old, residing at 8 St. Ann's Court, two blocks west of Soho Square. Her day had begun normally with an early arrival at her artificial flower-making shop in Marshall Street, St. James, Westminster; however, unspecific physical discomfort set in around

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mid-morning, superseded shortly before noon by mild diarrhoea. The patient immediately suspected she was in the premonitory stage of cholera since some customers had mentioned that a severe outbreak was underway in nearby Broad and Berwick Streets. She sent for a hansom cab, which conveyed her to the Outpatient Hall of Middlesex Hospital.

Hmm. Astute observation and sensible decision; might have saved her life. Wonder if she had experienced cholera last summer, or perhaps in '49?

Nightingale returned to the case notes. Whilst awaiting examination, the patient's diarrhoea became copious and she was admitted to a medical ward for monitoring and treatment. Nightingale picked up her chart and entered ticks by the first two treatment recommendations, quickly scanned the remainder, and then asked Margaret Gillis, one of the ward nurses, to help her remove the widow from the bath tub and dry her while she prepared the medicines. When Nightingale saw that nurse Gillis had the patient dried off, dressed in a hospital gown, and sitting on a bed, she gave her four grains of calomel pills with a glass of saline water. She lifted the woman's mid-section as the nurse placed a bedpan under her buttocks. Both caregivers then moved on to a new patient until the little blue pills of mercurous chloride had purged the flower-maker's bowels of choleraic poison.

\* \* \*

Late afternoon

Two nurses brought up two cholera victims, a young woman and a girl, both in the early stages of collapse. One nurse remained in the ward to treat the girl, the other nurse returned to Outpatients.

Case notes stated the woman, 30 years old, was the wife of a tailor from 41 Broad Street, St. James. Caregivers at home had thought she was recovering when vomiting and diarrhoea ceased, but transferred her to hospital when she stopped passing urine and her pulse became feeble and skin surface grew cold. Hospital protocol for this stage called for applying heat to restore normal body temperature whilst encouraging the patient to ingest and keep down fluids until blood viscosity decreased, signalled by the resumption of a strong pulse.

Nightingale and nurse Gillis quickly slipped off the patient's clothes, put her in a warm bath, and readied two hot water bottles. Then Nightingale spoon-fed her a warm, thin meat broth as she lay in the tub; she couldn't keep it down. Nightingale then gave her ice to suck, with initial success.

Suddenly the flower-maker began projectile vomiting. Nightingale shifted her attention to the neighboring bed and was able to capture

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a geyser of whitish liquid for examination: small, white albuminous flakes in a thin, turbid liquid. Then the patient's bowels evacuated in a torrent. The stool had the same rice-water appearance of the vomit but contained no bile -- signature symptoms of second-stage cholera.

Nightingale again responded in accordance with hospital protocols. The patient was given glasses of saline to replace lost electrolytes and several drops of laudanum, a tincture of opium, to moderate the effect of calomel administered previously. As the patient sipped liquids, Nightingale prepared the counter-irritant prescribed on the admission chart: a turpentine stupe. She folded a cotton cloth doused in warm turpentine into a small rectangle and placed it on the patient's lower abdomen. The skin turned warm and reddened as the blood was drawn to the surface by the medicated plaster.

Nightingale understood the rationale. Cholera was a blood-born disease, and the disease-causing poison must be redirected from the alimentary canal to the skin, from which it could harmlessly vaporize into the surrounding air. Harmless, that is, if the ventilation was good. Nightingale checked the windows in the ward; they were wide open. And the beds were far enough apart. Everything was in order. There was no danger of infectious communication in her ward.

She walked to the bed of the little girl

from Upper Rathbone Place, a few blocks south-east of the hospital, a gas-fitter's daughter brought in the same time as the Broad Street woman. Nightingale read the physician's case and treatment notes while the nurse from Outpatients finished bathing the cholera victim.

The clock in a nearby church belfry tolled twice.

\* \* \*

Evening

The woman from 41 Broad Street looked cadaverous.

Nightingale was astounded. She had left the woman's side less than an hour ago when her skin surface began to warm slightly in response to the application of hot water bottles. The patient seemed to be rallying.

Her appearance made a mockery of Nightingale's hopes. Emaciated, shrunken body with a bluish cast. Nightingale searched for a pulse but found none. Yet the woman was awake and rational, even smiled wanly at Nightingale, who wondered if she had misjudged her condition until a faint, husky request for water jolted her into reality again.

Nightingale asked a nurse to bring a fresh block of ice, from which she shaved several chips and placed a couple on the patient's tongue; it was cold and gray. She stroked her forehead,

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finding it cold and sweaty to the touch. Her countenance was corpse-like: sunken cheeks and eye-sockets, and bluish lips as cold as the tongue. Nightingale placed one of the woman's hands between both of her own; it was also cold. She lifted one of her own hands a mite and noted the blue fingernails eerily stand out against the white, corrugated skin on the remainder of the hand. Nightingale had been forewarned about terminal signs.

But what now appeared an inexorable demise could at least be made less uncomfortable if Nightingale applied a powerful rubefacient. She walked over to the stock of medicines sent to each ward from the hospital apothecary shop. She extracted a recipe card for *Cataplasma sinapis* and followed the directions for preparing a mustard plaster: equal parts mustard and linseed meal, to which she added drops of warm vinegar until the mixture became a flowing paste. She then poured the mixture unto a square of coarse fabric, folded it to the desired shape, placed it on the patient's abdomen, and waited until it exhibited the desired amount of redness.

\* \* \*

Time of death: 11:30; cause of death, "cholera maligna" (12 hours after commencement of fatal attack).

As Dr. Stewart completed the patient's

chart, Nightingale and a nurse finished washing the flower-maker's lifeless, emaciated body. The night porter, William Elliot, helped them lay it in the shell, a closed metal coffin-like box on wheels. Elliot then pushed the shell containing the remains of the artificial flower-maker out of the ward and towards the stairs down to the morgue.

Nightingale sat for a few minutes, collecting her thoughts. The night sky was clear, so the outside temperature was dropping, but not to the degree that windows couldn't remain fully open. Breezes out of the northeast freshened the air in the ward. The ward was dark except for a single gas burner.

The ward door opened and two nurses from Outpatients helped a young woman to a vacant bed. Nightingale undressed her whilst nurse prepared a warm bath. When they had her settled in the tub, Nightingale reviewed the case notes and admission chart. The patient was also an artificial flower-maker, twenty-four years old, married to a tailor and residing at 25 Great Titchfield Street, Marylebone. She began displaying symptoms of cholera at 11:00 p.m. whilst still working in Marshall Street, where she had been since early morning.

The address seemed familiar. Nightingale checked the other flower-maker's chart; both had fallen ill in Marshall Street.

Co-workers had brought the woman to Middlesex Hospital without delay. Dr. Stewart had

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admitted her immediately because she presented symptoms of choleraic diarrhoea, along with instructions that treatment should be limited to a warm bath and a mustard emetic until further notice.

Nightingale remembered their conversation from the previous afternoon. The appropriate treatment was to assist nature, not overwhelm the young woman's body and chance pushing what might be an ordinary case of diarrhoea into full-blown cholera.