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School of Social Sciences

'Neither curable nor incurable but actually dying':
The history of care at the Friedenheim/St. Columba's Hospital,
Home of Peace for the Dying (1885-1981)

by

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ABSTRACT

FACULTY OF SOCIAL AND HUMAN SCIENCES
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'NEITHER CURABLE NOR INCURABLE, BUT ACTUALLY DYING': THE HISTORY OF CARE AT THE FRIEDENHEIM/ST. COLUMBA'S HOSPITAL, HOME OF PEACE FOR THE DYING (1885-1981)

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This thesis fills a manifest gap in the history of end-of-life care in England through an exploration of the circumstances, position and importance of the Friedenheim, Home of Peace for the Dying (1885-1981), thought to be the first proto-hospice in this country. As yet virtually unexplored in published works, the nature of this hospital and the ethos of care provided there are demonstrated through evidence drawn from a multiplicity of sources, including archival records and personal testimony. By definitively establishing the chronological evolution of the institution, its locations and facilities, discrepancies in current lists and commentaries are clarified. Analysis of the nature, scope and influence of this hospital, which offered specialised care only for the terminally ill, illustrates and informs the emergence of specialised care for the dying in England.

The thesis tests the accepted primacy of the institution by an examination and comparison of coeval establishments for the sick and dying. The founder, Frances Davidson, sought to provide a place for the poor to die and the space thus provided for clinical, spiritual and social care is explored. The complexities of managing this philanthropic institution and sustaining its financial viability are exposed through consideration of its administration and evolution. Analysis of patient profiles, morbidity data and referral statistics furnishes insight into the evolving nature and place of the hospital within London's medical and philanthropic worlds. Details of the clinical, social and spiritual attention given to the patients reveal the breadth of care provided for them. Finally, the thesis discloses links with Cicely Saunders and challenges the received assumption that the Friedenheim, by now called St. Columba's Hospital, played no part in the establishment of the so-called 'modern' hospice movement.

The extensive and detailed results of this research confirm and justify for the first time the Friedenheim's accepted place as the London pioneer of dedicated institutional care for dying people and place it at the inception of specialised care in England for those at the end of life.

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ACADEMIC THESIS: DECLARATION OF AUTHORSHIP

I, Helen Isobel Broome, declare that this thesis and the work presented in it are my own and have been generated by me as the result of my own original research.

'Neither curable nor incurable but actually dying': The history of care at the Friedenheim/St. Columba's Hospital, Home of Peace for the Dying (1885-1981)

I confirm that:

- This work was done wholly while in candidature for a research degree at this University;
- No part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution;
- Where I have consulted the published work of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- None of this work has been published before submission.

Signed:

Date:

ACKNOWLEDGEMENTS

ABBREVIATIONS

Given the differing locations of the various source documents, an indication of the archive holding the material precedes each abbreviation where only one copy has been discovered.

HL	Holborn Library, London
KCL	King's College Archives, London
LMA	London Metropolitan Archives, London
SMHA	St. Mary's Hospital Archives, London
UoL	University of Lancaster
A/FWA/X/Y000/0	London Metropolitan Archives' alpha numeric references for the archives of the Family Welfare Association
A/KE/000(0)00	London Metropolitan Archives' alpha numeric references for the archives of the King's Fund
CLSAC/SCH/000X/00	Original reference for material once held at Camden Library, but now at Holborn Library
FSCAR/SR/YYYY:pp	Friedenheim/St. Columba's Annual Report/ Superintendents' Report/YEAR:page

FSCAR/MR/YYYY:pp   Friedenheim/St. Columba's Annual Report/

                          Medical Officer's Report/YEAR:page

SMHA/CF/nn   St. Mary's Hospital Archives/Correspondence

                          File/item number

SMHA/CM/VV:pp   St. Mary's Hospital Archives/Council

                          Minutes/VOLUME:page

SFTK   *Service for the King*; publication of the Mildmay

                          Mission Society, held at the Mildmay Mission

                          Hospital, London

UoL/SCF/RR   University of Lancaster/

                          St. Columba's/Friedenheim/ Material received

                          from the Rev. D. Rudall

SChH/SCH   Document concerning St. Columba's Hospital, in

                          the attic archives of St. Christopher's Hospice

CHAPTER 1 – INTRODUCTION AND LITERATURE REVIEW

1.1 Introduction

Society's evolving attitudes to the dying process and death itself have, in the Western world, been historically analysed and illustrated by, for example, Ariès (1975, 1977), Howarth (2007a), Jupp and Gittings (1999), Lewis (2007), Seale (2000), Vovelle (1993, 2000) and Walter (1994). In England, following a period[1] when, it was suggested, death was 'denied' (Ariès 1975, 1977, Walter 1991), there has, since the latter part of the twentieth century, been a resurgence of interest, discussion and research into the needs of dying individuals (Howarth 2007a, Kellehear 1984). This interest has been particularly evident among sociologists (Howarth 2007a, Kellehear 1984) and latterly, in England, also public administrators and politicians (DOH 2006, 2008, NCPC 2006a, 2007a, 2008a, 2008e). An upsurge in popular literary depictions of dying, called pathographies, such as those by Diamond (1998), Noll (1989), Picardie (1998) or Richardson (1997) (discussed by Armstrong-Coster 2001, 2005) is evidence of an increasing interest in dying and death within the general public and the media (for example BBC TV 2006, BBC Radio 4 2004, Driscoll 2009, Gledhill 2007, Howarth 2007a, Reid 2007, Tempany 2010, Wells 2009). Areas concomitant to death, such as grief, bereavement and burial are also being re-assessed within society, giving rise to a multiplicity of popular expressions of evolving social

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[1]This period dates from approximately the mid/late nineteenth to twentieth centuries, and varies by country (Ariès 1975:55-103).

customs such as the mass mourning of celebrities or victims of crime with spontaneous floral and toy offerings (Foltyn 2008, Merrin 1999, Walter 2005), the erection of roadside memorials for accident victims (Clark and Franzmann 2006, Collins and Rhine 2003), internet memorial sites such as www.ForeverMissed.com, www.lastingtribute.co.uk or www.muchloved.com and the growing interest in so-called natural, woodland burials (Clayden and Dixon 2007).

Although a natural process and event, the pains of dying and death, like giving birth,[2] may be assuaged with medical assistance (Lewis 2007, Stoddard 1978:9).Yet at a time when death itself is being redefined by the medical establishment (Glover 1977, Kastenbaum 2004a, Mason and McCall Smith 1991, Payne et al. 2004) and the new speciality of palliative care is being developed (GMC 2009a, 2009b, Watson et al. 2005), the place and role of that medical establishment within contemporary life and death are being questioned. Bio-ethics, informed consent and patient autonomy, particularly within the institutionalised setting of a hospital, are subjects of discussion and research as facets of post-modern identity (Clark 2002b, Conrad 1992, 2007, Foucault 1973, Illich 2001, Lupton 1997, 2003, Seale 2000, Turner 1992, 1995, Walter 1994).

Current management of individuals' dying trajectories owes much to the national and international success of the so-called 'modern' hospice movement, which has stimulated research among clinicians and sociologists into dying, death and grief. Encompassing in-patient, day- and home care, hospice programmes for those at the end of life seek to incorporate clinical excellence, exemplary nursing support and compassionate care which recognise the individual nature and needs of each patient. The first modern hospice, St. Christopher's, was opened in Sydenham in 1967 as an alternative to hospital for those close to death needing in-patient treatment. Its approach, developed,

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[2] This analogy has been adopted by practitioners styled Death Midwives (sometimes called Transition Guides) who support the terminally ill person throughout their dying trajectory. See, for example, [www.**deathmidwifery**.com](http://www.deathmidwifery.com) accessed 27.01.2010.

guided and implemented by Dr, later Dame, Cicely Saunders sought, within exemplary medical and psychosocial therapy and symptom control, to recognise the uniqueness of the individual in his or her dying trajectory. In addition, the hospice offered another option over place of death, and thus, it is suggested, particularly appealed to late modern society in Anglophone countries where the 'tendency to plan for and control major life events [is] …an important feature of self-identity' (Seale 2000:925; see also Lawton 2000:4-8, 12). The inception of what was to become the hospice movement came, therefore, at a time in society which was propitious for its development and in turn, the acceptance, visibility and growth of the movement itself then arguably became one of the causal factors in the continuing increase of professional, academic and lay interest in dying and death.

St. Christopher's was not, however, the only home which cared for the dying in or near London at the time of its opening. Previously, five Victorian or Edwardian institutions in the area had offered an institutional resource dedicated to those dying: the Friedenheim Hospital, later called St. Columba's; The Hostel of God;[3] St. Luke's House;[4] the Home of the Compassion of Jesus (closed in 1960); and St. Joseph's Hospice. Saunders was to acknowledge the contribution made by these early homes for the dying to her work (Saunders 2005b) but, citing Humphreys (2001), characterised them as not having had, 'much impact upon general care of dying people' (Saunders 2005b:xviii).

Indeed, the size and individual nature and operation of these homes precluded a large number of patients being treated, and little effort appears to have been made to disseminate either the principles or the specialised knowledge gained there. These homes are, however, of interest as examples of philanthropic undertakings which illuminate attitudes towards death and those dying, the role played by religion within care, and the constraints and opportunities involved in

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[3]Originally the (National)Free Home for the Dying (see Burdett' Yearbooks 1898-1910) and subsequently Trinity Hospice
[4] Later Hereford House

managing charitable institutions. Founded over sixty years before St. Christopher's opened, their records also demonstrate an evolution in care practice of interest to sociologists and even clinicians. In addition, the Friedenheim, which the literature generally suggests was the first of these homes, merits recognition as an example of one woman's pioneering achievements in the provision of accommodation for the dying poor.

The Friedenheim, later known as St. Columba's Hospital,[5] was founded in London in 1885 by a Scotswoman, Frances Mary Davidson (1840-1920), and existed there until 1981. For nearly one hundred years, it provided care for terminally ill individuals, remaining active throughout two world wars and serving many thousand individuals before its closure.[6] In spite of its apparently accepted place as the pioneer in England of institutional care for the dying however (Hospice History Programme,[7] Humphreys 1999, 2001, Lydon 1998, Murphy 1986, 1990, Saunders 1988, 2005b), little or nothing has been published about the Friedenheim/St. Columba's and this assumption has remained unsupported.

In an age of national and international interest in the subjects of dying and death therefore, the lack of accurate information or consideration of the work of the Friedenheim/St. Columba's is a significant omission in the historiography of care for the dying in England. The earlier, similar work of Jeanne Garnier in France and Mother Mary Aikenhead in Ireland has been documented and

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[5] Nomenclature proved to be a problem throughout the existence of the Friedenheim/St. Columba's and, indeed, this research. In this thesis, the institution cannot be termed a 'hospice', since that term's use specifically to denote an institution offering terminal care was coined only in 1967 by Saunders. Davidson initially called the institution a 'Home' but although continuing to refer to the institution as a 'home', officially adopted the more professional sounding, 'Hospital' in its title c. 1890 (UoL/StC/F/RR/1899). In accordance with Davidson's own and later practice, the Friedenheim/St. Columba's, along with the other proto-hospices, are referred to here as Hospitals, Homes or Institutions. The name change from 'Friedenheim' to' St. Columba's' in 1914 is discussed in Chapter 5.

[6] No exact patient numbers are available for the entire life of the hospital. Between 1885 and 1947, there were c. 7,500 admissions, although this number includes a number of re-admissions. No figures survive for the years after 1947.

[7] http://www.hospice-history.org.uk/byhospicename?id=0003&search=Friedenheim&page=0 (accessed 14.10.2006)

recognised (Anon 1999, Corr and Corr 1983, Kerr 1993, Kutscher et al. 1983, Saunders 1988, 1996a, 2005b, Siebold 1992, Stoddard 1978, Winslow and Clark 2005), but not only is the name of the Friedenheim's founder, Frances Mary Davidson, unknown, her work and that of her successors there and at St. Columba's Hospital is essentially unrecorded in the literature. As an original British expression of concern for terminally ill individuals which apparently owed nothing to other European initiatives,[8] the work of this, the first proto-hospice, merits investigation both for itself and for its contribution to the history of care for the dying. It is only by consideration of this first exponent in England of specialised institutional care for those who are terminally ill, that the full progression of practice in this country can become clear.

This thesis, therefore, is centred on the work of the Friedenheim/St. Columba's, and its evolution and place in the history of dying and death in England.

The chronological and administrative development of the hospital in its various locations from 1885 to 1981 had first to be definitively established through analysis of contemporary documents before research could be undertaken into the operation of the institution itself. Management and leadership issues, which arguably played a central role in the growth and subsequent decline of this independent institution, were then examined. The methods used to disseminate information about the hospital, and the recognition it received contributed to an understanding of its place within the general and medical communities.

Davidson sought to provide a place for her patients where:

> …all can be done to reduce pain, to comfort and soothe sorrow and
> anxiety, and most of all [provide] quiet, and opportunities of spiritual

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[8] Davidson is reported as saying, 'I had not known there was anything "of the same kind" as mine [i.e. a home for the dying] anywhere' (Butler A.R. 'My first visit to Friedenheim' c. 1903:17 UoL/St.C/F).

help to enable them to look forward without dread to what lies before them.[9]

The full nature of this organisation, therefore, could only be understood by investigating the substance of care[10] given there and the methods used by management and staff to cater for the needs of their dying patients. Characteristics of this patient body were examined to discover the nature of admission policies which included or excluded applicants to the home, as well as the type of support extended to them and their families.

The paucity of surviving records following the acquisition of the home by the National Health Service (NHS) in 1948 has meant a greater emphasis in this thesis on the years 1885-1947, although an overview is presented of the final years of the hospital, when its connections with Cicely Saunders were also explored.

The results of this research bring new information to our understanding of how the early proto-hospices operated, as well as their ethos of care. They complement earlier work in this field (Goldin 1981, Humphreys 1999, 2001 and Winslow and Clark 2005, 2006) but demonstrate that the omission of the Friedenheim/St. Columba's from the historical record has led to an incomplete view of this early history. Previous studies concentrated on homes founded by, or with strong links to, formal religious organisations, and revealed an underlying institutional religiosity which permeated staffing and the lives, care and deaths of patients there. The Friedenheim, however, had no such formal denominational ties and proposed a different, less institutionally religious approach to the dying process. Without chapel or permanent Chaplain, the

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[9] FSCAR/SR/1901:8 Note the ambiguity as it is not clear whether Davidson is referring to the dying process or a life after death.

[10] The concept of 'care' is, however, varied and difficult to define in detail. Following concept analysis, McCance et al. suggest there are four critical attributes involved in caring for the sick: 'serious attention', 'concern', 'providing for' and 'getting to know the patient' (McCance et al. 1997:247). See also Barker et al. (1995) and Crigger (1997) for further discussion of this theme.

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Friedenheim lacked a central, institutional religious focus, and, indeed, the staff held a variety of different confessional beliefs. The influence of any one established church or denomination was, therefore, dissipated.

Although care at the Friedenheim and later St. Columba's offered many and important opportunities for religious and spiritual consolation, the physicians were the only professional men intimately involved with the hospital management and patients on a daily basis. They are named individuals, whose personalities, through the reports they wrote for the hospital's Annual Reports, become clearly differentiated.[11] Arguably, their influence and power will have affected the approach to patients, particularly in the matter of pain relief which is discussed later (Chapter 8:193). This enhanced prominence of the medical profession, the ethos of patient care and the management characteristics of this idiosyncratic establishment mean that it cannot be subsumed within the examples of Victorian homes for the dying run by religious Sisterhoods or organisations.

Awareness of the operation of the Friedenheim/St. Columba's therefore adds to and modifies our knowledge of the history of institutional care for the dying in England and brings added depth to the study of the Victorian management of death. It suggests a more complex approach to nineteenth century institutional care of the dying is needed, which must necessarily include the efforts of individuals operating under the imperative of personal motives of faith as well as those of organised religious bodies.

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[11] See Chapter 8:186

1.2 Literature review

This review was both a starting point for research into the Friedenheim and situates results within the current historiography of institutional care for the dying during the nineteenth century and beyond. After noting the absence of any mention of the work of the proto-hospices within the general literature on institutional care in the nineteenth century, this section then focuses on material relating to the early homes for the dying and, in particular, the Friedenheim.

Hospitals in the Victorian era

Hospitals, particularly the long-established London teaching hospitals, held an influential place in medical life and their function and development has been comprehensively researched in the literature.[12] When the Friedenheim opened in 1885, the general medical establishment was undergoing unprecedented change (Cherry 1997, 1998, Granshaw 1990, Heasman 1964, Lomax 1996, Mooney et al. 1999, Poynter 1961, Prochaska 1992, Risse 1999, Rivett 1986), exemplified in extensive reorganisation of existing hospitals, an expansion in the number of specialist hospitals for specific conditions and the foundation of a multiplicity of privately-funded, smaller hospitals which were the result of personal initiatives.[13]

As a charitable institution intended to receive those of the dying who were without means or familial resources, the Friedenheim was classified as one of those small hospitals created as the result of private endeavour.[14] Its professional status was recognised by Burdett in *Burdett's Hospitals and*

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[12] In spite of being named 'Home' or 'House', the proto-hospices were classified as 'Hospitals' although at that time, the majority of hospitals played only a peripheral role in the care of the dying (see Chapter 3:61).

[13] Institutions for the care of 'incurables' and tubercular patients are examined in greater detail in Chapter 4.

[14] See above for the problems of nomenclature.

Charities: The Year Book of Philanthropy and Hospital Annual[15] which included it
and later institutions for the dying in the lists of London hospitals.[16] The 1894
edition of the *Year Book* even contains a major appreciation of the work of the
Friedenheim in an editorial with the heading: 'Chief Events and Progress in
1893: Homes[17] for the Dying' (Burdett 1894:lxx). This panegyric, which discusses
the value of the work of the Friedenheim and recommends it to the *Year Book*'s
readers, remains unrecorded in any evaluation of the work of either Burdett,
Victorian hospitals or proto-hospices in general (see below). There appears to
be no other recognition of the innovative nature of the early institutions for the
dying in the historiography of hospitals of the period.

Although it is documented that hospitals such as St. Bartholomew's, Guy's or St.
Thomas's either did not admit, or discharged, moribund patients (see, for
example, Abel-Smith 1964:37, Dingwall et al. 1988:1-2 or Rivett 1986:30),
hospital research and literature ignores the fate of these people. Cherry (1997,
1998), Granshaw (1990), Heasman (1964), Pinker (1966), Poynter (1961)
Prochaska (1992) and Rivett (1986) all fail to mention any of the homes or refer
to provisions made for dying patients. The new hospitals for the dying have
possibly been ignored because of the relatively small number of patients they
were able to accommodate in the overall picture of health care, or perhaps
simply because the unique nature of these establishments went unrecognised.

An organisation which played an influential role in London hospitals over this
period was The King's Fund or King Edward's Hospital Fund (previously called

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[15] This is the title used between 1920 and 1928. It changed slightly over the years but here the
volumes will simply be referred to as Burdett's *'Yearbooks'* followed by the year of publication.
[16] Originally classified under the heading 'Orphanages, Homes and Charities' (which included, for
example, a home of rest for horses), by 1898 Burdett classified the Friedenheim under 'Special
Hospitals: hospitals for the chronic and incurables' which, though recognising the professional
nature of the institution, failed to appreciate the specialised class of patient received there
(Burdett 1898:955).
[17] The second 'home', mentioned only in passing but which justified the plural noun, is the
Roman Catholic Hospital of St. John and Saint Elizabeth. The entry for this hospital makes it
clear, however, that the hospital was for patients with advanced or long-standing disease who
would not be required to leave when their condition became terminal (Burdett 1894:516). This
hospital still exists and now contains a dedicated unit for terminally ill patients, St. John's
Hospice, with 19 in-patient beds (www.stjohnshospice.org.uk accessed 12.06.09).

the Prince of Wales' Hospital Fund). This charitable body was established by the Prince of Wales in 1897 for the disbursement of funds to support voluntary hospitals in London. The history and evolution of this Fund are described in detail by Prochaska (1992) and to some extent by Rivett (1986).[18] Although the Fund supported the Friedenheim/St. Columba's financially up to 1956, neither work mentions this hospital or indeed any of the other proto-hospices, possibly reflecting the lack of importance accorded to these Homes by the Fund's contemporary committee.[19]

Important and original initiatives in medical institutions therefore remain unexplored in the literature of hospital developments in England. The declaration by Burdett that the Friedenheim was supplying accommodation for the dying, 'the right way' and the further statement that 'Other homes of the same kind are talked of and it would be a great thing to have a home of peace for the dying in every poor district of every large town' (Burdett 1894:lxx) have remained unnoticed and unreported in current and contemporary hospital and hospice literature.

Victorian and Edwardian homes for the dying

Philippe Ariès (1975, 1977) and later Michel Vovelle (1993, 2000) situate the Victorians' attitudes towards death in an international and temporally comparative context as part of their broad philosophical overview of society's

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[18] The Fund and its workings are of importance to the study of the Friedenheim for two reasons, one based in the 19th century and the other of current interest. Firstly, the granting of monies by the King's Fund to the Home validated its status as a serious charitable hospital in the eyes of the public and of potential benefactors. Secondly, before making any disbursement, it was the practice of the King's Fund to send official 'Visitors' to evaluate the hospital and report back to the Central Committee on all areas of operations. These reports, where extant, therefore constitute a valuable source of contemporary third-party material about the establishment.
[19] In any given year, for example, where the Friedenheim would be treating hundreds of patients, other beneficiaries of the King's Fund, such as Guy's Hospital or St. Bartholomew's would be treating thousands. For comparison purposes, in 1922 *The Times* reported that St. Columba's had received £200 compared with a donation of £4,400 to St. Thomas's Hospital (The Times 31.10.1922:7 Col. B). The Hostel of God received £80 and St. Luke's Hospital for Advanced Cases £125 in the same distribution.

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evolving approach to death. Specifically British attitudes towards dying and particularly death ritual in the Victorian era have been examined retrospectively in a number of texts, notably Curl (2004), Gittings (1988, 1999), Hurren and King (2005), Jalland (1996, 1999), Litten (1991), Morley (1971) and Strange (2002, 2003, 2005). These texts explore the ways in which death was perceived and marked by the Victorians, covering both ends of the social spectrum, from the very poor to the aristocracy. None, however, has considered the Victorian innovation of specialised institutional care specifically intended for the dying.

Within the more specialised literature on palliative care however, Goldin (1981), Humphreys (1999, 2001) and Winslow and Clark (2005, 2006) have authored studies which describe the Victorian and Edwardian homes, hospitals or hospices for the dying and are of particular importance as, unlike most other references to these proto-hospices in this literature, they are based on research in primary source material. Goldin, as well as Winslow and Clark have also emphasised the homes' links to the modern hospice movement and their influence on Saunders through her work at St. Luke's and St. Joseph's.

The most extensive comparative study is that of Humphreys, in her unpublished PhD thesis on Victorian and Edwardian homes for the dying, '*Undying Spirits': Religion, Medicine and Institutional Care of the Dying 1878-1938* (Humphreys 1999). Drawing on this thesis, in 2001 she published: '"Waiting for the last Summons": the establishment of the first hospices in England 1878-1914'.[20]

Humphreys argued that historiographies of Victorian death and philanthropy overlook both provisions for the care of the dying and the contributions of both men and women philanthropists to that area. In both thesis and journal article, she therefore explored two questions: the importance of the development of institutional care of the dying and the reasons behind the establishment of

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[20] To avoid confusion, it should be noted that the institution founded in 1878 to which Humphreys refers in the title was Our Lady's Hospice for the Dying in Harold's Cross, Dublin, Ireland.

these homes. Humphreys then went on to compare three of the early homes in greater detail: the Hostel of God, St. Luke's House and St. Joseph's Hospice. These three homes present counterparts to, and comparisons with, the Friedenheim as approximately coeval establishments providing similar services.

Underlying her argument for the importance of these establishments is the fact that these homes for the dying '…represented the beginnings of a recognition that dying might be regarded as a *process*… occurring over an identifiable period of time from the diagnosis of "dying" until the moment of death' (Humphreys 2001:150). This firmly established them in her eyes as the precursors of modern hospices even though they might be, '…highly individualistic, idiosyncratic and inward-looking' (Humphreys 2001:162), and that those who ran the homes '…made little attempt to disseminate their ideas' (Humphreys 2001:162).[21]

Humphreys further argued that, '…at the same time, the existence of homes that did not call themselves hospices tells us that the history of the care of the dying is not concomitant with the history of hospices' (Humphreys 2001: 162). She thus indicates that, in England, the concept of some type of institutional care which is specifically dedicated to the dying antedates the modern hospice movement by some eighty years.

The three homes described by Humphreys were founded, '…as part of the wider missionary efforts of their respective denominations and, more specifically, as part of the work of the particular religious organisation or order to which they were attached' (Humphreys 1999:50).

The early homes for the dying were for the 'deserving' poor and Humphreys used this observation as the basis for exploring both the philanthropic and medical background to these institutions. Humphreys made much of the fear

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[21] Although the evidence shows that Davidson did, in fact, hope to disseminate her ideas and create further homes similar to the Friedenheim (Anon 1887, Burdett 1894: lxx, Rundle Charles 1893:180), her attempts, too, were minimal.

and stigma attached to the workhouse and workhouse infirmary by all classes, supporting her conclusions with a wealth of references (Humphreys 2001:152-153). The dread of the workhouse and its infirmary were then linked and extended to include the disposal of the body and the ignominy of the pauper burial. Here, Humphreys' conclusions must be tempered, however, by the subsequent work by Hurren and King (2005) as well as Strange (2005), which demonstrated that nationally, workhouse practices towards the dying may not always have been as inhumane as those she described and also outlined here in Chapter 3.[22]

In spite of their common Christian heritage, Humphreys argued that '…differing denominational underpinnings played a large part in shaping the way in which they [the early hospices] were run and in determining the attitudes towards death and dying of those who worked in the homes' (Humphreys 2001:156). She further contended that '…death was subtly manipulated to help further the more pressing and ultimate objective, of saving souls, a goal which underlay virtually all religious-based institutional work during this period' (Humphreys 2001:162).

Humphreys' work lays a valuable foundation on which to build the individual histories of these various homes for the dying, locating their inception in the overall context of Victorian society, philanthropy, voluntarism, religion and medical practice.

She concentrated on the spiritual background of these homes however, and argued that the opening of the hospitals for the terminally ill was an extension of the missionary work of their parent organizations (Humphreys 1999:50). Providing a place to die was subsumed within the religious imperative of the

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[22] The notorious reputation and the perception of conditions prevailing inside workhouses however, both among the general public and those likely to enter them, was of importance to Davidson and her patients, even if it may not have reflected the reality of care in the totality of workhouses across the country.

various missions, High Anglican, Methodist or Roman Catholic, to save souls. Investigation into these spiritual aspects of the homes therefore led her to concentrate on, and describe the religious dimensions of care which were based on the confessional purposes and practices of the homes' founders. While legitimate for the homes she researched, this approach cannot, however, simply be assumed valid for the totality of the early proto-hospices. As the most wide-reaching and comprehensive study yet published, Humphreys' findings have shaped the existing views on early hospice care, and from them it might be inferred that all of the early homes were off-shoots of formal, religious organisations. This research will show, however, that other priorities existed in parallel at the Friedenheim, which was not a religious foundation and where medical and spiritual care held a different relationship to that explored in the other homes.

In 2005, Winslow and Clark published an appreciation of the work at St. Joseph's Hospice, Hackney, to commemorate the centenary of that organisation. This research was summarised and a methodology added for the subsequent publication of an academic journal article in 2006. The frequent use of photographs and in particular the oral or first-person testimony of staff and families are notable and bring a graphic directness to the text. With a very few exceptions (for example Armstrong-Coster 2004, Lawton 2000, Young and Cullen 1996), the voice of the person dying is rarely heard directly in any literature concerned with death. Failing that, the eyewitness accounts and testimony of disparate members of the care teams at St. Joseph's over a number of years are the more valuable and interesting. Much was made of the years spent in St. Joseph's by Saunders and the experience she gained there.

In contrast to the independent Friedenheim, this research made clear the underlying support of the Mother House in Dublin which permeates all aspects of the hospice's work as part of the broader mission of the Religious Sisters of Charity. This support provides spiritual guidance for the care undertaken at the hospice and also, more practically, was the source of a supply of nurses during

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the early years. Winslow and Clark's work remains the only in-depth study of any of the early 'hospices' and is particularly remarkable for the direct testimony of its many witnesses.

In 1981, Goldin published a paper on St. Luke's House which included an encomium on Saunders' work and a historical description of the background to then current hospice practice. Based on transcripts made by Saunders of the founder's reports, a Dr Barrett, Goldin then described in greater detail the foundation and to some extent the practice at St. Luke's, including photographs of buildings, publications, wards and personalities.

These key works throw light on the religiosity and histories of the proto-hospices described, and bring much informative data about the institutions and their operation. They clarify the history of palliative care in England and its influence on the modern hospice movement but contrast with the lack of any sustained research on the Friedenheim, the first of these homes. Their data enable and enrich comparison with the Friedenheim while highlighting the omission of research into this establishment which pre-dated them.

The Friedenheim

As implied above, the literature occasionally mentions the Friedenheim and suggests it was the first of the Victorian homes for the dying. Specific information about the institution is rare, however, and frequently contradictory.[23] In the light of the institution's potential place in the history of the terminal care in England, this information deserves scrutiny.

In 1915, the hospital privately published *St. Columba's Hospital or Home of Peace* by L.A. Streetly-Smith. This thirty-five page booklet described, in general

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[23] The discrepancies, inaccuracies and lack of original research in the literature were also noted by Humphreys (Humphreys 1999:10, 11).

and uncritical terms, the inception of the hospital, its move to Hampstead and the work carried out there. Intended as a promotional publication to stimulate donations, the booklet lacks any critical or analytical insight and dwells on the need for the services St. Columba's supplied, the sad circumstances of the patients it welcomed, and the hospital's extensive royal patronage. Written during the lifetime of the founder, it is, however, of interest for some historical details supplied.[24]

More recently, it would appear that Caroline Murphy's chapter entitled, 'From Friedenheim to hospice: a century of cancer hospitals' in Granshaw and Porter's *The Hospital in History* (1990:221) might be a source of information about the Friedenheim. This work was based on Murphy's 1986 PhD thesis, *A History of Radiotherapy to 1950: Cancer and Radiotherapy in Britain 1850-1950* (Murphy 1986). The title of the thesis gives an indication, however, that Murphy's main interests lay elsewhere than in the Friedenheim as a proto-hospice.[25] Her thesis revolved around the treatment of cancer, and she reported there on the evolution of curative radiotherapy over a hundred year period. The Friedenheim was incidental to that theme.

The source of some of Murphy's information on the Friedenheim has proved impossible to trace and appears to have been unreliable. Research by Humphreys, as well as that undertaken for this thesis, has revealed several errors in Murphy's primary material. Some of the general data appear to have

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[24] The accuracy of these details must be confirmed from other sources. See, for example, Rippin and Flemming 2006 or Schein 1983 about foundation myths and charismatic leaders within organisational cultures.
[25] Murphy is a scientist, with an MSc in animal breeding, who has carried out research on cytogenetics.

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come from annual *Reports of the Glasgow Cancer and Skin Institution*, particularly those for 1890 and 1891.[26]

Specifically regarding the Friedenheim, Murphy stated:

> The first British Friedenheim, named after Princess Alexandra, had been founded at Swiss Cottage, North London, in 1889. This 42-bed institution was "a home of peace for the dying"†. The term 'Friedenheim' (synonymous with the modern use of the French word 'hospice') was also used to describe a form of German TB institution in 1887, but the term has now fallen out of use‡.
>
> †Medical Directory 1889, London: Special Hospitals
> ‡ Friedenheim: German, literally 'home of peace'. Cf. Friedhof (literally 'peace yard'), current Germand [sic] usage for 'cemetery' (Murphy 1986:39-40).

In her 1990 work, she wrote that:

> Plans made by the cancer hospitals in the 1890s for the establishment of 'hospices' – freed from any religious connotations under the name of 'Friedenheims' – illustrate recognition of the particular needs of the dying, though in the event they came to nothing (Murphy 1990:221).

And later:

> The extra pressure that the increased use of radical surgery placed on the available beds was doubtless in some part responsible for the

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[26] This institution was run by Dr H. Murray, apparently a maverick physician who resisted and campaigned against any form of surgical treatment for cancer patients but who showed great compassion for the destitute and dying (Murphy 1986:34-43). In the 1980s, these reports were held at the Mitchell Library in Glasgow. Extensive but unsuccessful searches with the generous help of library staff leads, however, to the conclusion that they are now missing. Other potential sources in Scotland and the British Library have been approached for copies of these reports, but without success.

decision reached independently by the London, Manchester, and Glasgow cancer hospitals to establish 'Friedenheims'. A Friedenheim – a 'home of peace' for the dying – had been established for terminal TB patients in Germany in the 1880s (though the word never seems to have reached a German dictionary). The Medical Directory, however, shows that the first British Friedenheim, the Princess Alexandra's Friedenheim, was opened in Upper Avenue, Swiss Cottage (now the site of the Camden Local History Library) in 1889.*

*See Medical Directory 1894-1913 under London: Special Hospitals (Murphy 1990:227)

In spite of the fact that Murphy is one of the few authors to recognise the religious independence of the Friedenheim, inconsistencies with research results presented here imply unreliability in some other of Murphy's primary material. For example, documents contemporary to the Friedenheim which will be examined later (Chapter 5) show that the Friedenheim opened in 1885 (not 1889) in Mildmay Road, Islington only later (1892) moving to Upper Avenue, Swiss Cottage, where it was opened by HRH Princess Mary Adelaide, Duchess of Teck, not Princess Alexandra. Particularly unfortunate is the inference which might be drawn from her work that the Friedenheim was mainly associated with cancer patients. As will be shown, although the Friedenheim did focus on cancer patients from the 1930s onwards, originally it was intended primarily as a home for patients dying from tuberculosis, but which nevertheless welcomed terminal cases of whatever aetiology.[27]

The origin of the name 'Friedenheim' and its spurious German connection are discussed later (Chapter 5:110). It is unfortunate that an apparently major

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[27] This research has also failed to find the source of Murphy's assertion that the London, Manchester and Glasgow hospitals were planning to open 'Friedenheims.' One of her sources may possibly have been the *Glasgow Herald* of 26 February, 1897 which reported on the Annual General Meeting of the Glasgow Cancer Hospital and stated, 'The old hospital building was being overhauled with a view to its conversion into a Home of Peace for incurable patients, on the model of the "Friedenheim" of the Continent…' (Glasgow Herald 1897 Issue 49).

source of information which cites the Friedenheim in its title appears to have been based on some unreliable primary documents.[28] This misinformation can be traced through subsequent works and persists today. See for example, Lewis (2007:125) and Lydon (1998), discussed below.

Published by the European Association for the History of Medicine and Health Publications, Paul Lydon's *Catalogue of Records Retained by Hospices and Related Organisations in the UK and Republic of Ireland* contains a section on defunct hospices including the Friedenheim/St. Columba's (Lydon 1998:114-115). Although correcting the date of the hospital's foundation, Lydon appears to have relied mainly on Murphy's work for much of his explicative introduction and lists only the archive material to be found at St. Mary's Hospital, Paddington. The extensive reports available at the London Metropolitan Archives which form the bulk of surviving material concerning the Friedenheim/St. Columba's have been omitted. Archives now held by the International Observatory on End of Life Care (IOELC) were received only after the book's publication.

Humphreys (1999) provided a short, two-page summary of the work of the Friedenheim, drawing on five main primary sources dating from 1886 to 1915 (Humphreys 1999: 48-49) but did not explore its operation in any depth. In particular, she appears not to have accessed the Annual Reports which were produced or exist irregularly to 1900, but are then available annually to 1948.

The Friedenheim is cited on line by the Hospice History Programme. This Programme, begun in 1995 at the University of Sheffield, aims to foster academic study in the history of hospices. Its web site[29] includes a brief history of known hospices and pays tribute to the experimental and pioneering nature

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[28] Murphy, now Dr Rutter, was contacted but was unable to recall at this distance in time the source of her information.

[29] http://www.hospice-history.org.uk/byhospicename?id=0003&serach=Friedenheim&page=0 (accessed 14.10.2006)

of the Friedenheim. The home's first move in 1892 to Upper Avenue Road, Hampstead is catalogued, where it actually offered between 40 and 48 beds (Burdett, Friedenheim Annual Reports), not the 35 stated on the web site. The final move to Spaniard's Road, Hampstead which took place in 1957, more than twenty years before its closure, is not mentioned. The source for the assertion that the hospital rested, 'on a solid Anglican basis' would have been useful since the home was started by a Scottish Evangelical and the Medical Officers were Baptist, Methodist and, possibly, nominally Anglican.[30]

One other published work of original research refers to the Friedenheim, but in the context of local history: *'Hampstead Public Services', A History of the County of Middlesex: Volume 9,* 1989 Baker, T.F.T. (ed).[31] The section on Paddington and Hampstead[32] gives a succinct (13 line) history of the hospital from 1885 to 1981 drawn largely from King Edward's Fund archives and the Hospital Year Books (1947 and later editions) (Baker 1989: 138-145). A further section in Volume 9 on North End, Littleworth, and Spaniard's End (Baker1989: 60-63 and 66-71)[33] is concerned with the history of the house later occupied by St. Columba's Hospital, as it was by then named, to which the Friedenheim had moved in 1957. The source material included press references from the 1980s.

Cicely Saunders and the proto-hospices

Saunders authored some two hundred publications covering the clinical, nursing, philosophical, psychological and spiritual care of the dying. In several of these, she described her relationship with the early homes for the dying and their influence on the development of her ideas (Saunders 1987, 1988, 1993,

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[30] During the period 1892-1947, the Friedenheim/St. Columba's had only three medical directors (see Chapter 8). Unlike the first two, the religious allegiances (if any) of the third, Norman Sprott, are not clear. Mrs Rudall (see Chapter 2:38) remembers him as a 'nominal Christian' (conversation 24.09.2009). His burial service was carried out by an Anglican clergyman (Jersey Record Office, St. Helier).

[31] Available on line at http://www.british-history.ac.uk/report (accessed 31.07.2006)

[32] Available on line at http://www.british-history.ac.uk/report.asp?compid=22649 (accessed 31.07.2006)

[33] Available on line at http://www.british-history.ac.uk/report.asp?compid=22641 (accessed 31.07.2006)

1996a, 1996b, 2000, 2001a). Her biographers have also addressed this theme (du Boulay 1984, Clark 1998, 2001a, 2001b), as have those writing about the history of the hospice movement (for example Kutscher et al. 1983, Stoddard 1978 and see above). The practical and theoretical insights she gained from her connections with the proto-hospices were complemented by a limited body of early medical literature on the care of the dying.[34] With the exception of Sprott's paper 'Dying of cancer' (1949, see Chapter 8:197 and Appendix C), however, she rarely mentioned St. Columba's or its staff by name, therefore raising the question of her involvement, if any, with this hospital. Some sort of relationship between Saunders and senior staff at St. Columba's did exist, however, and the nature and details of this are explored in Chapter 10.

Summary

Institutional care of terminal patients as practised in the five Victorian and Edwardian homes for the dying is not mentioned in studies of Victorian hospitals or works devoted entirely to the study of Victorian death, dying and mortuary practice such as Jalland (1996, 1999). Three of the five homes: the Hostel of God, St. Luke's House and St. Joseph's Hospice, have been described by Goldin (1981), Humphreys (1999, 2001) or Winslow and Clark (2005, 2006). Of the Friedenheim, the first, experimental home and for some years the largest, little accurate and no analytical work is available.

One of the questions which arises out of the review of the literature is the reason for the omission of the Friedenheim from the history of the care of the terminally ill. At a practical level, Humphreys implied that little primary research material is available (Humphreys 2001:150). Admittedly, fewer documents have survived than in the case of St. Joseph's for example, but the Annual Reports

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[34] For example, Saunders specifically mentions Abrams et al. (1945, in Saunders 2001b, 2005b), Glyn Hughes (1960, in Saunders 2001a, 2005b), Hinton (1963, in Saunders 2001a, 2005b), Horder (1948, in Saunders 2005b), Kübler Ross (1975 and 2003, first published 1969, in Saunders 2005b), the Marie Curie Memorial (1952, in Saunders 2001a, 2005b), Parkes (1996, first published in 1975 in Saunders 2005b), Snow (1890, in Saunders 2005b), Sprott (1949 in Saunders 1958) and Worcester (1940, first published 1935 in Saunders 1987, 1992a, 1993).

and Council Minute Books, as well as documents associated with the King's Fund and the Charity Organisation Society (COS) have been in public hands for many years. These documents are complemented by material which came into the possession of the IOELC in 2002. More relevant, perhaps, is that much of the earlier work has been driven, directly or indirectly, by its connection with Cicely Saunders and the modern hospice movement rather than by examination of the institutions as such. Categorised as a 'defunct' hospice and with no ostensible connection with Saunders other than in passing and generalised references, there appeared perhaps to be little reason to investigate the Friedenheim.

The absence of accurate, detailed information about the Friedenheim/St. Columba's is highlighted in this review, in spite of the fact that this institution merits attention on several counts. Knowledge of this institution extends our understanding of Victorian institutions and results add to the body of work on health practices at that time. More importantly, however, this research also expands our perceptions of the early proto-hospices, the care offered to those dying there and the role played by religion in that care. The examples of early institutions described by Humphreys were all extensions of missions to the poor and operated under a formal, religious imperative. The Friedenheim was, however, a lay organisation, where the faith of the staff found a different expression to that in the homes managed and administered by an established religious denomination. In the Friedenheim, spirituality and religious conversion played a less active role in patient care, potentially leading, already in the early days, to the enhanced importance of medical staff. The research results described here therefore contribute to a more complete picture of the nature of early institutional provision for those dying.

Thesis structure

Current published material about the Friedenheim/St. Columba's and its founder is incomplete, inconsistent and confused. This thesis, therefore,

clarifies the institution's position within the history of care for the dying in England and goes some way towards describing its founder and her long-lasting influence on the home. It demonstrates the innovative nature and purpose of the home when contrasted with other available institutional provision for the dying and reconstructs elements of the care offered. Findings reveal that in spite of the personal faith of the founder and her successors, there are key differences between the Friedenheim/St. Columba's and coeval institutions which were part of, and managed by religious organisations.

Chapters 1 and 2, having introduced the themes which will be discussed, broadly situate the study within the historiography of early institutional care of the dying and describe the methodologies used in this research.

Chapters 3 and 4 explore the institutional options for the dying before the opening of the Friedenheim and then examine the previously undocumented life of the founder, Frances Davidson. Currently, there are inconsistencies in the little published information about the hospital's locations and facilities which are therefore resolved in Chapter 5. Management and leadership issues are explored in Chapter 6, as well as the ways in which the institution promoted its services.

Annual Reports have been discovered covering the years to 1947, as well as other documents including minute books, notes, photographs and reports. These are examined in Chapters 7, 8 and 9 and provide details, not only of the patients, but also of the care afforded the dying, the dead and the bereaved through the doctors, nurses and other staff.

The final years of the hospital are examined in Chapter 10, together with the hospital's links with Cicely Saunders. Finally, in Chapter 11, conclusions are drawn from the preceding chapters and indicate areas of future research.

The following chapter reviews the methods used to discover and interrogate the material which provided this information.

CHAPTER 2 - METHODOLOGY AND SOURCE MATERIAL

A personal note

My particular interest in the Friedenheim arose while I was researching the theoretical and academic background to my practical experience as a hospice volunteer worker. This voluntary work covered various positions and has extended over seventeen years in hospices in the USA and the UK. The years working at a large, community-based hospice near Chicago were particularly wide-ranging and informative. There, as well as being involved with strategic decisions at Board level, quality control issues, authoring articles for the Annual Reports and volunteer training, I worked directly with the bereaved, particularly bereaved children, and was closely involved with the dying, their families and the staff who cared for them. This work has continued in an in-patient facility in the UK, and thus my involvement in end-of-life care has covered many of the currently available types of hospice care. This practical experience has therefore inevitably contributed to my personal interpretation of what constitutes a 'good death' for patient, family and staff as well as my understanding of hospice work in general.

Personal observation and active involvement in hospice administration and the reality of the dying trajectory, death and grief has helped me understand and interpret the source material in a way which would, perhaps, have been less complete, had I not had this background. On the administrative side, for example, the US hospice depended to a large extent on charitable donations

and the accounts given by the Friedenheim's superintendents, the fund raising efforts and even Annual Reports demonstrated many unexpected similarities, tensions and concerns as the twenty-first century version in Chicago. I could, therefore, not only empathise, but also bring a direct and critical understanding of the issues to my analyses of the material.

Similarly, lengthy, sometimes daily, attendance at the bedsides of the dying has given me direct knowledge of the practical needs of those in their final days and hours, as well as their soon to be bereaved families, friends and the professional staff caring for them. Many of these needs are universal and transcend time and culture, therefore my understanding of the, frequently pragmatic, issues concerned has enhanced and informed my comprehension of material written over a hundred years ago.

2.1 Methodological challenges

The nature of this enquiry into the Friedenheim/St. Columba's has included techniques commonly used in both historical and sociological research such as archival research and live interviews with those who had direct knowledge of the hospital. Indeed, Van Maanen et al. have argued for the value of such a cross-disciplinary approach in understanding institutional processes and the emergence of particular social practices (Van Maanen et al. 1993:v). This is particularly relevant as the Friedenheim is held to be the earliest example of specialised, institutional care for terminally ill individuals in England and thus represents one of the first steps in recognising the dying as a social group with specific needs.

The Friedenheim, by then called St. Columba's Hospital[1] and managed by the National Health Service (NHS) through St. Mary's Hospital, Paddington, closed in 1981. Very few documents were retained by St. Mary's following its closure[2] and there was thus no obvious body or organisation where I could initiate my research. My first task was to discover what, if any, material had survived the hospital's closure and where it could be found. Research results would depend on the accessibility, scope, quantity and quality of these documents.[3]

It became clear that the majority of available material antedated 1947 and the absorption of the hospital within the NHS. Though limited in certain ways, it nevertheless provided sufficient value, volume and details to permit several strands of information to be followed throughout the years 1885-1947. Some information about the hospital from the years following its takeover by the NHS has also survived, as well as indications of connections with Cicely Saunders.

As background to the documentary evidence, I hoped to talk to people who had known the hospital in an occupational capacity before its closure, particularly from the Swiss Cottage days.[4] The important ethical issues normally surrounding research with dying patients and their relatives were, in this case, less relevant due to the professional nature of their contact with St. Columba's. However, as some of those who had known the hospital might potentially be vulnerable due to their age, I had to take care in my approach. One in particular, I learned, had been at St. Columba's at a particularly difficult time of her life. My introduction to her and our subsequent interview had to be handled with as

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[1] The German-sounding name, Friedenheim, was changed to St. Columba's Hospital at the beginning of the First World War in 1914. See Chapter 5:109
[2] Personal communication from Kevin Brown, Archivist, St. Mary's Hospital, Paddington
[3] I knew, for example, that Winslow and Clark (2005:2) had been able to draw on extensive archival material kept in London and at the mother house of the Sisters of Charity in Dublin for their history of St. Joseph's Hospice. I feared (and was proved correct) that such prolific material would not be available for a defunct institution such as the Friedenheim.
[4] I had originally thought to discover and interview surviving relatives of St. Columba's last patients, but the historical material proved so rich and the nature of the hospital so changed during the NHS years that this plan was abandoned. It remains an area which could potentially be explored.

much sensitivity as possible, including a willingness on my part to desist at any stage – even before our meeting – should circumstances so indicate.

The other early homes for the dying had, I knew, been founded by religious organisations, in one case under the auspices of a medical man, Dr Howard Barrett[5] and I felt it desirable to situate the Friedenheim's founder, Frances Davidson and her institution in this context. I discovered some of Davidson's surviving relatives, although firm information about, or documents concerning their ancestor were severely limited at this distance in time.

This chapter describes my successful and sometimes unsuccessful strategies to discover this dispersed, incomplete and frequently elusive material as well as how I analysed and presented it. Triangulation of the information to create a more rounded picture was rarely possible, but results were of a sufficient volume and consistency to permit the elaboration of a sustained argument about the location, care and ethos pervading the institution.

2.2 Locating sources

Previously published references to the Friedenheim/St. Columba's (see Chapter 1) gave me an indication of the sources used by their authors. At first sight it did not appear, however, that this material alone would provide an adequate foundation for an in-depth analysis of the institution and I hoped to find further original material. This was achieved through the use of information technology, the discovery of as-yet unexplored archive material as well as re-examination of the old, and the personal testimony of a few live witnesses, some of whom had known St. Columba's at the Swiss Cottage location. Ultimately, materials

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[5] Goldin makes it clear that St. Luke's House was an offshoot of the West London Mission, a nondenominational organisation, although attached to the Methodist Church. Dr Barrett was responsible for the suggestion to found the hospital 'as a branch of the mission' (Goldin 1981:403).

concerning the subjects of this research were found variously in the archives of the Hampshire Records Office, the Holborn Library, the International Observatory on End of Life Care at the University of Lancaster, King's College Archives, London, the London Metropolitan Archives, the Mildmay Mission Hospital, the Royal London Hospital and St. Mary's Hospital Archives, Paddington. Contemporary newspaper and journal articles, as well as census data also provided information and background. Searches at the Mitchell Library in Glasgow and the archives of the Knights of St. John of Jerusalem in London failed to provide any relevant material.

Research in archives

Valid materials appropriate for archival research can vary from the concrete, such as houses or gravestones,[6] to the ephemeral, such as electronic communication, as well as the more usual document. 'Document' is not coterminous with 'text' and the expression includes plans, diagrams, photographs or other visual elements. Among textual records, a further distinction can be drawn between those intended for general publication (loosely 'professional') and those intended by the writer for limited or no distribution, such as letters or diaries (loosely 'personal') (Prior 2003, Scott 1990). Research for this thesis reflected this entire span of material from granite gravestones to ephemeral telephone conversations and from professional correspondence and reports to private photographs and diaries.

Although a London institution for its entire existence, I nevertheless found material relating to the Friedenheim all over the United Kingdom, from Aberdeen, Scotland to St. Helier, Jersey in the Channel Islands. An explanation for this geographical spread can be found in the work of Hill, who argues for the dispersal of archival material during three stages of what he terms

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[6] See, for example Thomson's comparison of vernacular tombstone lettering (Thomson 2006).

'sedimentary' depositions of archival documents, none of which is certain or systematic (Hill, 1993:9-13). The primary layer consists of consciously or unconsciously selected material, laid down by the individual or organisation which produces the document (Hill 1993:9). This is followed by the more uncertain, 'secondary sedimentation' phase after the death of an individual or the demise of an organisation, when future research materials are in the hands of relations, executors or successors who may have personal reasons for imposing further selection processes on this material. The third, or 'tertiary sedimentation' occurs when documents reach an archive and are accepted, rejected, culled or organised by the archivist (Hill 1993:8-20). Maintaining Hill's geological analogy, in the case of the Friedenheim/St. Columba's, a certain erosion of this sedimentation, peculiar to records from the time and place of this study, might also have occurred. This was a London institution, and the restrictions and bombing of the city during World War II took their toll on the use and survival of paper as well as other records.

It should be borne in mind that these 'sedimentation' processes may take place independently of each other and in different locations, such as the place of work and at home. The Friedenheim/St. Columba's papers were, from the outset, both in England and in Scotland. Those in England passed through the hands of several people who themselves lived in, and then retired to, different areas, retaining and destroying certain material. The geographical spread of the Friedenheim material is not, therefore, surprising.

In this context it is noticeable that most of the publicly held data I have drawn on come from secondary archival sources i.e. archives primarily formed around another organization. For example, I was able to consult the COS and King's Fund archives which include copies of reports and some letters to and about the Friedenheim. These texts were retained by virtue of their relevance to the work of respectively the COS or the King's Fund, not because of the Friedenheim/St. Columba's itself.

The contents of any archive, personal or public, depend on the actions of an archivist, and researching the Friedenheim has been hindered by the absence of any one person or organisation (such as the NHS) taking responsibility for preserving any, some, or all of the Friedenheim material. A wealth of potentially rich resources has therefore been lost and the survival of much of the primary data I used has been due to the unofficial actions of some interested individuals.

The existence of one box of documents pertaining to the Friedenheim and St. Columba's, for example, is entirely due to the foresight of two, non-professional 'archivists', Olive Howlett, sometime matron of St. Columba's and David Rudall, voluntary, part time chaplain there in the 1950s (see below). In recognition of their appreciation of the work carried out there, they saved those documents which contributed to the 'story' they wished to be told. These documents, which include the only surviving copies of 19th century Annual Reports issued by the Friedenheim together with other early published material, are now preserved in the International Observatory for End of Life Care (IOELC) at the University of Lancaster. By now, the majority of extant material traced is held in public collections where their safety is, hopefully, assured.[7]

Disappointingly few of Davidson's own writings, particularly private papers have been found. In the past, the papers of the privileged and powerful were more likely to be retained for future generations than those of the less influential (Cook 1997, Hill 1993, Prior 2003, Scott 1990). Davidson was a fairly wealthy member of the upper middle class and I therefore hoped that some, if not many papers would have survived. At least four factors may, however, account for the paucity of documentation.

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[7] I hope that the material which I have acquired in the course of this research can, at a later date, join one of these official collections.

Up to the mid-twentieth century, personal papers were, for the professional archivist, of secondary importance to the professional and therefore less likely to be retained (Cook 1997). Secondly, the founder of the home was a woman. Cook cited Gerda Lerner's work[8] which, '…convincingly [traces] from the Middle Ages to this century the systematic exclusion of women from society's memory tools and institutions, including archives' (Cook, 1997:18, see also Moss 2000:7). Archives mirror the community in which they were created and in family-centred Edwardian society, dominated by the *paterfamilias* or at least a man, it is perhaps not surprising that the 'good works' of an unmarried female were not deemed worthy of retention by the archivists or even family members of the period. Certainly, there are major exceptions to this generalisation,[9] but Davidson's activities in a geographically confined and possibly uncomfortable area of work did not gain the widespread contemporaneous recognition which might have ensured survival of a fuller archive of material.

Thirdly, the Davidson family was one which was prolific in 'good works' and Frances was one among several siblings whose work stretched beyond the confines of her local community.[10] At that time, it may have been felt that there was no particular reason to retain her letters or diaries. Finally, the Friedenheim/St. Columba's was a relatively small hospital, the importance of which went unrecognised by its contemporaries.

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[8] Cook does not cite a specific reference or work but may have been referring to Lerner's *Creation of Feminist Consciousness* (1993), particularly, I surmise, the Introduction and Chapters 11 and 12.

[9] See, for example, the extensive surviving papers of Octavia Hill on http://www.nationalarchives.gov.uk/a2a/results.aspx?tab=2&Page=1&ContainAllWords=Octavia+Hill (accessed 11.10.2008)

[10] Frances' sister Katharine (Katharine Helen 1845-1925) was one of the first three Deaconesses ordained by the Church of Scotland and was active in the care of Scottish fisher girls. Another sister, Williamina, (Williamina Saida Davidson, 1856-1939) founded several homes for soldiers and was awarded the O.B.E. for her, 'Work for the troops at Redford Barracks, Colinton' on 01.14.1920 (Supplement to the Edinburgh Gazette, 01.01.1920:919). Their brother George (George Louis Outram Davidson 1868-1939) was a founder member of the Royal Aeronautical Society and is credited with the invention of a flying machine already in 1898, see *www.leopardmag.co.uk/feats/5/those-magnificent-scots-and-their-flying-machine.*

Each archive, public or private, is individual and required a different approach, based on the stage of research. Most guides to archival research operate at a basic level, introducing researchers to the physical constraints and practicalities of archival research. Vela (2008) offered, for example, five lessons for the novice researcher, culled from her experience in 'unmined' archives. More specialised studies can be also be found, however, such as that of Spoo (Spoo 2001) on archival research and copyright, the academic implications of restricted access to archives (Panofsky and Moir 2005) or the role of 'special collections' in intellectual life (Schuchard 2002). Thereafter, however, it is the, '...scent of the slow hound and the snap of a bull-dog'[11] which permit a scholar to, '...find and identify significant manuscripts and editions amongst formidable piles of dross' (Moss 2000:7).

Due to the different types of holdings, created for a variety of organisations, and the evolution of my research, progress was rarely linear or even thematic. A pragmatic approach had to be developed, where each archive collection was mined, once or more frequently, for available information about the Friedenheim/St. Columba's. On at least two occasions, I even played the role of archivist by ensuring the safety of documents owned by the Rudall family (see below) which would otherwise have been destroyed.

In addition to the more usual types of documentary evidence in various archives, I also discovered an autobiographical novel which described the Davidson's family life in Scotland in the year 1868-1869. In spite of its apparently fictional nature, this nevertheless contains some very specific references to Frances Davidson's actions and motivation before she left for London and founded the Friedenheim. In view of the question of accuracy which must arise from any such work, it is examined in greater detail below (p 41).

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[11] Sir Walter Scott, *The Antiquary* (London 1902:28), cited in Moss 2000:7

Personal testimonies

Research for this thesis was not wholly restricted to archived material and I sought supplementary background information, particularly about the Swiss Cottage days, from five live witnesses: Doris Baker, James and Janet Davidson, Freda Rudall and Christine Kearney. Ethical permission was sought and granted[12] from the University's Ethics Review Committee before talking to them and my approach was adapted to each case. Early on in each conversation, the interviewee was requested to countersign a letter outlining his/her understanding of the research purpose, the reason for the meeting and his/her agreement to the conversation and subsequent use of material gathered. Afterwards, they were offered a transcript of my notes, with the invitation to check these for accuracy and amend them if desired. The respondents, and in one case her family, were also offered copies of as much or as little of the final thesis as they desired.

Through a recent (2005) letter to Saunders from the Rev. Rudall held at the IOELC[13] and subsequent introductions, I was able to identify and meet two people with first-hand memories of St. Columba's. I approached them through a third party (family member or friend), followed by a letter, and then phone call explaining in greater detail the purpose and scope of the research project. If they agreed to meet, and as these interviewees were elderly, I suggested a neutral venue of their choice, such as a tea-room, with, if desired, the presence of a friend.

Our interviews could best be described as unstructured conversations designed to elicit memories of the hospital and encourage reminiscence. Intended only to provide preliminary background information, they in fact, provided more physical evidence of the work at the Friedenheim/St. Columba's. Mrs Rudall

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[12] Reference number: RGO REF 5414 SOC20067-21
[13] I am indebted to Professor David Clark, then at the IOELC for allowing me to research their archives.

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(see below) kindly gave me a photograph album, a book of newspaper cuttings, annual reports and copies of some relevant correspondence. Miss Baker drew a floor plan of the Avenue Road location as she knew it in the 1950s. The question of anonymity within this thesis did not arise as these, and the other interlocutors were happy to be identified; their identity and circumstances forming an integral part of their testimony.[14]

Both Mrs Rudall and Miss Baker expressed great pleasure, not only in 'telling the story' of St. Columba's as they knew it but also in the thought that the story of this hospital, which they felt had provided such a valuable and necessary service, might reach a wider audience. Given their enjoyment and interest in our conversations, I felt absolved, therefore, in this instance of ethical concerns about the possible 'exploitation' of witnesses, as described in Plummer (2001) or Coles (1997). Although I could be perceived as having taken 'ownership' of their stories (Plummer 2001:216-218), they edited my notes of our meeting and have been given full, public acknowledgement of their contribution.

Similar precautions were taken before meeting James and Janet Davidson as well as Christine Kearney.

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[14]Although only expected to provide background information, as with any research conducted with live witnesses, I considered any potential effect on these individuals before approaching them, particularly on Mrs Rudall and Miss Baker, who might be perceived as vulnerable. We also considered the implications of publishing their names in this thesis (and in Mrs Rudall's case, that of her husband) and all agreed. The precedent in the Rudalls' case had, of course, been set by Saunders with Clark (Clark 2002a). James Davidson is a published author and Janet Davidson has created a web site publishing a transcription of her relative's diary.

2.3 Evaluating the evidence

Archival evidence

Together, the disparate archives contain a complete set of Annual Reports, dating from the late 1880s to 1947 as well as some promotional publications. Although varying slightly in content, the Reports all provided admission and discharge numbers as well as deaths, together with basic financial details in standard balance sheets. Aggregated details of diagnoses on admission were available for many years, as were patients' ages and occupations as well as, occasionally, the names of referring hospitals. Statistical data obtained from the Friedenheim/St. Columba's Annual Reports or other documents were neither of a volume nor a complexity, however, to warrant the use of sophisticated software programs. Data were entered on Excel™ spread sheets from which all tables and charts have been derived.[15]

Accompanying the figures in the Annual Reports are the Introductions and Medical Reports written by a succession of Superintendents, Chairmen and Medical Officers. Each reflects the personality of its author and the current concerns and successes of the institution which he or she wished to bring before its supporters.

The Annual Reports can be read in conjunction with the Minutes of the Executive Council written between 1901 and 1947. These are the less public concerns of those running the hospital and were, in many cases, more revealing of the reality behind the public face of the hospital presented in the Annual Reports.

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[15] I briefly considered using prosopographical analysis of either the patient or the nursing body. Although discrete populations could easily be identified, without either comprehensive probationer or nursing staff listings or any patient registers, there were insufficient data on which to found any sort of valid study.

Other major sources of information were generated outside the hospital, such as the various reports and letters originated by the King's Fund and the COS. These cover both the findings of their official Visitors, meant for the organisation's internal use, and also letters, mainly to the general public, about the probity and general value of the institution. A certain number of administrative memoranda, such as the one shown in Appendix A, are also retained within these files.

Articles in the local and national press, grouped primarily at the beginning and end of the twentieth century, also provided occasional glimpses into working methods of the hospital.

The Saunders archives, held variously at the IOELC in Lancaster and the King's College Archive in London, were an unexpected source of much interesting material which provided insights into Saunders' connections with St. Columba's.

Much, however, is missing. Financial data are scanty, reduced to the balance sheets published in the Annual Reports between 1900 and 1948 and summaries prepared for Burdett's *Yearbooks*, The King's Fund and the COS. Only nine years of the more detailed Finance Committee Minutes survive. Further, very few documents seem to have escaped destruction which can inform the final, post-NHS years of St. Columba's.[16]

The greatest silence, of course, is that of the patients themselves whose only testimony remains their words, reported through a third party and cited for promotional purposes. In considering the care given in the Friedenheim, the direct testimony of those concerned would have been invaluable but here, as

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[16] The Archivist at St. Mary's Hospital Paddington which oversaw St. Columba's and would be the source of surviving documents has assured me that nothing exists of the post-NHS years. (Personal communications from Kevin Brown, Archivist of St. Mary's Hospital, Paddington, January, 2007 and March, 2009) Searches at the LMA and the Wellcome Institute have also proved fruitless. A brief, two-page document was discovered in St. Christopher's archives and is discussed in Chapters 5 and 10.

with so much research into the treatment of terminally ill patients, I have largely been dependent on the selectively reported words and opinions of caregivers and family rather than the people directly concerned: the dying themselves.

Live witnesses

Freda Rudall

Much of the early Friedenheim/St. Columba's material at the IOELC came from the Rev. David Rudall and had been sent there by his eldest son, Colin Rudall, after his father's death. I made contact with Colin Rudall and it became clear that his mother, Freda Rudall, was willing to talk to me, although she felt that her direct knowledge of St. Columba's was very limited. I nevertheless met her as she was then the only person I was aware of (apart from Colin Rudall and his brothers who were then young children) with direct memories of the hospital.[17]

Mrs Rudall is the widow of the late Rev. David Rudall, who served as volunteer part-time chaplain to the hospital between 1952 and 1957. Her connection to the hospital is closer than this brief, indirect association might initially seem, as the then Matron, Olive Howlett, became a close family friend and confidante for the rest of her life.[18] Miss Howlett joined the hospital in 1932, retiring as Matron in 1958. She saved many of the early papers concerning the Friedenheim from destruction and, on her retirement, passed these papers on to Mr. Rudall for safe keeping. At one time, he contemplated writing a history of the institution, part of which still exists.[19] Saunders wrote to him in 1964 saying, 'I am anxious to learn what I can of the history of St. Columba's', but no reply was recorded in the published volume of her letters (Clark 2002a:65-66).

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[17] Interestingly, it later transpired that the Rev. and Mrs Rudall had, in the context of their connections with St. Columba's, also met Cicely Saunders and visited St. Christopher's Hospice.

[18] Olive Howlett died in 1993, aged 92 years. (Gravestone, Milford on Sea, Hampshire) The Rev. David Rudall conducted her funeral service.

[19] Five pages at the UoL, (IOELC) Box labelled 'St. Columba's Hospital/Friedenheim: items donated by the Rev. D. Rudall', Item 9

Consultation of Saunders' archives revealed that Mr. Rudall did, in fact, answer and some desultory correspondence took place between them over the following years which is discussed further in Chapter 10:278. His health failing, Mr. Rudall, at the suggestion of Saunders and shortly before his death in 2002, decided in turn to pass the documents on to Professor David Clark then responsible for the Hospice History Project at the IOELC in the University of Lancaster.

Although Mrs Rudall's direct personal memories of St. Columba's are few, her family has been instrumental in saving much of the early source material for this thesis. She later also gave me Miss Howlett's private photograph album of St. Columba's, a scrap book of press cuttings, some Annual Reports as well as correspondence between her husband and Saunders' P.A., Christine Kearney.

Doris Baker

I am indebted to Mrs Rudall for my introduction to Doris Baker, whose mother had died at St. Columba's in the 1940s. Left alone at the age of 15 and at her own request, Miss Baker was taken in by the hospital and employed there as a ward maid. She lived and worked both in Swiss Cottage and later in Hampstead Heath until c.1960. I was able to meet Miss Baker who provided personal memories and anecdotes of her time at the institution. She took a great interest in this thesis, but sadly died unexpectedly in October, 2008, before its completion.

Research by Fentress and Wickham (1992) and Thompson (2000) on memory and accuracy has demonstrated that, although by then in their mid-eighties, there was a strong likelihood that reliance could be placed on the testimonies of both Mrs Rudall and Miss Baker, given their close physical and/or emotional connections with the Institution or personalities involved.[20] As noted earlier,

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[20] See also Fentress and Wickham (1992:8-40) and Thompson (2000:118-172) for an extensive discussion of the potential bias, accuracy or selective nature of oral history.

however, both Mrs Rudall's and Miss Baker's main contribution to this research was in the provision of additional documentary evidence to that held in public collections, rather than personal anecdote.[21]

Christine Kearney

In the context of Saunders' involvement with St. Columba's, I was also able to talk to Christine Kearney, Saunders' P.A. at St. Christopher's for many years. Ms Kearney was able to provide some undocumented, first-hand information and memories linking Saunders to the people and work at St. Columba's.

The Davidson family

A search revealed that a relative of Frances Mary Davidson, the founder of the hospital, is transcribing and publishing extracts of a family diary on the World Wide Web. In the hope of finding additional information about Frances Davidson, I made contact with this relative, Janet Davidson, by email through her website http://freepages.history.rootsweb.ancestry.com/~missannedavidson/page%2047.htm), later visiting her and her husband, James Davidson, in Scotland. James is a descendant of one of Frances' brothers and holds many family documents, some of which refer to Frances and her upbringing. The Davidsons kindly showed me two sets of diaries, one written by Frances' aunt, Anne Davidson, and the other by Gertrude Fennell, a cousin. Both diaries provided background information about family and lifestyle,[22] and Anne Davidson in particular made several references to her niece. The family photograph albums yielded a few snapshots of Frances and her numerous siblings as well as the house in Scotland where she grew up and the cottage nearby where she died.

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[21] The occasional, personal memories of Miss Baker have been clearly attributed throughout.
[22] Gertrude Fennell's diaries held references to the baby Frances only in passing. They provided no information which was directly pertinent to this research.

Mademoiselle's Story

In the context of family history, however, Janet Davidson introduced me to a *roman-à-clef* [23] entitled *Mademoiselle's Story*, written by a Mrs Ryffel who was employed as a governess in the Davidson family in 1868-1869. This work forms part of the family archives and is considered by them to be, though fictional, based on real experience and a factual account of their family life at the time. Janet Davidson also provided a copy of the key, inherited at the same time as the book, to all the names occurring in it. This shows that in *Mademoiselle's Story*, Mrs Patrick Davidson (Mary Ann Leslie 1817-1898) is known as 'Lady Hepburn'[24], her daughter Williamina, 'Willie' and her daughter Frances, 'Susan'.

Table 2.1 Extract from typewritten and manuscript 'key' to characters in *Mademoiselle's Story*

'Explanation of Names and Places in Mll's [sic] Story [unknown handwriting]'

Ravenswood	Inchmarlo
Lady Hepburn	Mrs Davidson
Susan	Fanny [Frances]
Helen	Katie [Katherine]
Margaret	Mary
John	John [Coachman]
Willie	Mina [Williamina]
Frank	Georgie [George]
Mrs. St. Clair	Lady Outram (née Jane Anne Davidson)

Source: James Davidson, used with permission

[23] 'Roman-à-clef': a novel in which real people or events appear with invented names (The Oxford Dictionary of English (2nd edition revised).
[24] Mademoiselle may have chosen to flatter Mrs Davidson by ennobling her, partly since the eldest Davidson daughter, Jane Anne, had married the son of an earl and become Lady Outram. In the book, however, Lady Outram was demoted to 'Mrs St. Clair'.

Mademoiselle's Story can be read without reference to its provenance simply as an autobiographical morality tale intended for the edification and amusement of children. The story opens with Mademoiselle's arrival in Scotland after a long journey from Holland where she had held a post in a school for young ladies. Arriving at night and fatigued by the journey, she is introduced to numerous family members including the two main protagonists of the story; 'Lady Hepburn' and her youngest daughter, 'Willie'. Mademoiselle's difficult childhood and adolescence in Switzerland are touched on and thereafter the action evolves around her various problems teaching and disciplining the lively, tom-boyish 'Willie'. The 'Hepburns'' family life is described in detail, including the daily round of lessons for the children, visits to and from family, the importance of religion, particularly on Sundays, as well as family picnics and play outside. Mademoiselle's life in Scotland is facilitated by the kindness and understanding of 'Lady Hepburn' who is the axis of the family and to whom everyone turns for advice on practical and spiritual matters. In the final chapters, Mademoiselle decides to leave the family and renew her friendship with a young Swiss man who has been courting her, but with the promise of returning to Scotland at some unspecified later date to look after 'Mrs St. Clair's' growing family.

As a source of information, potentially distorted by its moralistic purpose and need to tell a good story, this material had to be approached with caution. Although it cannot be presumed a reliable factual source, there were, nevertheless, several reasons for supposing that some of the information about 'Susan' [Frances] which appears in this work was likely to be reasonably accurate. Firstly, the nature of the genre itself: protagonists in *romans-à-clef* are given code names precisely to disguise their identity since the story to be told is a real one.[25] Two separate branches of the Davidson family also vouch for the

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[25] Chen (1997) differentiates true romans-à-clef from novels in which characters are simply based on real people by the systematic matching of characters and actions to a key (clef). 'The key unlocks the historical secret otherwise hidden behind the veil of fictionalized characters' (Chen 1997:5).

fact that, within the family, this work is held to be a true account of that period in their history. Further, 'Susan' [Frances] is not the main protagonist in the story and as a peripheral character, her actions, or even inclusion in the story, are not pivotal to its theme. The author would have had little need to embellish or alter details about her.[26]

In this otherwise unremarkable story, there are two references which stand out stylistically due to their unusual specificity. Both have to do with 'Susan' [Frances] and both refer to real-life phenomena.[27] These references assert that 'Susan' [Frances] read the biography of Agnes Jones and, arising out of this, subsequently resolved to work with the Mildmay Mission[28] in London. The biography of Agnes Jones and her pioneering nursing work in the Liverpool Workhouse Infirmary are discussed more fully elsewhere (Chapter 4:82), as is the work of the Mildmay Mission (Chapter 4:84). This research, however, has revealed the accuracy of the second statement and, with its wide circulation and national popularity, a reading of Jones' biography was not improbable (see Chapter 3:55).

Given its provenance, this biographical novel cannot simply be dismissed or ignored. Faced with an absence of relevant family or personal papers, as well as extremely limited references to Davidson elsewhere, I have therefore chosen to use parts of this work for illustrative purposes only. Some extracts are cited later in this thesis as a possible indication of Davidson's lifestyle during the years before she founded the Friedenheim.

Exploration of four further branches of the Davidson family proved unfruitful, all expressing interest in their ancestor but denying any ownership or knowledge of relevant family papers or artefacts.

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[26] Alternatively this might, of course, mean that the author was less concerned to ensure the accuracy of the information. There is, however, third-party support for Ryffel's assertions, some of which were written with the benefit of hindsight and are examined below.
[27] These are in fact the only un-coded references in the entire work.
[28] See p 83

None of Davidson's private papers, such as diaries, journals or letters, has been traced and indeed, may no longer exist, so the personal face of the woman remains largely hidden and can only be deduced from her public writings.

Accuracy of data

I estimated potential sources of bias in the interviews, whether from the informant, me as researcher, or the interaction itself (Plummer 2001:157) but considered them, in the context of these particular interviews, of little relevance to the research outcome since the interviewees mainly provided me with further documentary evidence rather than personal knowledge of the institution. The exception, however, was Miss Baker, who had happily lived at St. Columba's for several years and enjoyed fond memories of her colleagues and working life there. Her opinion of the hospital under the leadership of Olive Howlett was uncritical and positive.

With the exception of incidents related in *Mademoiselle's Story*, in general, there has been no reason to doubt the accuracy or authorship of any of the research documents, including numerical data. Where a particular passage has been written anonymously or signed only with initials, this has been clearly stated in the reference. Disease and mortality figures tally from year to year in the Annual Reports.

Understanding and reporting written material, particularly historical, will, however, be affected by the reader's bias, experience and previous knowledge. In addition, author bias, a constant in all written material, may influence objectivity. The majority of surviving written works by Frances Davidson, for example, are the introductions she wrote to the Annual Reports. Particular care must be exercised in their interpretation as the Annual Reports were promotional publications written for existing and future donors and patrons

with a view to encouraging their continuing support for the home. The Reports' presentations of hospital life must clearly, therefore, be read with the constant awareness of the authors' primary intentions. The same caveat applies to the majority of early articles appearing in contemporary newspapers and journals, which are, what would now be called, press releases, rather than third party reporting. The closure of the home in 1981 was covered by local and national press, as a result of a vigorous but ultimately unsuccessful local campaign to keep the hospital open, and these reports, too, are subject to individual reporter and newspaper bias.

In particular, testimony attributed to patients, however interesting, obviously cannot be accepted unconditionally. Even if their remarks have been accurately transcribed, we cannot know to what extent these represent their real feelings, addressed, as these remarks were, by vulnerable people to their carers. There are some examples where surviving relatives purport to report the direct speech of the recently deceased, but these, too, need to be interpreted with caution.

For a third party opinion of the work of the home, I had examples of reports written either for the COS or for the King's Fund as well as correspondence with both organisations referring to the Home. Although these reports purport to be neutral, they too, will have been influenced by author and organizational bias.

Aware of these caveats, I have nevertheless striven for accuracy and objectivity in the material presented in the following chapters. In particular, my experience in writing similar documents, such as hospice promotional material, has helped to understand the authors' concerns and interpret their words, while maintaining my own awareness of personal bias.

CHAPTER 3 – NINETEENTH-CENTURY PROVISION FOR TERMINALLY ILL PATIENTS AND DISPOSAL OF THE DEAD

In order to test the suggested innovative, specialised and dedicated nature of the Friedenheim in 1885, its operation must be compared and contrasted with other contemporary institutions where those terminally ill and with few financial or familial resources might have expected to die. As an extension of care, the post-mortem treatment of bodies is also briefly considered. This examination reveals the unavailability or inappropriate nature of such accommodation for the dying, signalling the need recognised and fulfilled by Davidson at the Friedenheim.

For the Victorians, institutions were a 'universal panacea' according to Crowther (Crowther 1983:57), and Harris emphasises the growing preference in that era for institutional solutions to social problems, including health care (Harris 2004:94-103). Four major manifestations of the institutional response to health needs in the late nineteenth century are considered here: workhouse infirmaries (often simply called 'infirmaries'),[1] voluntary or general hospitals, specialist hospitals for incurables, and tuberculosis sanatoria.[2] These four types

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[1] Although the literature frequently includes workhouse infirmaries under hospital provision in the late nineteenth century (see, for example, Abel Smith 1964:46-66 et seq.), a distinction between workhouse infirmaries and hospitals proper has been made here as their treatment of dying individuals differed (see below).

[2] Another major group of special institutions, those for the mentally ill such as the Hampshire County Lunatic Asylum, have not been included due to their lack of relevance to the theme of this thesis. However, see, for example, Ayers 1971:37-48 or Harris 2004:99-102.

of institution must be considered in terms of their suitability for, and availability to the Friedenheim's intended patient body, described by Davidson as those '...in the last stages of illness ...rejected by the General Hospitals ...whose insufficient means and friendless condition prevent their being properly nursed and cared for to the end.'[3]

3.1 Background

In the nineteenth century, except in cases of violent or unexpected death, most people died at home having been nursed by family, friends and servants through illness or old age. This was true across all social strata, although different professional help would, if necessary, be summoned according to the social class and financial means of the family concerned (Dingwall et al. 1988:3, Harris 1994:63-67, Jalland 1996, 1999, McGilloway 1977:45).

The middle and upper classes might, for example, retain the services of a physician as well as a nurse to assist with hands-on patient care.[4] Jalland, in particular, explored the dying trajectories of those with families and servants at their bedsides and described the relationship of the moneyed classes to their physicians during the Victorian period (Jalland 1996, 1999 and see also Harris 1994:57-58).

For many of the poorer classes, however, even the services of a 'Shilling Doctor' were beyond their financial reach (Strange 2005:37-39), although nursing help might be provided by a 'handywoman', who would assist with basic physical care for the sick and laying out the dead (Dingwall et al. 1988:130). Some deprived urban areas saw the establishment of charitable missions which gave

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[3] FSC/AR/1901:5

[4] William Rathbone, the Liverpool philanthropist, was so appreciative of the services given by a nurse to his dying wife in 1850s that he instigated a local system of home nursing which ultimately contributed to the creation of the District Nursing Service.

access to drugs and medical treatment (Heasman 1962). The growth of philanthropic visiting schemes, essentially organised by the middle classes for the poor in both urban and rural locations (Heasman 1962, 1964, Howse 2006, Prochaska 1980, Summers 1979, 2001), saw further help potentially available during times of illness (Denny 1997, Dingwall et al. 1988, Heasman 1962, 1964, Prochaska 1980, Summers 1979, 2001).

In poorer households, however, the 'first and largest' source of nursing care would have been the person's family (Dingwall et al., 1988:7, 9-13). This is supported by Strange, who extensively explored both the affective and economic reasons behind this crucial dependence on family and household, particularly in the care of the dying (Strange 2005:27-65). Harris further examined the concept and make up of a 'household' which might include not only family, but friends, neighbours and even colleagues, all of whom might have assisted the dying (Harris 1994:63-64, 66).

Given the importance of the 'household' in nursing care, it is perhaps surprising that only Strange described the '…stories of suicides, and lonely and bitter deaths [which] draw attention to the plight of those who died without family or friends to nurse or soothe them' (Strange 2005:61).

A lack of suitable accommodation might prove a further problem for the dying poor. The initial impact of public health and sanitary reformers on the chaotic and unsanitary urban housing conditions which had developed since the beginning of the century remained limited (Harris 2004:127-130). Strange reported that, '…although housing standards improved towards the end of the century, a substantial percentage of poor families continued to live in concentrated areas of slum housing' (Strange 2005:49), where even the most devoted family member would have had difficulties coping with major haemorrhages, malodorous, fungating tumours or extreme pain. The problems which arose, therefore, when the sick or dying person had neither family nor appropriate housing, have been recognised, but the only resort for such cases, it

is suggested, was accommodation in the workhouse (Abel-Smith 1964: 46-47, Dingwall et al. 1988:3, Strange 2005:41). The nature and suitability of the institutional provision available in the late nineteenth century for those dying without family, friends or appropriate accommodation before the advent of the proto-hospices is therefore discussed below.

3.2 Workhouses

Workhouses or poorhouses had been a feature of English social life since the sixteenth century, when they had been established by some parishes to care for both the impotent and able-bodied poor (Crowther 1983, Longmate 2003). Following the enactment of the New Poor Law in 1834, however, the punitive and deterrent roles of workhouse incarceration became more important than any social support function for the physically needy (Abel-Smith 1964, Ayers 1971, Crowther 1983, Longmate 2003). Forsythe and Jordan found that:

> … the prisons and workhouses deliberately stereotyped and excluded their inmates from the wider society. These total institutions often had the effect of destroying self-respect amongst those sent there, who learned to view themselves either as outcast by society or as inferior to other people (Forsythe and Jordan 2002:858).

Described contemporaneously as 'ante-chambers of the grave,'[5] and the most likely destination for the dying poor,[6] the physical surroundings and conditions in the workhouses can be contrasted with those provided at the Friedenheim.

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[5] Wakely, Thomas in *The Lancet* (1841) 1 May 1841:194
[6] Davidson's interpretation of 'poor' and the social selection criteria attached to admission to the Friedenheim are discussed in Chapter 7.

Buildings

The internal and external design of workhouses resembled prisons and was intended to enhance the deterrent effect of incarceration there. Families were split up[7] and the men, women, girls and boys accommodated separately. Theoretically, the sick, including the dying, were housed in special wards, but in practice able-bodied, dying and ill inmates were accommodated in the same rooms (Abel-Smith 1964, Crowther 1981, Longmate 2003).

The depiction of a workhouse ward in Figure 3.1 shows the 'beds' on which the sick and dying were placed, separated by low wooden boards and accessible only from the foot, thus inhibiting any nursing care. The sleeping area is against a back wall and, in the workhouse depicted, any mattresses lie directly on the stone floor, making it probably cold, damp and impossible for the bedridden to see out. A single blanket hangs at the head of each unoccupied bed, suggesting that this is the only available covering. The windows are partially boarded up, blocking both fresh air and light, and there is an absence of any comfort, decoration, cleanliness or privacy. There appears to be some provision for heating through the large stove pipe, but the apparently able-bodied and babies are together in the same room as the ill and dying.

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[7] A theoretical exemption to this rule applied to married couples over sixty years of age (Longmate 2003:143-144).

ILLUSTRATION 3.1 Female Workhouse Ward, 1873

For copyright reasons, this image: Getty Images no. 50691936 'Etching of female ward of British home for the destitute' cannot be reproduced within an E-Thesis.

See http://www.gettyimages.co.uk/detail/50691936/Time-Life-Pictures.

The workhouse infirmaries and medical care

Abel-Smith described conditions in workhouse infirmaries as 'unacceptable in any medical establishment' (Abel-Smith 1964:46-47). In London, workhouse inmates accounted for some 1% of the total metropolitan population in the mid-nineteenth century (Ayers 1971:16) and as the following table shows, the proportion of sick among these inmates was significant. In 1866, for example, 88% of all adult metropolitan workhouse inmates needed some form of medical care; the percentage rising to 91% among the adult males.

TABLE 3.1 London workhouses, 1866: Adult population

Adult Population of London's Forty-three Workhouses at the end of 1866									
Able-bodied		Temporarily Disabled		Old and Infirm		Total	Total sick	%
Men	868	Men	3,014	Men	6,068	9,950	9,082	91
Women	2,031	Women	4,032	Women	7,617	13,680	11,649	85
Total	2,899		7,046		13,685	23,630	20,731	88

Source: Report of W.O. Markham and U Corbett (Inspectors of the Poor Law Board) on the Metropolitan Workhouses, 18th January 1867 (BPP, 1867, vol. lx (H/C 18) 119) Adapted from: Ayers 1971:16

The sick were of course not necessarily moribund but, writing in 1865, the reformer Louisa Twining estimated that nationally, between 30,000 and 40,000 people were obliged to, 'seek shelter during the last months of their lives in the workhouse' (Twining in Anon 1865:3).[8]

Workhouses had not been constructed to accommodate large numbers of ill and dying people, and the subsequent overcrowding[9] was one of the factors contributing towards the neglect of the inmates. These overpopulated, unsanitary and in many cases inhumane workhouse infirmaries became notorious following press coverage of the deaths of two London inmates, Timothy Daly, in Holborn Union Workhouse in December 1864 and Richard Gibson, in St. Giles' in February 1865. In both cases, Coroners' juries found that the deaths had been caused or hastened by inadequate conditions and care in the infirmaries, including, in Gibson's case, neglect by the doctor.[10] The deaths of both men were extensively reported in *The Times*.[11] Subsequently, the

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[8] Twining's figures probably imply a different base than those of Abel-Smith (Abel-Smith 1964:46) but both give an indication of the extent of the problem.

[9] Dryburgh (2004) reported on the Bolton workhouse where one room, containing three beds, housed a married couple, their three children, three other women and seven orphan children; a total of fifteen people. (Dryburgh 2004:129)

[10] *The Times* December 28, 1864:10 Issue 25067, Col. D and *The Times* March 31, 1865:11 Issue 25147 Col. B

[11] See Footnote 19, p 56

medical journal *The Lancet* instigated a series of nearly thirty inquiries spearheaded by Doctors Anstie, Hart and Carr into all the London workhouse infirmaries. These reports, published over eighteen months between 1865 and 1866 revealed in detail the shortcomings in hygiene and medical care to be found in many of the institutions.[12]

The anonymous physician who inspected the Shoreditch workhouse infirmary and authored the *Lancet* report on that establishment was cited in an editorial of *The Times* in 1865. It testified to the medical 'care' being dispensed:

> The Commissioners found "in one ward two paralytic patients with frightful sloughs of the back; they were both dirty, and *lying on hard straw mattresses*; the one dressed only with a rag steeped in chloride of lime solution, the other with a rag thickly covered with ointment. This latter was a fearful and very extensive sore, in a state of absolute putridity: … and the stench was masked by strewing dry chloride of lime *on the floor under the bed*. Both these patients have since died. No inquest has been held on either."[13] (Italics as original)

The Lancet authors were quick to defend the workhouse physician who was part time, non-resident and also acted as dispenser, sometimes paying for drugs out of his stipend (Carruthers and Carruthers 2005):

> …there are no prescription cards hung over the [240] patients' beds. So that he is supposed to recall to memory every morning as he passes the bed the treatment which each patient has had, to make up his mind as to variation, and then, after completing his rounds and on descending

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[12] Gibson-Brown wrote about Southwark infirmary, for example, where ward ventilation consisted only of perforated zinc shafts,: '[T]here were several cases of offensive discharges: one particularly, a case of cancer, which, no disinfectant being used, rendered the room almost unbearable to the inmates.' Gibson-Brown, R (1865) Report on the Workhouse of St. George-the-Martyr *The Lancet* Vol 86 Issue 2193:304 9 September 1865
[13] *The Times*, Editorial 03 August, 1865 Issue 25254 p.6 col. F

into the dispensary, to remember *en masse* all the changes he desires to make, and forthwith prepare the medicines." (Italics as original)[14]

There were no trained nurses to administer the medication, 'The women are mostly a very inferior set, the male nurses are peculiarly rough, ignorant and uncouth.'[15] One patient, indeed:

> ...very ill, had not had her medicine for two days, because the very infirm old lady in the next bed, who it seemed was appointed by the nurse to fulfil this duty, had been too completely bedridden to rise and give it to her.[16]

The editorial concluded that all these patients get, '...is a hard straw bed to lie upon, and just food and medicine enough to enable them to die of prolonged suffering instead of mere want.'[17]

Abel-Smith (1964:55-56) and Carruthers and Carruthers (2005:159) reported that in 1865, there were only 142 paid nurses in London to look after 21,000 sick and dying workhouse inmates. Few of these nurses were trained, and most of their time was spent supervising the pauper staff. There were only three paid night nurses in the whole of London. 'Passive cruelty was general'.[18]

Public awareness of workhouse conditions

Various publications and the popular press ensured that knowledge of living and dying conditions in workhouses extended to all strata of society not just social

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[14] Bid.

[15] Ibid.

[16] Ibid.

[17] Ibid. In 1894 and throughout 1895, some thirty years later, *The British Medical Journal* (BMJ) was to denounce provincial and Irish workhouse conditions, through a series of reports demonstrating that matters had been slow to improve.

[18] Twining, Louisa, *Workhouses and Pauperism* 1898:202, cited in Crowther, 1983:176

and medical reformers such as Louisa Twining or Florence Nightingale. In July, 1841, for example, John Critchley Prince published an account of the reception he encountered in a Kent workhouse in *The London Monthly Magazine*. He described the malodorous, vermin-infested room he shared with eight other men and four women, several of whom were ill. One, an old woman, died during the night, 'unshriven, unpitied and unknown' (Prince 1841).

The inquest and subsequent report into the death of Timothy Daly referred to above was extensively and graphically reported in eleven different editions of *The Times* newspaper in 1864/1865[19] as was the inquiry into the death of Richard Gibson a month later.[20] In a combination of straight reporting and editorials, where the content veered towards the sensational, *The Times* ensured that between December, 1864 and April, 1865 no regular reader of the paper could remain in ignorance of conditions in workhouse infirmaries.[21]

The new craft of investigative journalism[22] further disseminated details of workhouse life and death. In January, 1866, James Greenwood's sensational and slightly salacious account of his experiences as a disguised vagrant or 'casual', entitled 'A Night in a Workhouse' was published as a series of articles in the *Pall Mall Gazette.* These articles achieved instant popularity and were re-published as both shilling and penny pamphlets aimed at all levels of society. In the articles, the author described his reception, the enforced, supervised bath in communal bathwater and the close sleeping arrangements of the mostly naked

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[19] *The Times*: December 28, 1864:10 Issue 25067 Col. D; December 29, 1864:6 Issue 25068 Col. F; January 09, 1865:10 Issue 25077 Col. G; January 11, 1865:10 Issue 25079 Col E; January 13, 1865:10 Issue 25081 Col. D; January 14, 1865:12 Issue 25082 Col. A; January 16, 1865:6 Issue 25083 Col. C; February 04, 1865:5 Issue 25100 Col B; February 06, 1865:9 Issue 25101 Col A; February 09, 1865:6 Issue 25104 Col. G

[20] *The Times*: March 31, 1865:11 Issue 25147 Col. B; April 10, 1865:8 Issue 25155 Col. G; April 07, 1865:12 Issue 25153 Col. B; April 08, 1865:10 Issue 25154 Col. E; April 10, 1865:8 Issue 25155 Col G; April 20, 186:12 Issue 25164 Col B; April 21, 1865:8 Issue 25165 Col. B

[21] In addition, coroners investigating deaths in the workhouses caused by neglect, 'frequently castigated local officials for dereliction of duty, a situation that was often reported in the press' (Green 2006:139).

[22] Freeman argues that none of these journalists in fact experienced workhouse life for any length of time. 'Conditions were simply too bad for incognito investigators to risk their health over long periods' (Freeman 2001:109).

men. The melodramatic nature of Greenwood's revelations spawned popular ballads and even a play based on his experiences.

Sensational works highlighting conditions in the workhouses continued into the twentieth century. Mary Higgs published her *Glimpses into the Abyss* in 1906 (Higgs 1906) describing conditions she had encountered when entering various refuges disguised as a vagrant. She dwelt particularly on the dirt and vermin which were prevalent, and her disgust at the obligation to wear a dirty nightgown previously used by another occupant. More sober articles on national and metropolitan infirmaries were published in the *Fortnightly Review*[23] under the titles 'The Condition of our State Hospitals' and 'Metropolitan Infirmaries for the Pauper Sick'. Dickens' *Household Words*,[24] *Blackwood's Magazine* (1858) and the *Edinburgh Review* also published reports on conditions in the workhouse infirmaries. The vogue for Dickens' works[25] also provided popularised accounts of the treatment received by the indigent.

A further work which must be considered here is *The Memorials of Agnes E. Jones* by Her Sister, since there is evidence to suggest that this biography was pivotal to Davidson's decision to leave Scotland and work among the poor in London (see Chapter 2:41 and Chapter 4:82).

This posthumously written biography of Agnes Jones (1832-1868)[26] is based on letters and diary entries selected and edited by her unnamed sister. Coming from an upper middle-class, Anglo-Irish background, Jones' deep religious

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[23] *Fortnightly Review* December 1865 3:217-226 and April 1866 4:459-463
[24] See particularly 'A Walk in a Workhouse' by Dickens, C. *Household Words* 25 May 1850
[25] See in particular: *Oliver Twist* (1838), *Uncommercial Traveller* (1860-75), *Our Mutual Friend* (1864-5)
[26] Electronic searches for this work generally give the name of the author as 'J. Jones'. This is, however, probably inaccurate. In the original editions, no indication of the author's name is given and she is simply styled 'Her Sister'. Ross and Ross name the author as Josephine Higginbotham, Agnes Jones' married (and only) sister (Ross and Ross 1988: unpaginated Acknowledgements). Although widowed by the time she compiled and wrote the work, there is no evidence that Higginbotham reverted to her maiden name. The work can be found in this Bibliography under 'Anon 1871'.

convictions led her into service with the poor and sick. After rigorous nursing and religious training at the Deaconess' institution at Kaiserswerth in Germany, she joined Mrs Ranyard's Bible women in a senior administrative capacity, and then later complemented her nursing skills by studying as a Nightingale nurse at St. Thomas' Hospital in 1862 (Anon:1871:245-251). With the support of Florence Nightingale and Liverpool philanthropist, William Rathbone, in 1865 Jones took up the post for which she was to gain national and posthumous recognition, that of the Superintendent of Nurses at Liverpool Workhouse Infirmary.

Jones is credited with being the first to bring professional nursing skills to the, by now, notorious workhouse infirmaries (Anon 1871, Burdett-Coutts 1893, Carruthers and Carruthers 2005, Crowther 1983, Longmate 2003).[27] Nothing in her training had prepared her for the difficulties encountered in Liverpool, however, where she was in charge of 1,350 patients with, eventually, the support of probably a further twelve Nightingale nurses. After three years in Liverpool, during which time she re-organised the infirmary and attempted to introduce professional standards, overwork and ill-health eventually took their toll and she died at the age of thirty five (Anon 1871, Ross and Ross 1988).

The book's appeal was on several levels, incorporating as it did the real-life tragedy of a young woman's death whilst fulfilling her mission, an uplifting story of service to God and an insight into the conditions prevailing in workhouse infirmaries. Readers found Jones' life the more unusual in that, as Crowther reported, 'Workhouse nursing did not attract ladies, still less nurses who had been trained in the voluntary hospitals' (Crowther 1983:177).

The work contains a lengthy, eulogistic introduction by Florence Nightingale and, in American editions, also one by the Rev. Henry Ward Beecher, where it

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[27] Summers (Summers 1989) explored Jones' motivation in depth and contrasted it with that of both Florence Nightingale and Jane Shaw Stewart. She convincingly argued for the primacy of religious impetus behind Jones' work, before any desire to improve clinical practice (Summers 1989:35-37).

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was published under the title *Una and her Paupers*. In spite of the fact that the book is, in McGregor's words, 'unsurpassed in its sickly piety' (McGregor, 1955:57), its popularity was such that twelve editions had been published between 1871 and 1885, of which three editions were issued within the first year.

Improvements in infirmary conditions

The negative stereotype of care in the workhouse infirmaries must be qualified by targeted, recent research based on contemporary material. Hurren and King (2005) as well as Strange (2005), for example, demonstrated that death and care in workhouses might, in some cases, have been more compassionate and patient-driven than generally reported.[28] Strange, indeed, noted that some workhouse staff were 'not insensitive to the needs of the [dying] poor' (Strange 2005:62). These studies are confined geographically to specific areas of the country however,[29] and only further research will show the extent to which their findings can be generalised nationally and how they can be reconciled, for example, with the BMJ reports of 1894-1895[30] or the rising demand, and therefore perceived need, for burial insurance described by Harris (Harris 2004:80-83).

By the time that the Friedenheim opened in 1885, there had been some amelioration of workhouse conditions. Joseph Rogers (1820-1889) started campaigning for Poor Law medical reform and improvements in workhouse infirmary care after 1856, when he was appointed medical officer in the Strand Union workhouse. He advised *The Lancet* on their 1865 investigation into London workhouses and, in 1866, founded the Association for the Improvement

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[28] Their work raises the interesting question of the potential need for specialised homes for the dying, such as the Friedenheim, in all parts of the country and suggests that generalisations about such need cannot be made.
[29] Hurren and King researched workhouses in Hulme in Lancashire and Brixworth in Northamptonshire, whereas Strange reported on a Gloucestershire institution.
[30] See p.74

of London Workhouse Infirmaries. This was followed in the 1870s by the Poor Law Medical Officers' Association (Abel-Smith 1964, Richardson and Hurwitz, 1997). The Workhouse Nursing Association was founded in 1879 to promote higher standards of nursing in union workhouses, and encouraged the appointment of at least one trained nurse in each infirmary (*The Nursing Record and Hospital World*, No. 727 Vol. XXVIII:1 8 March 1902, *British Journal of Nursing* 1914:250).

Improvements to the workhouse infirmaries, and particularly the accommodation of the ill in special institutions away from the able-bodied, were, however, slow to be realised. The sordid conditions described above were only gradually replaced by more professional and caring establishments.

In a situation which would be echoed under the new National Health Service in 1948, these ameliorations were, however, aimed at the sick and only incidentally encompassed the dying, whose needs went unrecognised. In the Metropolitan Poor Act, specific reference to the dying is made only by reference to allocation of costs involved.[31] The sick and, presumably, dying and dead in the asylums were also deemed suitable for use in medical and nursing instruction:

> Where the asylum [institution] is provided for the reception and relief of the sick or insane it may be used for the purposes of medical instruction and for the training of nurses, subject to Poor Law Board regulations.[32]

Fear and detestation of the workhouse were slow to dissipate among its likely inmates, irrespective of improvements which were made. Contemporary literature, press reports, cartoons, ballads and broadsheets perpetuated the more sensational aspects of workhouse life and death among the populace and

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[31] Public General Statutes, 1867 (30 and 31 Vict. C.6 Sections 24, 32 and 69.6 cited in Ayers, 1971:259-268
[32] ibid. Section 29

did little to relieve the terror induced by the notion of entry there. Crowther (1983), Hussey (2001), Longmate (2003), Phillips (1976), Richardson (2000), Skinner (2005) and others have demonstrated that fear of the workhouse and the stigma of enforced residence in such an institution extended well into the twentieth century in spite of all government measures to allay them.[33]

3.3 Hospitals and their dying patients

Burdett summed up the position of the dying patient and his/her family vis-à-vis hospitals thus:

> Many who see a husband or wife in the last stage of hopeless illness think at once of a hospital, and suppose that, for such a case, the doors of every hospital must needs stand open night and day. It is not so. Against the man [sic] whose days are manifestly numbered the doors even of the hospital are fast closed and necessarily so. The hospital is for those who can be cured and restored to health and the power to work (*Burdett's Hospitals and Charities Annual*, 1894:lxx).

The general hospitals, usually known as voluntary hospitals, included the major London teaching hospitals such as St. Bartholomew's Hospital (Barts), Guy's Hospital and St. Thomas's Hospital. Admission as a patient was through letters

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[33] There appear to be good reasons for this. Townsend (1962) records some of the reports from his researchers collecting data in 1958-60 from old peoples' homes housed in the old workhouses. 'The ward is reached up twenty steep steps, the staircase walls being pitted and peeling. On the windswept landing are 12 w.c.s in two rows of six, with no doors, no wooden seats and divided from each other by only iron bands three feet high. The stone floors were saturated with urine and one man could be seen groping with his trousers in a confined space… In the washroom there are six basins in a row as well as six easy chairs. In two of these old men sat reading newspapers and a third, in a wheelchair, was washing at a basin. There are three dormitories with 30, 27 and 4 beds. The largest is also a day room and its two divisions are separated by a row of flimsy bed-screens. (Townsend, 1962:66)

of recommendation[34] dispensed by the governors of the institution (Abel-Smith 1964:36, Carruthers and Carruthers 2005, Cherry 1997, 1998, Granshaw 1990, Hardy 2001:15, Poynter 1961, Prochaska 1992, Rivett 1986). These voluntary hospitals were charitable institutions supported by individual and institutional subscribers (Harris 2004:95-96) for the cure of patients and then, as now, they were concerned with statistics, funding and long-stay patients.[35] In order to attract and maintain philanthropic supporters, it was necessary to demonstrate through discharge and turnover figures that their primary mission, that of curing patients, was being accomplished. Admission of patients 'in a dying condition' was therefore discouraged[36] as was admission of the chronically ill.[37]

Hospitals, in addition, were known to discharge patients once cure was deemed impossible, a situation which was to continue into the 1950s (Marie Curie Memorial 1952:25)[38] and this research has shown that many patients received at the Friedenheim had been sent there from the large teaching hospitals as

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[34] This requirement declined in importance, however, during the second half of the nineteenth century as medical criteria became more important.

[35] See Abel-Smith 1964:40 for the techniques used by hospital administrators and doctors to falsify numbers

[36] *Hospital*, Vol. 31, April 1935:99 cited in Able-Smith, 1964:37

[37] Abel-Smith 1964:36, 156, Anon 1865:6, Carruthers and Carruthers 2005, Cherry 1997, Granshaw 1990, Harris 2004:96, Mooney et al. 1999, Prochaska 1992, Rivett 1986. 'One hundred of the most eminent medical men in England' testified that: 'We witness almost daily the pitiable and helpless condition of persons so situated ['destitute incurables'] and are often obliged to refuse them admission, in consequence of the regulations of the institutions to which we are attached. These regulations are absolutely necessary, for the reason that the general hospitals… were established for the treatment of curable diseases…' (Anon 1865:6)

[38] Two exceptions to this general practice were the hospital of St. Elizabeth and St. John, a religious (Roman Catholic) institution in Great Ormond Street which catered for 'advanced or long-standing disease' (*Burdett's Hospital and Charities Annual* 1894, Section heading 'Chronic and Incurables' p 516) and the Royal Marsden, which had a special ward for patients with terminal cancer.

well as from smaller institutions (Chapter 7:142).[39] These general hospitals, however, cared for only a small proportion of the country's ill and, as appears from the above, an even smaller number of the dying.

3.4 Tuberculosis sanatoria

The scale and destruction caused by tuberculosis in social and economic[40] terms have been widely discussed (Boland 1948, Bryder 1988, Dubos and Dubos 1953, Harris 2004, Smith 1979). Described as 'the greatest killer of the human race' (Dubos 1953:102), tuberculosis accounted for one death in every eight at the beginning of the twentieth century (Bryder 1988:1), of which a quarter were young people under 25 years of age. This trend continued, and by 1948, although overall numbers had declined, 29% of tubercular deaths were still within this age group.[41]

The reality of death from tuberculosis was far from the Romantic image of early Victorian times (Sontag 1991:31). Symptoms could last for months, extending to years, and included fatigue, loss of appetite, severe weight loss, chest pain, fever, night sweats and the coughing up, not only of bloody sputum, but extensive tubercular haemorrhages when the patient could rapidly lose a large

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[39] It would be interesting to compare mortality rates at the different types of institution, but the calculation of relevant, comparable figures is, even today, fraught with problems and inconsistencies (Jarman et al. 1999 and Wright et al. 2006). In Victorian times, 'Hospitals calculated mortality rates in different ways to suit their particular goals' (Iezzoni 1996:1081) and Nightingale also underlined this unreliability in her *Notes on Hospitals* (1859), writing, 'Accurate hospital statistics are much more rare than is generally imagined, and at best they only give the mortality which has taken place *in* the hospitals, and take no cognizance of those cases which are discharged in a hopeless condition, to die immediately afterwards, a practice which is followed to a much greater extent by some hospitals than others' (cited in Iezzoni 1996:1081) (Italics as original).

[40] Smith suggests that sixty percent of the 4,000 residents of Liverpool workhouse infirmary were 'paupers because they were consumptives, and not the other way round' (Smith 1979:292).

[41] Registrar General 1881-1890, 1901-1910, Central Statistical Office 1948, 1949. In comparison, in 1948, the 5-25 age group accounted for only 1% of cancer deaths.

volume of blood.[42] The lingering death and incurable nature of tuberculosis might, it could be supposed, make such patients eligible for entry to a hospital for incurables (see below). However, even before the disease was discovered to be communicable, these hospitals did not generally admit tubercular patients[43] and, along with insanity and other conditions, a diagnosis of tuberculosis formed one of the criteria for exclusion (Cook 2006:85, 95).

A partial response to the needs of tubercular patients was the creation of specialised hospitals,[44] geographically isolated sanatoria and sometimes even entire villages.[45] Bed numbers, however, were always insufficient; a situation which still existed in 1948 when Boland reported a waiting list of 8,000 for the 32,801 beds available in England and Wales (Boland 1948:17-18).[46] Accommodation in hospitals and sanatoria was also primarily available for '…early cases so that they [the promoters] could see results in terms of 'cure'' (Bryder 1988:30, see also Boland 1948:18 and above) rather than terminal cases.[47] Midhurst Sanatorium even advertised itself as, 'Not meant to be a Home for the Dying' (Bryder 1988:25). Even workhouse infirmaries 'strove to emulate voluntary [general] hospitals by concentrating on acute and 'curable' cases, thus excluding tuberculous patients' (Bryder 1988:22).[48] Hinting at the economic reasons behind its policy, Bryder concluded that, 'Possibly the most

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[42] One patient at the Friedenheim, for example, is recorded as having lost five pints of blood in his final days FSC/AR/MR/1914

[43] The situation regarding the admission of tubercular patients to the homes for incurables was evolving and confused, with different practices in the various homes. The difficulty of diagnosing non-pulmonary tuberculosis compounded the problem (Cook 2006:85 and passim).

[44] In England and Wales, the number of tuberculosis hospitals grew from 14 (1,075 beds) in 1891 to 53 (4,200 beds) by 1911 (Harris 2004:228).

[45] One of the large, early sanatoria was Nordrach-on Dee, which opened around 1900 near the Davidson family's summer home in Banchory.

[46] Added to these figures should be the un-notified cases of tuberculosis which caused, for example, 3,468 deaths in 1945 (Boland 1948:18).

[47] E. R. Boland, Dean of the Medical and Dental Schools of Guy's Hospital wrote in the British Medical Journal that: '…there was no type of case for which it was so difficult to secure admission to the general hospitals as the tuberculous case, largely because of the danger of infection, but also because many physicians regarded pulmonary tuberculosis as being as much outside their responsibility as syphilis.'(BMJ 2 1948:18)

[48] Nevertheless, in 1908, it was estimated that in London, '4,000 cases of consumption were admitted annually to the London [workhouse] infirmaries, with about 2,500 deaths (Bryder 1988:32).

serious indictment of the [National Tuberculosis] Service was the neglect of advanced or chronic cases who had no hope of recovering their working capacity' (Bryder 1988:261).

It was recognition of this 'neglect' and the lack of institutional accommodation in particular for those dying of tuberculosis that was one of the driving forces behind the opening of the Friedenheim (see Chapter 4).

3.5 Specialist hospitals for 'incurables'

In his *Yearbooks*, Burdett classified the Friedenheim/St. Columba's as one of a number of specialist hospitals for incurables, the first of which, the Royal Hospital for Incurables (RHI, now the Royal Hospital for Neuro-Disability) had opened in 1845. In 1861, a second, rival establishment, the British Home for Incurables (BHI, now the British Home and Hospital for Incurables), was established (Cook 2004, 2006:3-15). By 1898, Burdett listed no fewer than 62 hospitals for incurables across the country (Burdett 1898:955-961).[49] These hospitals were ultimately intended for patients whose long term disabilities precluded their ability to earn a living or care for themselves. Primarily aimed at middle-class patients - the 'poorer class of servants' was not to be admitted (Cook 2006:63 and 84) - these hospitals were established 'for the relief of incurable cases of disease, accident or deformity'[50] but excluded many medical conditions, including insanity, epilepsy and infectious diseases.[51] Although

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[49] There were 27 such establishments listed in London, 24 in the provinces, 6 in Scotland and 5 in Ireland. Of the London hospitals, 5 were for women, 2 were for women and children and 4 exclusively for children. (Burdett 1898: 955-961). The 1898 edition of Burdett includes (on p 956) an otherwise unrecorded listing for a Home for the Dying at Wimbledon SW whose offices were at 281 Strand WC. This is one of the institutions marked with an asterisk signifying that 'no return has been received [by Burdett's], although repeated applications for information have been made'.
[50] BHI inaugural meeting, cited by Cook 2006:11
[51] Original rules of the BHI, cited by Cook 2006:199 and see also Burdett (1898:955).

evidently not all patients enjoyed long lives, some lived at the hospitals for incurables for over forty years (Cook 2006:93).

It is evident that these hospitals for chronic incurables can be clearly differentiated from the Friedenheim, which admitted only patients thought to be in the terminal phase of illness and close to death. At the time, however, particularly among Burdett's lay and even professional readership, the distinction may have been less clear. Both the RHI and the BHI had been founded before the Friedenheim, had successfully promoted their institutions widely and presumably had an extensive donor base among the philanthropically inclined (Cook 2006). The Friedenheim was listed by Burdett as another such hospital and lacked a specific name for its type of work. It could only distinguish itself by reiterating that it was intended for '*only* those *in the last stages of illness*… It is for those whose insufficient means and friendless situation prevent their being properly nursed and cared for to the end' (Italics as original).[52]

Destitute incurables in workhouses

During the years following their foundation, both the RHI and the BHI altered the medical criteria for admission several times, and there appears to have been no consensus of opinion on the exact definition of 'incurable' (Cook 2004:83-101). Perhaps symptomatic of this confusion of terms in Victorian times, the paper *Destitute incurables in workhouses* read by Margaret Elliot at 'the Social Science meeting at Glasgow' in September 1860 (Elliot 1860), although addressing, for the most part, the plight of chronic incurables, also touches on the specific needs of those actually dying. Even fifteen years after the founding of the RHI, Elliot labels as 'incurable' both those with chronic conditions or long-term care needs and those close to death. Quoting contemporary statistics

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[52] FSCAR/1901:5

which reveal the extent of the problem, Elliot eloquently pleads the case of 'destitute incurables' (here, specifically the dying) whose only refuge can be the workhouse:

> When consumption, cancer or dropsy seize upon the men and women of that vast class who are only able to support themselves by their labour without laying up provision for the future, what resource is provided for them?...For the *incurable poor*, for those who have no friends, no homes, whose diseases are the most agonising which human nature can endure, and who have not even the hope of recovery to sustain them – what resource, I ask again, have we provided? The only answer is *One small new hospital near London!* (Elliot 1860:3-4). (Italics as original)[53]

Elliot was apparently unaware that the patients she describes here, though literally 'incurable', would not have been eligible for the incurables' hospitals by reason both of their social and medical condition. This paper is, however, of particular interest as it identifies the chronically disabled and dying as specific groups within the sick poor.

Elliot's paper had a widespread distribution over a period of several years among reformers and the medical establishment alike (see Anon 1865), possibly perpetuating the confusion between those chronically disabled and those close to death, but nevertheless demonstrating awareness of the gap in available provisions: a gap which would give rise to the Friedenheim twenty years later.

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[53] Later in the paper (Elliot 1860:5), it is made clear that Elliot was referring here to the RHI, although then fifteen years old, together with two small hospitals in Scotland. She seems to have been unaware of the restrictive admission regulations. Nothing discovered to date has revealed whether or not Davidson was aware of this or the later paper, Anon 1865.

3.6 Post mortem disposal of bodies

In 1843, Edwin Chadwick published a *Supplementary Report on the Results of a special Inquiry into the Practice of Interment in Towns*, (Chadwick 1843) in which he described the lengths to which some of the poor, living in a single room, were driven in the treatment of their dead. In the absence of public mortuaries, the corpse would lie in a bed during the day and at night the body would be moved to a table or the floor; a situation which might last for as long as ten days. Corpses were kept in the home for such an extended period of time, as the onset of putrefaction rendered them useless for dissection and therefore safe from body snatchers.[54] Chadwick found this practice not only distasteful but also unhealthy as the miasma of putrefaction was thought actively to spread disease, not merely indicate its presence. The absence of public mortuaries would not be remedied until the 1890s, and bodies of the poor awaiting burial, if not kept at home, were housed in the dead houses of the local workhouse.

The treatment and disposal of dead bodies in the workhouses contributed to the degradation of dying there. The deceased, for example, might be 'washed and laid out, all in full view [of the other inmates] for there were neither curtains nor screens in these rooms.'[55] Longmate also cited an unattributed 1878 report which described how, 'The dead are laid in shells, the boards unplaned inside, upon a sprinkling of sawdust, perfectly naked, with a strip of calico over the body only (Longmate, 2003:149)'.

Describing the 'penny-pinching' pauper funerals which followed death in workhouses, Longmate argued that, '...the authorities never seem to have understood how bitterly such economies were resented' (Longmate, 2003:149) and reports exist of '...dung carts doubling as hearses for pauper funerals or

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[54] See below. I am indebted to Dr Pam Fisher of the University of Leicester for drawing my attention to this reference and showing me some of her unpublished research into mortuaries. See also Fisher 2009.
[55] This citation (in Longmate 2003:148) appears to be from Twining, L (1880) *Recollections of Workhouse Visiting and Management*, London 1880 but is not directly attributed.

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drunken undertakers letting a little pauper girl's body tumble out of the coffin in front of her mother' (Forsythe and Jordan 2002:858).

A Parliamentary Report in 1850 described burial practices in St. Pancras:

> These burials take place twice-a-week, on Tuesday and Friday… when the whole number are put into the grave together, and one service is read over them as is not unusual.[56]

A further indignity perceived, not only by the poor, but by all strata of society was that of dissection,[57] and popular antipathy was such that anti-dissection riots took place all over the country.[58] The new anatomical-pathological model

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[56] PP1850 (1228) xxi cited in Crowther, 1981. In London, another possible disposal for the bodies of the poor from Bridewell Hospital and the prisons was the incineration of their corpses within the City of London gas works along with the 'condemned meat and offal of the markets' (Eassie 1878:230). Introduced 'around 1844', this practice lapsed, however, following objections from the Church (Eassie 1878).

[57] This section draws heavily on Richardson's exhaustive work *Death, Dissection and the Destitute* 2nd Edition 2000, University of Chicago Press, Chicago. Richardson (2000) traced the popular antipathy to post mortem dissection as far back as the granting of four hanged felons' bodies to the company of Barbers and Surgeons by Henry VIII in 1540. She cited this alliance of the medical profession with the judiciary and ruling elite as crucial to the history of dissection in England, asserting that, '...dissection became recognised in law as a punishment, an aggravation to execution, a fate worse than death' (Richardson, 2000:32). By 1753, dissection, along with gibbeting, had become one of a series of disposals available to the judiciary in cases of murder or treason. 'The intention of both punishments was to deny the wrongdoer a grave.' (Richardson, 2000 p37)

[58] Aberdeen, Davidson's home town, has a vivid history in these matters. A riot occurred there in 1832, when the entire (and newly built) Anatomy School was razed to the ground by a crowd of some 20,000 people following the discovery of partially buried body parts in a school yard. It seems likely that local enforcement authorities connived in some way with the rioters, deliberately holding back their intervention until after the Anatomy School was destroyed; by which time intervention was no longer necessary as the crowd dispersed peacefully. Richardson suggested this restraint was possibly due to an underlying trust in the crowd by the 'prudent elite' (Richardson, 2000:92), but it can also be interpreted as a manifestation of that elite's own unease at this treatment of the dead, echoing that of the poor themselves. The riot and subsequent destruction of the School remained a notorious event in that city's history. A further scandal was to erupt in Aberdeen in June, 1899, fourteen years after the Friedenheim opened, which reached the national press. Investigations at the Nellfield Cemetery revealed that widespread unauthorised exhumation had occurred with the subsequent random re-interment of miscellaneous body parts, some following partial burning in the cemetery furnace. The number of 'spare' coffin lids and handles revealed the extent of this crime and charges of grave desecration were brought against William Coutts, Superintendent. (*Glasgow Herald* 07.06.1899, *Daily News* 08.06.1899, *Leeds Mercury* 08.06.1899, *The Times* 09.06.1899, 10.06.1899 and 12.06.1899).

ILLUSTRATION 3.2Public mortuary

Slate mortuary dated 1906 attached to the Victorian hospital preserved in Padarn Country Park, Llanberis. Photograph courtesy of Paul Sivyer. Used with permission

of disease which became current towards the end of the eighteenth century (see Chapter 8) led to an increased demand for autopsy material in the medical schools, themselves experiencing a rapid growth in number (Dingwall et al. 1988:20-23). As early as 1819, the surgeon John Abernethy had proposed using paupers' bodies, in addition to felons', for dissection and anatomy teaching.[59] The Anatomy Act of 1832[60] legally confirmed this by allowing the bodies of those dying in workhouses and hospitals to be passed to medical institutions for dissection under certain conditions. As Richardson said, 'What had for generations been a feared and hated punishment for murder became one for poverty' (Richardson, 2000:xv).

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[59] Abernethy, J (1819) Hunterian Oration. London 1819. Cited in Richardson (2000)
[60] 2 &3 William IV C. 75 See Harris 2004:51 for a more detailed consideration of the terms of the Act.

The legitimate supply of bodies was still inadequate however, and abuse of the system became widespread. Fake mourners might claim the dead from the workhouse, wardens might be bribed to hand over cadavers or the crowded and ill-dug graves of the poor, each containing up to thirty-six bodies might simply be robbed (Laqueur, 1983:116).

Death in the workhouse was feared therefore on three counts: firstly the manner of dying, which followed degrading admission procedures, separation from family and, in many infirmaries, totally inadequate medical care ensuring death from 'prolonged suffering instead of mere want'.[61] Secondly, the post mortem disposal of the body to an unmarked, multiple grave, probably via an anonymous pauper's funeral[62] would only increase the stigma of death in the workhouse. Finally, any surviving family or friends would also have to face the increased likelihood that, even if claimed, the body might subsequently 'disappear' and be subjected to the perceived ignominy of dissection in an anatomy school pre- or post-funeral.

It is against this background of social and medical neglect of the dying poor that the innovative nature of the Friedenheim, the first home in England specifically designed to cater for some of this population, will be examined in the following chapters.

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[61] *The Times*. Editorial 03 August, 1865:6 Issue 25254 Col. F
[62] Laqueur's paper describes paupers' funerals as, 'both terrifying to contemplate oneself and profoundly degrading to one's survivors' as they demonstrated 'social worthlessness, earthly failure and profound anonymity' (Laqueur, 1983:109) See Chapter 2:59, however, for a more positive view of pauper treatment and funerals.

CHAPTER 4 – FRANCES MARY DAVIDSON AND THE FRIEDENHEIM

The existence of the Friedenheim was due to one woman, Frances Mary
Davidson (1840-1920) and records show that her commitment to the home was
total and continued into her eightieth year. She demonstrably imposed her
vision and will on the home's Executive Council which cooperated with, and
then succeeded her in the daily management of the institution. The nature of
this direction was such that it was to imbue staffing, administration and
management for not only the years immediately after Davidson's death, but
until the hospital was taken over by the NHS in 1948.

Modern management theory explains the importance of the founder in creating
and embedding 'staunchly defended' (Schein 1983:25) cultural elements into an
organization. She or he brings 'assumptions that underlie the values and
determine …behaviour patterns [and even] such visible artefacts as
architecture…' (Schein 1983:14).[1] An exploration of the background and
formative events in the life of the woman who founded the Friedenheim is
therefore pertinent to understanding its operation and ethos of care. This
chapter investigates how Davidson's background contributed to her
interpretation of, to echo Burdett's words, the 'right way' to care for the dying.
Methodological problems associated with researching her biography were

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[1] In view of this remark, it is interesting to note that the Swiss Cottage premises chosen by
Davidson for the Friedenheim bear a distinct resemblance to the family's country home
Inchmarlo, near Banchory and this was even spontaneously remarked on by James and Janet
Davidson.

discussed in Chapter 2, but the suggestions here are internally consistent and agree with externally verifiable data.

4.1 Background

Prochaska's *Women and Philanthropy in 19th Century England* (1980) provides a comprehensive review of the social forces prevailing at the time of Davidson's undertaking, to which a specifically Scottish dimension can be added by Checkland's *Philanthropy in Victorian Scotland* (1980) and Marshall's *Virgins and Viragos* (1983). In Victorian Scotland, Marshall described increasingly restrictive social conventions, which demonstrated:

> …a revived preoccupation with theology and a censorship of the books
> thought suitable for young ladies to read. The *joie de vivre* of the
> eighteenth century was replaced by a gloomy sentimentality, and
> women turned more and more from dancing and the theatre to doing
> good works (Marshall 1983:251).

The education of girls was essentially different from that of boys, with little science or maths and a greater emphasis on religion and domestic accomplishments (Prochaska 1980:3). Although literacy levels were high in Scotland at the time and extensive education for girls was the norm (Marshall 1983:252-255), Davidson received her education before the opening of the more academic schools for girls.[2] Further, Aberdeen, the place of her birth and childhood, was not in the forefront of higher education for women, and its University was one of the last of the Scottish universities to admit women students when it did so in 1894. The domestic training Davidson doubtless

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[2] For example George Watson's Ladies' College or the Edinburgh Institute for Young Ladies (Marshall 1983:257-258)

received in managing a large household, however, would have found a natural extension in running the Friedenheim 'Home'.

Girls were encouraged by education and religion to involve themselves with charity[3] and, as one of the 'large number of "surplus women" without husbands' (Prochaska 1980:2), Davidson found a role in life outside marriage and motherhood in her philanthropic work.[4] She can be absolved, however, from one of the charges laid against philanthropic women in the Victorian age, namely that '…the insatiable demand for reliable servants was an important factor behind the benevolence of late eighteenth and nineteenth-century women' (Prochaska 1980:148). The very nature of her work precluded the recipients of Davidson's charity from ever providing her or her acquaintances with direct service in return.

4.2 The early years

Born in 1840, Davidson was the second of ten children of Patrick Davidson (1809-1881) and Mary Anne Leslie (1817-1898). Her father, in addition to his private legal practice, was a Professor of Law at the University of Aberdeen. The diaries of Davidson's aunt, Miss Anne Davidson[5] describe a large, sociable, seemingly happy family spending their time between Aberdeen and their country house, Inchmarlo, near Banchory, 20 miles west of the city. Anne Davidson occasionally mentioned the young Frances, rowdy family games

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[3] 'Christian love, particularly the Christian love of our fellow men' *Shorter Oxford English Dictionary*, 1933 (second 1987 printing) Oxford University Press

[4] Davidson seems to have been aware of her potentially 'surplus' position in society. In poignant lines in an early journal article, the anonymous author appeals to others to emulate her work with the dying, saying, 'If it has pleased God to deny her [the reader] the nearest and sweetest ties of earth [i.e. a husband and children], she needs others into which she can pour herself, and what could be more fitting for such a woman than this tender ministry?' (Anon 1887:65)

[5] See Chapter 2. Selected years available on line at http://freepges.history.rootsweb.com/~missannedavidson/index.html (accessed 28.09.2006), and otherwise in the possession of James and Janet Davidson.

played indoors with the children in inclement weather and frequent attendance at church services on the Sabbath.[6] Ryffel's *roman à clef,* discussed in Chapter 2, also suggested that the family spent winters in the city and summers on their country estate.[7] As a child, Davidson's world may therefore not have been the 'indoor world' of girls described by Prochaska (Prochaska 1980:3), as Ryffel's work suggests that the summers were spent outside, roaming the countryside, riding ponies, gardening, picnicking and playing (Ryffel 1890).[8]

It is this *roman-à-clef* written by the Swiss governess of Davidson's youngest sister, Williamina Saida (1856-1939) which potentially provides the best insight into the factors and character traits which were to lead to Frances Davidson's later work with the dying. As discussed earlier, this work[9] was written for the entertainment and edification of children and it must be recognised that Ryffel may have altered facts to accommodate her literary aims. However it appears to have been modelled very closely on the actual circumstances of the Davidson family and surviving family members have retained the 'key' linking each of the characters to a clearly-identified family member, servant, location and even pet animal. It therefore seems reasonable to regard it as a plausible source for the study of Davidson's early life. The 'key', held by different Davidson family members, identifies Frances Mary, but even without that, her place in the family as the second daughter, as well as her character traits show 'Susan', as she is known in Ryffel's work, to be the only possible portrait of Frances Mary within the book.[10] Davidson's later life and actions also confirm the likelihood

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[6] The family seems to have attended various different churches in the Banchory area, sometimes two different ones on one day. It is not clear what motivated a particular choice on a particular Sunday (Conversation with Janet Davidson, based on Anne Davidson's diaries).

[7] The problems associated with using Ryffel's work as a source were considered in Chapter 2 and are further examined below. All references must be considered with caution and cannot necessarily be taken as accurate.

[8] The camping analogy used by Davidson and cited below (p 90), of lengthening cords and strengthening stakes, would support this view.

[9] Mrs Ryffel (New Edition c.1890) *Mademoiselle's Story* Griffith Farran & Co., London

[10] An extract of this key to the Davidson family members and their pseudonyms can be found on p 41.

that many of the elements in Ryffel's description provide a plausible background for the Friedenheim's founder.

Although the work therefore cannot furnish irreproachable source material, in the absence of Davidson's own diaries or family letters, this account provides the only potential contemporaneous source of information about Davidson around the time she decided on her life's work.

As 'Susan', Frances Davidson played only a minor role[11] in the story of Mademoiselle's[12] personal growth towards professional competence, understanding and maturity, reached through discussions with 'Lady Hepburn' [Mrs Davidson] and insights acquired while teaching the tomboyish and energetic 'Willie' [Williamina]. Key elements relevant to Frances Davidson emerge from the story, however, as well as two unusually specific, un-coded references, examined below.

The family described by Ryffel was one of faith, expressed in service to the community and responsibility for others:

> Sunday at Ravenswood [Inchmarlo] was not less, but more than other
> days; it had always been so....Now that the children had put away
> childish things, they had kept to the something special for Sunday; only
> instead of toys to learn from, they had children to teach; instead of little
> treats for themselves, they gave treats to others (Ryffel 1890:68).

There are numerous examples given throughout the book of care and gifts provided for the needy, particularly children and the elderly.[13]

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[11] At the supposed time of the events in the story, Frances Davidson would already have been 28 years old, i.e. six years older than 'Mademoiselle'.
[12] Research has shown 'Mademoiselle' to be Fanny Adèle Henry, born c. 1846, who married John Gustave Ryffel in London on 19th May, 1875.
[13] See Ryffel 1890: 36, 39, 40, 73, 74, 75, 159, 178, 187 and 191.

According to Ryffel, the children attended church and, in the tradition of the Church of Scotland, were expected particularly to take note of the sermon, finding something personally applicable in the homily:

> 'Our pastor used to be very particular...,' said Mademoiselle, 'and made us write abstracts of his sermons...'
> 'We used to write abstracts for you, mother, in our young days,' said Susan [Frances]: 'ought not these children [her younger siblings] to do the same?' (Ryffel 1890:70).

Ryffel suggested that religious feelings coupled to moral issues were openly discussed. 'Margaret' [Mary Margaret Davidson (1846-1914)] and her brother 'Frank' [George Davidson (1858-1939)], 'used to have long conversations together, and he was always open and ready to talk of religion, and of his own feelings with regard to it' (Ryffel 1890:109).

Of all the family, 'Susan' [Frances] was reported as the one who nursed her nephews and nieces through severe colds (Ryffel 1890: 98,107) and then immediately volunteered to look after a brother in lodgings while he was in quarantine for scarlet fever (Ryffel 1890:107). Later in the year, she apparently returned to her sister's[14] house to nurse her through another confinement (Ryffel 1890:138).

Three passages are of importance for insight they may bring to Davidson's future calling and attitude towards work and marriage. The first occurred during a conversation which took place between Mademoiselle and Davidson's sister Katherine (1845-1925).[15] Talking about bringing up children, Ryffel wrote that 'Helen' [Katherine] said:

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[14] Mrs St. Clair [Jane Anne Davidson, married to Sir Francis Boyd Outram Bt.]
[15] Katherine would then have been approximately 23 years old.

'…I have rather a fancy for doing it on a large scale, and would not wonder if that turned out to be my vocation, and I found myself some fine day with a houseful of orphans or such destitute creatures…'[16]

'Do you mean to say you want to undertake such a tremendous work…for your pleasure?' [Mademoiselle] asked.'

'I did not think of pleasure exactly when I said that… my mother has always told us, that God expects more from us than just doing what pleases us most. He wants us to give our best talents and energies for the good of others…' (Ryffel 1890:140-141).

'Helen' [Katherine] was later reported as saying, '[Marriage] does not come naturally in a family where there are so many girls. We always get on very well with the gentlemen who visit us, but we never flirt. I believe we don't know how to do it' (Ryffel 1890:141-142).

The second passage comes shortly afterwards in the same chapter. Ryffel related an incident that allegedly occurred one day when the family were gathered on the stone steps in front of the house:

Helen [Katherine] was not the only one of the girls who felt a desire to find some special work for which she was adapted… Susan [Frances], who sat nearest her mother, was heard to say –
"There is so much work that ought to be done! I feel it is wrong for me to sit here, idly enjoying myself. I would like to find out some work, and be of some use in the world."

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[16] Katherine was only partially correct in these predictions. She became one of the first Deaconesses ordained by the Church of Scotland, worked with the Women's Guild and pioneered work amongst Scottish fisher-girls (Headstone in Banchory Churchyard, Warfield 1889:290). She never married.

When her family protested that they 'don't know what they would do without' her, she continued:

> "Oh I like nursing you all...but happily you do not require nursing always, and I would like to help those who are in more need of help."

> Perhaps it was in answer to her wish that just then someone came to tell that old John [the coachman] had hurt his leg. She rose instantly, went to her room for bandages, and hurried to the cottage by the riverside...Still Susan [Frances] would remain at the cottage that night, as his wife was very much unhinged and nervous at being left (Ryffel 1890:143-144).[17]

The final passage occurs in the last chapter of the book at the end of Mademoiselle's year-long stay with the Davidson family. Ryffel wrote that an aunt asks why 'Susan' [Frances] is looking so much brighter than of late, to which 'Lady Hepburn' [Mrs Davidson] apparently replied:

> 'She has found her vocation, and her mind is at rest...She has given herself to the service of the Lord among His poor, and has received her father's and my consent to go to the Mildmay Institution for Training.'

> Susan [Frances] had felt her vocation when reading the "Memorials of Agnes Jones," the Liverpool nurse. The words of Florence Nightingale quoted in the Introduction had been to her "the call to arms," and had fired her with an earnest enthusiasm to follow in her footsteps, and devote her life to the sick and suffering, seeking to lead the weary and heavy laden to the Saviour, who alone can heal their sorrows and give pardon and peace and rest (Ryffel 1890:213-214).

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[17] Note that the bandages are supplied from 'Susan's' [Frances'] room and that she is concerned for both John, and his family.

The book's final chapter implies that, having left the 'Hepburn' [Davidson] household when 'Willie' [Williamina] went to boarding school in 1869, Mademoiselle nevertheless intended sometime later to continue her career within the family looking after the children of the eldest daughter, 'Mrs St. Clair' [Lady Mary Outram] (Ryffel 1890:212-213). Ryffel also stated that she continued writing to 'Lady Hepburn' [Mrs Davidson] after she left their employment (Ryffel 1890:213-214). By the time of publication, however, Mademoiselle had become 'Madame Ryffel' with children of her own[18] and, in her own words,

> 'Lady Hepburn's [Mrs Davidson's] daughters have not hurried to their work; they prepared quietly for it, not neglecting the duties that fell in their way… Once they had entered the great Master's harvest fields, they found them for ever widening before them; and without seeking for talents they had not got, they found a full use for those they had (Ryffel 1890:214).[19]

Two questions arise in the context of the above citations. The first is about the consistency of dates, which appears to be impossible as stated and is discussed below. Secondly, the two references to the Mildmay Institution and the *Memorials* are stylistically incongruous, un-coded and appear artificially introduced into the narrative. Unusually specific, they are also examined in the following section.

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[18] Bertha, born 1876 and John born 1878
[19] Although this passage can be taken literally, there is also an indication of the Davidson daughters' acting as willing servants of God, in harmony with providence and accepting His plans

4.3 The Agnes Jones and Mildmay references

The *Memorials*

Internal evidence indicates that *Mademoiselle's Story* is set in the years 1868-1869. As noted in Chapter 3:57, however, the *Memorials of Agnes Jones* was first published in 1871 and Davidson cannot, therefore, have read the book in 1869. The date of the first edition of *Mademoiselle's Story* however, though unclear, is probably 1887 i.e. after Davidson had left home and opened the Friedenheim. Following the practice of eighteenth- and some nineteenth-century novels, it can be supposed that Ryffel included the *Memorials* anecdote in the final chapter – though in fact happening at a later date – as a literary device to tie up loose ends at the conclusion of the book. Although it is therefore unlikely, if not impossible, that the date Ryffel gives of Davidson's epiphany and call to service is accurate, the fact of her having read and been inspired by the *Memorials* is plausible.

In Jones' biography, extracts of her own writings are linked by commentary from her unnamed sister, who wrote:

> The memoir has been compiled… for Christian women, who, reading the story of her consistent walk in paths of no ordinary difficulty, and moved by the example of unwavering devotion to her heavenly Master's work, may go and do likewise (Anon 1871:299).

While the lasting effect, or indeed competence, of Jones' work has been called in question (Dingwall et al.1988, Smith 1982), the *Memorials* is a powerful, if sentimentalised presentation of her struggles.

Similarities in background between Jones and the young Davidson appear numerous and striking. Both came from well-to-do, close-knit families and both

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girls apparently started their philanthropic careers nursing the local poor from a base on their father's country estate. Enjoyment of nature and particularly plants and flowers was a constant throughout both their lives as was a connection with the Deaconess movement.[20] The parallels however, probably cease there. Jones committed herself to austere, even harsh training, first at Kaiserswerth and later in London, a path probably not chosen by Davidson.

In the *Memorials*, both Nightingale, in her introduction, and Jones laid great emphasis on the necessity for rigorous professional training (Nightingale in Anon 1871:xii-xv). No evidence has come to light of Davidson having undertaken any training before (or indeed after) 1885,[21] when she started her life's work. Given her connection with the Mildmay Mission (see below), the logical place for any training would have been with the Mission itself. Surviving archives for the multiplicity of organizations supported by the Mildmay Mission are, however, dispersed and incomplete but the first volume of Mildmay nurses' records[22] starts only in 1886, i.e. after Davidson had already opened the Friedenheim. The Friedenheim/St. Columba's records indicate that her role there was confined to supervisory and administrative matters, and although in daily contact with the patients and present at their deaths, she seems not to have actively nursed them. Memorial tributes to Davidson after her death, discussed later, imply that during her time at the Mission, she was a Visitor to the poor.

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[20] Davidson's connections with the organisation responsible for the Deaconess movement in England are verified and examined below.
[21] Ryffel's comment, 'without seeking for talents they had not got', might well imply that none of the Davidson women undertook further training.
[22] Held in the Royal London Hospital. Davidson's niece, Connie, started nursing training at the Mildmay Mission in 1887, but did not finish the course.

The Mildmay Mission[23]

Ryffel's reference to the Mildmay Mission is also unusually specific. As this was written or at least published later than the supposed action in the book, it seems inherently unlikely that the Mission would have been cited at all if Davidson had not, by then, had well-established connections with Mildmay. Evidence discussed below supports Ryffel's implication that Davidson began her work among London's poor with that organisation, and corroboration of her connections with the Mildmay Mission comes from other external sources such as Butler[24] and the Mission newsletter, *Service for the King*.[25]

4.4 1869-1884 - The years of 'quiet preparation' and the call to action

No record has been discovered of Davidson's actions during the sixteen years which intervened between the end of Ryffel's work and the opening of the Friedenheim, perhaps justifying Ryffel's suggestion that Lady Hepburn's [Mrs Davidson's] daughters 'have not hurried to their work' (Ryffel 1890:214).[26] These years are, though, of importance as the time when Davidson must have started her work with the poor and when she might have undertaken some kind of formal training.

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[23]Heasman (1962, 1964) describes the importance and impact of the medical missions, including the Mildmay. By the early twentieth century, the Mildmay Mission, founded in 1866, included two hospitals as well as running visiting schemes for the London poor, a school of nursing, a mission to railwaymen, respite homes for the staff and a revival hall for religious gatherings. It was also the origin and home of the Deaconess movement in England. See also Prochaska 1987. The history of the organisation is described by Thompson (1972).

[24] UoL St.C/F RR and see p 85.

[25] See p 86

[26] The possible inclination and desire to wait for clear guidance from the Lord was later to be echoed in Davidson's reluctance to enlarge the Friedenheim until she had a 'token' to advance. See p 123)

Mildmay and the moment of decision

Evidence of Davidson's connections to Mildmay during this time can be found in a small (8cms x 11.4cms)[27] pamphlet entitled: *My First Visit to Friedenheim* by Annie R. Butler[28] written c. 1903. As the following passage purports to be in Davidson's own words, it is reported in full. Butler had asked Davidson how her work started, to which she replied:

> "As a young girl," she said, "when others talked of what they would do when they grew up, I told them that what I wanted to do was to take care of sick people who had no one else to look after them. I do not know in the least what put the wish into my mind, but it was always there; and when anyone was ill at home the nursing of them fell naturally to me.[29] The chief treat, meanwhile, of my life was to go occasionally for a long visit to Mildmay, and there my desire for a Home like this grew stronger. One day in 1885, The Secretary of the Railway Mission, 131, Mildmay Road, with whom I was staying, said to me, 'But if you wish it so much, why don't you start one? There is a house next to this one to let, No. 133; why should you not take it, and begin? The suggestion was a sudden and rather startling one, much as I had thought of the matter before. Could I do it?"[30]

This passage incidentally supports many of the themes introduced in Ryffel's text, adding weight to the supposition of her reliability.

The first location that Davidson found for her Home, therefore, was in Islington at Mildmay Road, near the Mildmay Mission headquarters in Mildmay Park.

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[27] The size is possibly relevant as many contemporaneous publications issued by the Mildmay Mission were also of that size and used similar typography.
[28] UoL St.C/F RR
[29] This gives credence to Ryffel's account cited on p 80.
[30] Butler A.R. 'My first visit to Friedenheim' c.1903:15-17 UoL/St.C/F

After opening the Friedenheim, further evidence testifies to an established connection with the Mission.

In the early years, the Sister in charge of nursing care at the Friedenheim was from the Mildmay Nursing Home.[31] Further, in an undated report, probably c. 1887/8, the anonymous author stated that the Friedenheim 'has the sympathy and approval of friends at Mildmay, but is supported independently of Mildmay funds.'[32] The relationship between the Friedenheim and Mildmay, however, was amicable and the work and development of the Hospital were regularly reported in glowing terms in the Mission newsletter, *Service for the King* (SFTK), until 1906.

In an 1892 edition of *SFTK*, Davidson is styled an 'Associate' (SFTK 12.1892:271). Mildmay Associates were members of the Association of Women Workers created by Mrs Catherine Pennefather.[33] The Association was started in 1872[34] with the aim of uniting women actively engaged in Christian work and members undertook to 'unite in prayer, to join in the study of the Holy Scriptures, and to render to each other any help that lies in their power' (SFTK 06.1903:1). The 1892 citation comes seven years after the opening of the Friedenheim and is the only reference, other than Butler (c.1903), which firmly establishes a personal connection between Davidson and the Mildmay Mission, although not in the role of an active worker. These references are, along with the reports of the work of the Friedenheim in SFTK, testimony to enduring connections with the organisation.

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[31] A/FWA/C/D160/1 *Friedenheim*, Undated grey brochure, text partially written in November 1886. The sister was assisted by a night and a day nurse and a servant.

[32] A/FWA/C/D160/1 Undated Friedenheim brochure following letter dated February, 1887. This report emphasised that the Friedenheim, although geographically close to the Mission and employing one of their nursing sisters, was a separate institution, with separate funding and in need of separate donations.

[33] She was the wife and co-worker of the Reverend William Pennefather, founder of the Mildmay Mission and the Deaconess movement in England.

[34] Personal communication from Clare Troughton, Mildmay Mission archivist.

One piece of evidence has come to light which complements the Butler account and explains Davidson's interest in the dying, particularly those dying of tuberculosis. In the 1960s, the late Rev. David Rudall (See Chapter 2:34) was collecting information with a view to writing a history of the Friedenheim/St. Columba's. He approached Mrs Mai Thomson, née Davidson, a niece of the founder and now also deceased, for information. In a letter written to Rudall, dated simply 'March 4', Thompson wrote:

> I suppose you know how it all started? My aunt was working in the slums of London[35] (I do not know in what organization) and used to visit a girl who had tuberculosis in hospital. When nothing more could be done for her, she was sent home to die to a crowded home with several younger brothers and sisters. My aunt felt this was so wrong that she took the girl into her own lodgings and nursed her till she died. From then on she determined to have a Home where people could die who were turned out of hospitals and eventually St. Columba's was built. It used to be called Friedenheim Home of Peace before 1914. [36]

Combining the evidence from this letter, together with Butler's testimony, Davidson's *In Memoriam* (see below) and the Mildmay references, a tenable supposition emerges that at some point after 1870, Davidson came to London, perhaps on several occasions, and worked with the Mildmay Mission visiting the sick. Moved by the particular case cited by her niece, she determined to do something about the plight of those terminally ill patients, discharged from hospital though still needing nursing but with no suitable place where they could die.

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[35] Unfortunately, no details of this work in the slums have been discovered, but it would perhaps be fair to suppose that this refers to Davidson's work with the Mildmay Mission.
[36] UoL, IOELC. Box: St. Columba's Hospital/Friedenheim: Items from the Rev. Rudall, Item 16. In some ways this suggests an analogous experience to that of Cicely Saunders with David Tasma. The death of this unknown girl appears to have been the emotional and intellectual trigger which moved Davidson to action, as did Tasma's death for Saunders.

The death of Patrick Davidson

Another important event during this period was the death of Davidson's father which occurred in 1881. Although she is reported as, 'watching by the dying bed of her father, and tending him in his last illness',[37] it is not recorded whether she had already moved to London when his death occurred and to what extent this interfered with or affected her work at Mildmay.[38] Davidson's own *In Memoriam* states that, 'shortly after his [her father's] death she went to Mildmay and took up work among the railway and policemen'.[39] A potential discrepancy therefore exists between the dates implied by Ryffel and the anonymous writer of the *In Memoriam*. The *In Memoriam* clearly suggests that she came to Mildmay only after her father's death. Davidson is not specifically mentioned in Patrick Davidson's will and did not benefit from a separate inheritance which might have funded the Friedenheim.[40]

Aberdeen and London

Davidson's interest in service to the needy is implied in Ryffel's novel and documented in Thomson's letter, but no indication has been discovered of the reasons which took her away from her home city of Aberdeen to London.[41] Various explanations suggest themselves, including the domestic upheaval which must have ensued following her father's death when the family houses

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[37] F/SC/AR1921:16

[38] There is some evidence that part of the family moved to London following Patrick Davidson's death. The 1891 census records Davidson's mother living in New Grove House, Hampstead together with Frances Mary, two other daughters and one of her sons. When Davidson's mother died in 1898, her address was given as 5, Oak Hill Park, Hampstead.

[39] F/SC.AR1921:16

[40] General Register Office for Scotland 23.08.1881 Davidson, Patrick (Reference SC5/41/27 Stonehaven Sheriff Court 532-550)

[41] There is a passing reference in Ryffel (Ryffel 1890:206) that the family wished to spend some months in London in the winter of 1869/1870 due to the ill health of one of the other daughters.

passed to her eldest brother,[42] a growing involvement with the Mildmay Mission or the possibly spiritual and emotional pleasure she derived from her work in the slums (see also Prochaska 2008:72).[43] In addition, there may have been less overt need for philanthropic interventions in Aberdeen as, since 1868, the poorer population had had the services of one of the first medical missions and infirmaries in the United Kingdom (Heasman 1964). Harris also reported that, '…by the end of the nineteenth century, Poor Law medical services were widely catering for the whole of the working class [in Scotland]' (Harris 1994:59).[44] With a population of 73,805 in 1861 (Smith and Stevenson 1988:11), Aberdeen also had two poorhouses[45] which could accommodate 600 people.

Although the Davidson family was Scottish, their home address was written as North Britain, a style affected in the nineteenth century by the more anglophile Scots. The family was educated and travelled abroad[46] and may be supposed to

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[42] Credence can be given to this supposition from an article which appeared in *The Queen*, where the author (very possibly Davidson herself) describes the possible (female) founders of more homes similar to the Friedenheim:

> She has, perhaps, been the dear daughter of a large and prosperous household. Then death breaks up the old well-loved home. It is all right, quite in the nature of things, that it should pass to the new heir with his own fresh younger life. She would not wish it otherwise; it is the inevitable, suitable order of her class. "The old order changeth giving place to the new." But still life has become strangely empty. The old ties are broken, the old village and domestic duties gone. (Anon 1887:65)

[43] As reported on p 85, Davidson had reportedly told Butler that visits to Mildmay were her, 'chief treat… of my life' (Butler A.R. 'My first visit to Friedenheim' c.1903:15-17 UoL/St.C/F).

[44] There is an implied disagreement in Smith, however, who reported that the situation in Scotland was worse than in England. 'Able-bodied persons who presented themselves at the workhouse with some 'slight disablement' were sent to the stone-yard and quickly died, according to the Secretary of the Board of Supervision in 1892. …Highlanders were terribly ill served throughout the century. In 1892, 30 percent of Scottish paupers were over 60' (Smith 1979:355).

[45] St. Nicholas or East Poorhouse (c. 1847) which accommodated around 400 inmates and the Old Machar or West Poorhouse (c.1853) which accommodated about 200 inmates. http://users.ox.ac.uk/~peter/workhouse/Aberdeen (accessed 23.01.08). Scotland had been slower than England in building workhouses; Alison ((Alison, W.P. (1840) *Observations in the management of the poor in Scotland, and its effects on the health of the great towns*, Edinburgh, 1840, (cited in Houston, 2006)) claimed that in 1839 there were only four workhouses in Scotland compared with 587 in England. The population of Aberdeen in 1901 was 153,503 (Encyclopaedia Britannica available on line at http://en.wikisource.org/wiki/1911_Encyclop%C3%A6dia_Britannica/Aberdeenshire accessed 07.07.2009)

[46] Photographs in the possession of James Davidson, Newtonmore

have been aware of conditions in London through contemporary literature and press reports.

The date of Davidson's arrival in London is unknown, but her life there was such as to have created an extensive and well-connected circle of acquaintances[47] who were to support her financially, spiritually and emotionally when the Friedenheim eventually opened in 1885.

4.5 1885-1920 – Fulfilment and death

The creation of the Friedenheim was noteworthy in that the evidence points to the idea of a home for the dying being Davidson's own, and not the emulation of others working in the field, such as Garnier in France or Aikenhead in Dublin.[48] Writing circa 1903, Butler reported the following remarks by Davidson, given as a direct quotation:

> "My mother agreed to my trying the experiment [i.e. the opening of the Friedenheim in Mildmay Road in 1885], and the Home was soon opened with six beds. Before long I had ten, and in six years I felt that if the work was to go on at all, I should be obliged to lengthen my cords and strengthen my stakes.
>
> Full of this idea, I went home to Deeside for the summer, and there met Miss Schofield, one of Dr Harold Schofield's sisters. 'Your work reminds me of something of the same kind in Boston,' she said, and on her return home she sent me the account of Dr Cuyler's Hospital. I had not known

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[47] Over three hundred people were invited to three Open Days held at the new Hampstead premises in 1891 before refurbishment was started.

[48] By 1893 however, Davidson was almost certainly aware of Mother Mary Aikenhead and her (posthumously opened) hospital for the dying, Our Lady's Hospice for the Dying, at Harold's Cross, Dublin. A report of Aikenhead's work, along with that of Davidson, was published in *Woman's Mission* (Burdett-Coutts 1893:178-183 and 246-247).

there was anything 'of the same kind' as mine anywhere, and I was simply thrilled as I read the story of the little Home…"[49]

Davidson's commitment to the work at the Friedenheim was life-long. From 1892 until two years before her death in 1920 at the age of eighty, she lived at the institution in a small flat on the top floor, returning to Scotland only for a few weeks' vacation in summer. As late as May, 1918, although by now having retired through ill-health, she was still writing vigorous memoranda to the Management Council about alterations and improvements.[50]

In her *In Memoriam*, Davidson is described as 'quiet and retiring …never [allowing] her name to be brought forward',[51] qualities which may account for the paucity of facts surrounding her life. She is credited with a 'keen sense of humour, and a wonderful youthfulness' coupled with warm friendliness to 'nurses, servants, patients, patients' friends, and strangers'.[52] She gave great attention to detail to ensure that 'nothing was wanting in her Hospital as regarded skilled attention and material comforts for its inmates'.[53] 'Prayer was the mainspring of her life'[54] and her strong faith permeated all her work. She was appointed Lady of Grace of the Order of St. John of Jerusalem in England[55] in 1919 and was received by King George V and Queen Mary in July, 1920 when they 'personally expressed their recognition of her work for the sick and

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[49] Butler c.1903:17 UoL St.C/F RR 1893. The reading of this text raises several issues, all capable of explanation, but nevertheless giving rise to concern about the accuracy of some details. Elsewhere, for example, it has been reported that the Friedenheim opened with eight beds, not six. A web search has failed to trace Dr Cuyler's institution either in Boston, Massachusetts, Boston County Clare, Ireland or Boston Lincolnshire. I have failed to find references to Dr Cuyler in either American or British medical directories and there is no Dr Harold Schofield recorded in contemporary British medical listings. Dr A.T. Schofield, however, was associated with the Friedenheim for many years as Honorary Physician, see Chapter 5:97.
[50] SMHA/M/III:235 See Appendix B.
[51] F/SC/AR 1921:17
[52] Ibid. 1921:17
[53] Ibid. 1921:18
[54] Ibid. 1921:17
[55] The Order's archives no longer record the reason for, or citation associated with this honour (search November, 2007).

dying'.[56] On her death, their majesties sent a telegram of condolence to Davidson's sister, Williamina.[57] Frances Davidson died at Inchmarlo Cottage on 18th September, 1920, aged eighty.

The following two chapters discuss the building, facilities and growth of the home Davidson founded, as well as the management constraints and challenges involved in funding and running an institution through a period of nearly one hundred years and two world wars.

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[56] SMHA/FSC/CM III:21
[57] The telegram read, 'The King and Queen regret to hear of the death of your sister, whom their majesties had the pleasure of meeting so recently… Their Majesties desire me to express their sympathy with you in your loss. 21 Sept 1920. F/SC/CM II:21

CHAPTER 5 – DAVIDSON'S CONCEPT: BUILDINGS AND FACILITIES

During its lifetime, the Friedenheim/St. Columba's occupied three locations which corresponded to three phases in its evolution: the experimental, central and final periods. Given the importance of physical surroundings to the Victorians[1] and Davidson's own insistence that her institution should provide a place where the poor might die in home-like surroundings, these locations and their facilities are examined in detail below. Although this chapter mainly concentrates on the central period, it nevertheless includes physical descriptions of buildings and, where possible, their contents, over the lifetime of the hospital. These buildings formed the backgrounds, against which staff attempted to resolve the tensions between the provision of comfortable, home-like surroundings and nursing the sometimes 'unbounded' bodies of the dying (Lawton 1998) discussed in Chapter 11.

5.1 The experimental period: 133 Mildmay Road 1885-1892

Between 1885 and 1892, the Friedenheim occupied 133, Mildmay Road. Medical care was assured through the voluntary services of a local general

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[1] Bachelard 1969, Benjamin 1993, Hepworth 1999, Wilson 2003

practitioner,[2] with nurses working under the guidance of a Sister from the nearby Mildmay Nursing Home. Initially, the home accommodated eight patients cared for by three or four staff and Davidson appears to have managed the administration and finances of the Friedenheim singlehandedly.[3] The domestic nature of the Home is revealed by contemporary descriptions.

This was a 'small house' with net curtains at the windows, allowing patients to look out, without being seen themselves.[4] A legend over the entry read, 'In this place will I give peace',[5] but there was no '"brass plate" or signs of an "institution"'.[6] Furniture was 'simple' and 'arrangements home-like,'[7] with five male patients downstairs and three female above. Walls were, 'bright with texts and pictures, and flowers and Scotch heather …in the vases.'[8] There was space for a tiny dispensary and the 'needful accommodation of the staff' which consisted of a 'Sister from Mildmay Nursing Home, a Night and a Day Nurse and a Servant'.[9]

Although situated near the Mildmay Mission headquarters in Mildmay Park and adjacent to the Mildmay Railway Mission (Butler c1903:16),[10] the editors of *Service for the King,* the Mission newsletter, made it clear that responsibility for its foundation and upkeep were solely Davidson's. Their only connection was

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[2] Dr Samuel Tilcott Huggins, LRCP, MRCS, LSA (St. Bartholomew's and Edinburgh). Somewhat later, Butler was to report, however, that, 'In Mildmay days Dr. Burns Thomson and Dr. Maxwell were two of Miss Davidson's great stand-bys' Butler/UoL/St.C/F/RR/undated, c.1903:30). There may have been a succession of doctors over the seven-year period.

[3] It should be remembered that these twelve people constituted a considerably smaller household than that in which Davidson had grown up. The 1871 census shows that the Davidson family household consisted of seven indoor servants, numerous outdoor servants (possibly another seven, the records are not clear) as well as the twelve members of the family (Census 1871 Scotland Kincardine/ Banchory Ternan 252/00 002/00 0011). As the daughter of a relatively affluent, upper-middle class family, authorities suggest that Davidson would have been brought up and trained in the management of a large household (Marshall 1983:257-258, Prochaska 1980:3)

[4] SFTK 1887:10 'Small' is a relative term. The house, though single fronted, occupies four floors.

[5] A/FWA/C/D160/1 Undated brochure attached to Davidson letter dated 08.02.1887

[6] Anon 1887:65

[7] A/FWA/C/D160/1 Undated brochure attached to Davidson letter dated 08.02.1887

[8] Anon 1887:65

[9] F/SC/AR 1885:15 held at the University of Lancaster

[10] UoL St.C/F RR

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that of 'unity of spirit',[11] describing the Home as 'an experimental effort, begun by one lady, mainly at her own expense, and entirely on her own responsibility.'[12]

At some point around 1891, the neighbouring building, 131, Mildmay Road, which used to house the Railway Mission, was acquired to extend their premises. Bed numbers appear to have increased only by two, however, giving a total of ten beds.[13] The leases of both buildings expired on Lady Day (25th March), 1892.

The first publicly available information about the Friedenheim is in an article which appeared in *The Queen*[14] in January, 1887. Unattributed,[15] its primary purpose is unclear: whether to raise funds for the Friedenheim or encourage similarly placed ladies to open further homes in their own neighbourhoods. The article, however, brought the existence of the home not only to the attention of the public for the first time, but also to the notice of the Charity Organisation Society (COS)[16] and its then Secretary, Charles Stewart Loch.

Although its influence on policy makers in both government and the voluntary sector was to decline from the mid-1880s onwards, the COS was still the established arbiter of charitable giving in London and, importantly, the

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[11] SFTK 1887:9 The SFTK fails to mention the presence and 'guidance' of the Mildmay nursing Sister and there is no way of knowing whether this was a paid or voluntary post.

[12] SFTK 1887:9-10 The immediate circumstances behind taking that particular house and actually starting to receive the dying depend on the source consulted, although they are not incompatible. According to Streetly-Smith, Davidson noticed the empty house while walking with a friend and discussing her desire to, '… provide a place wherein [the poor] might die' (Streetly-Smith, 1915: 8-9). Butler, however, implied that the rental of the house was suggested by the Secretary of the Railway Mission with whom Davidson was staying (Butler, c.1903:16, UoL St.C/F RR), a Miss Campbell. The Railwaymen's Mission had moved in February, 1885 from 78 Mildmay Park to 131 Mildmay Road. It catered for the men carrying out work on the North London, Great Eastern and Great Northern Lines. I am indebted to Claire Troughton, archivist at the Mildmay Mission in London for this latter information.

[13] F/SC/AR/1891:18

[14] Anon (1887:65)

[15] Internal evidence suggests it was written either by Davidson herself, or one very close to her, such as her sister Mary Margaret.

[16] See Harris 2004:74-75

organisation to which potential donors turned to establish the credibility and financial probity of a charitable endeavour. These were established by the COS through inspections carried out by their Visitors, who subsequently issued reports to headquarters.[17]

Having received requests for information from the public generated by *The Queen* article, Loch wrote to Davidson in February, 1887, asking about the Friedenheim. In return, she sent a printed, descriptive brochure, requesting that the hospital should not be included on any list of charitable institutions as it was, 'entirely private and very small', adding that replying to applications would take up too much of their time.[18] Thereafter, a series of increasingly irate memoranda exist over a period of some four years between Loch, Davidson and local branches of the COS as Loch tried to obtain information about the Friedenheim.[19] Once the hospital moved into its new premises in 1892, however, relations with the COS appear to have improved. Subsequent reports and letters indicate approval of the work and the manner in which it was carried out, while highlighting deficiencies, invariably material, correction of which, it was felt, would enhance operations.[20]

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[17] COS and King's Fund Visitors appear to have assumed the cloak of the independent Visitors attached to the Voluntary Hospitals of the late eighteenth century, whose mission was to evaluate performance and suggest improvements in order to reassure contributors of the hospital's good management.

[18] A/FWA/C/D161/1 letter to Loch dated 08.02.1887

[19] A/FWA/C/D161/1 letter from Loch dated 22.02.1887, A/FWA/C/D161/1. Letter to Loch from H.V. Toynbee, dated 23.02.1887. A/FWA/C/D161/1 report made by A Fletcher marked 'Approved 22.04.87'. A/FWA/C/D161/1 letter from Loch dated 09.07.1891. A/FWA/C/D161/1 Letter to Loch dated 14.07.1891. A/FWA/C/D161/1 Postcard to Loch from Davidson dated 14.07.1891. A/FWA/C/D161/1 Letter from Loch to Islington Committee dated 17.07.1891. A/FWA/C/D161/1 Letter from Islington Committee to Loch dated 22.07.1891. A/FWA/C/D161/1 Letter from Islington Committee to Loch dated 06.10.1891. By then, Davidson was living in Hampstead, managing the home in Islington and actively seeking new premises. There is a definite feeling in the correspondence that she may have been deliberately avoiding the COS representatives in Mildmay Road, possibly due to time constraints and the fact that a move to new premises was imminent. A/FWA/C/D161/1 Letter from Loch to Islington Committee dated 14.12.1891

[20] Although the Friedenheim/St. Columba's also had connections with the Hospital Saturday Fund and Hospital Sunday Fund, no communications between the organisations have been traced from either the Islington or the Hampstead days.

Through her early work in Islington, Davidson was able to confirm her initial premise that there was a need for residential care for some of the terminally ill: 'The ten beds are occupied by about 40 persons a year... Miss Davidson has to refuse three hundred applications every year for the forty she is able to accommodate.'[21] The move to larger premises to accommodate this need appears to have been encouraged, if not inspired by a new London acquaintance of Davidson's, Alfred Schofield, who remained associated with the hospital for nearly the rest of his life.

Alfred T. Schofield

Alfred T. Schofield M.D., M.R.C.S. (1846-1929) was actively involved with the Friedenheim/St. Columba's until 1926[22] and lent his name to many of the promotional letters and articles which appeared in the lay and medical press throughout this period.

He appears to have taken up the cause of the Friedenheim with enthusiasm around 1891 when he became aware of its work in Islington, and subsequently published an article in the *Contemporary Review*.[23] This article became the source of much of what might be described as early promotional literature in the years that followed and was extensively quoted and referenced. In it, he confirmed Davidson's original premise that 'there [was] not to be found any

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[21] F/SC/AR/1891:18 This is not exactly the same proportion cited by Burdett (*Burdett's Hospitals and Charities Annual*, 1894:lxx), but the two figures give a general idea of the magnitude of the problem and the need for the undertaking.

[22] Schofield was a prolific author and published over seventy books on many aspects of medicine. He mainly wrote on nervous disorders (*The Unconscious Mind* (1898), *The Springs of Character* (1900), *Nerves in Disorder* (1903)), and parenting and hygiene (*Good Health for All, set forth in a series of hygienic chats* (1916), *The Directory of Domestic Hygiene* (1927), advocating the necessity for that subject's inclusion in young women's education. He also developed a method for preparing beef tea with milk which he described in *The British Medical Journal* and *The Nursing Record* of 25 February, 1892:156. Although also writing on Christianity (*The Knowledge of God* (1905), *The Man and the Mule* (1908), *God Over All* (1918)), he had a long term interest in spiritualism (*Another World: or, the Fourth Dimension* (1888), *Modern Spiritsm* (sic) (1920)).

[23] Schofield, A.T. (1891) 'A Home for the Dying' *Contemporary Review* March 1891 vol. LIX:423-427

refuge, home, or hospital but the workhouse for the man who is neither curable nor incurable, but actually dying', until 'a Scotch lady, at her own expense, opened the first eight beds of "Friedenheim"' in 1885 (Schofield 1891:423, 424).The article is also of interest as it incidentally demonstrates that by 1891 Schofield, and therefore probably also Davidson, were aware of the home for the dying established by the Sisters of Charity in Dublin in 1879.[24]

An article which appeared in *Our Hospitals and Charities* in 1905 also mentions the support Schofield gave to the Friedenheim:

> About eighteen years ago the need for such a home was realized by the foundress, Miss Davidson. She saw hopeless cases necessarily discharged from the urgently needed beds of the hospitals… and for these she started a home with six beds. A few years later, supported by Dr Schofield, she acquired… the beautiful house and grounds close to Swiss Cottage now known as Friedenheim.[25]

In 1904, the record of an interview between Schofield and an unnamed representative of the King's Fund potentially, however, gives rise to confusion. Schofield's identification of himself with the Friedenheim's work led his interviewer to infer that he was responsible for its foundation. A note of the interview reads:

> Dr. Schofield explained that this institution was the outcome of an article of his in the "Contemporary Review" some years ago,[26] and that it was founded at a meeting in his drawing-room. He attends weekly to

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[24] Our Lady's Hospice for the Dying had been founded at Harold's Cross near Dublin under the auspices of the Religious Sisters of Charity and inspired by their founder, Mother Mary Aikenhead. In 1900, five Sisters came to London and opened a mission in Hackney, part of which became St. Joseph's Hospice (Winslow and Clark 2005). None of the other homes, either on Continental Europe or in antiquity, were mentioned in this article.

[25] Vol. 1 No. 12 January 15th, 1905. A copy of this journal is held at Royal London Hospital Archives.

[26] Schofield, A.T. (1891) 'A Home for the Dying' *Contemporary Review* March 1891 vol. LIX:423-427

supervise all admissions to the institution as they keep a clearly defined line from any institution for incurables.[27]

It is impossible to establish how this misunderstanding arose, but may explain the insistence in later communications with the King's Fund,[28] *Service for the King*, *Burdett's Hospital and Charities Yearbook* as well as various in-house publications that the creation of the Friedenheim was the work of one person, Davidson, in 1885, antedating Schofield's article by six years.

It was, however, Schofield's original article in the *Contemporary Review* which heralded the Friedenheim's transformation from private 'Home' to more public 'Hospital'. The subsequent opening of the larger establishment with increased bed capacity can be seen as a turning point in the evolution of residential institutional care specifically intended for the dying, perhaps unrecognised or articulated as such by those running the institution itself.

5.2 The central years: 8, Upper Avenue Road (later re-named and re-numbered 98 Avenue Road), Hampstead 1892 - 1957

The impetus behind the acquisition of the Hampstead premises appears to have been twofold: firstly the Islington leases were due to expire but Davidson was also moved by her inability to accommodate all those requesting admission to the Friedenheim. A long lease was therefore purchased on a house on Upper

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[27] LMA/A/KE/251/1/1 This misapprehension is responsible for the possibly misleading entry in 'Hampstead: Public Services', A History of the County of Middlesex: Volume 9: Hampstead, Paddington (1989) pp. 138-145. URL: http://www.british-history.ac.uk/report.asp?compid=22649. (accessed June 2006), which reads: 'St. Columba's Hospital or home of peace was founded in 1885 as the Friedenheim hospital after a meeting at the home of a Dr. Schofield and largely at the expense of Frances Mary Davidson who became the honorary superintendent.'

[28] LMA/A/KE/251/1/3

Avenue Road, Hampstead where, in addition, the purer air outside the city was felt to be beneficial to tubercular patients.[29]

A review of the facilities available at the Avenue Road location indicates the extent of the project undertaken by Davidson. Sunnyside, as the house was then called, was a large house on three floors with a basement and extensive garden. It had a Greek Doric porch and had been built, '…by 1862 and possibly in 1847'.[30] Over the years, the number of patients who could be accommodated in the hospital varied according to building works and finances with a maximum number of 50 beds. Figure 5.1 shows the Friedenheim c. 1905.[31]

ILLUSTRATION 5.1 The Friedenheim in Upper Avenue Road c. 1905

Friedenheim Hospital.

Author's own collection

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[29] SFTK, January 1892:20 This view certainly appears accurately to reflect the situation in Hampstead although the quality of the air is unlikely to have been solely responsible. Smith wrote that, 'In 1895 Hampstead had a reported rate [of tuberculosis] of 93 per 100,000 while St. Gile's, St. Saviour's and St. Olave's had 330 per 100,000' (Smith 1979:289).

[30] http://www.british-history.ac.uk/report.asp?compid=22639 Accessed September, 2006

[31] The exterior façade of the house provides a striking contrast to workhouse exteriors, but of course raises the question of the extent to which some of the patients might, in fact, have felt intimidated by these fairly grandiose surroundings.

In retrospect, it is clear to see that the move to Hampstead was of crucial importance and brought with it a shift from 'amateur' to professional, home to hospital and small to significant. A purely private initiative now became of necessity a more public undertaking due to the scale of the operation and the need to draw on wider sources of funding. This increase in size forced Davidson to create the management, fiscal and promotional structures to direct and maintain this much larger institution (see Chapter 6).

Davidson took possession of the Avenue Road house before the Islington leases expired, moving furniture, books and other belongings in on 24th March, 1892.[32] The buildings needed extensive conversion to make them suitable for her purpose and although a dying child was re-admitted for four days until her death in July 1892,[33] the Home was not ready to receive patients until January, 1893, nearly two months after its official opening on 7th November 1892 by HRH the Duchess of Teck.[34] The extent of the refurbishment gives an idea of the size of the undertaking. Gas and water pipes had to be repaired, the kitchen needed upgrading and pantries, lavatories and baths had to be installed on each floor.[35] The billiard room was divided to form the staff sitting room and a dispensary. Plans were made for the installation of a lift and extensive interior decoration

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[32] Already on Saturday, 26th March 1892, she invited a large number of friends - according to Davidson's sister, Mary Margaret Davidson, over 150 - to view the new premises and take part in a meeting for praise and prayer in the 'large drawing room'. UoL St.C/F RR Davidson, M.M. *Friedenheim,* 1893

[33] Beatrice Tucker, aged ten, particularly asked to return to the Friedenheim. She had left the Mildmay Road building in July 1891, but her condition deteriorated during the winter and, by the following summer, she was very close to death. She asked to be readmitted and came (with her mother accompanying her) on July 12th 1892, dying four days later. In remembrance of this first patient, her bed was named the 'Beatrice Bed' in what became the Ina Ward (UoL St.C/F RR 1893 MMD).

[34] Princess Mary Adelaide Wilhelmina Elizabeth, Duchess of Teck (1833-1897), granddaughter of King George III.

[35] UoL St.C/F RR 1893 AR and SMHA/CF/2,8 It should be remembered that at this stage, all responsibility still essentially rested on the shoulders of Davidson alone.

was undertaken.[36] Davidson herself moved into the top flat which was to be her home for the next twenty-four years on 16th May, 1892.

Photographs show wards and day rooms which were spacious, with ample room between beds for nursing, patient lockers and screens (later curtains) to afford some degree of privacy. All wards had views on to the garden with open fires for heating, decorative plants and pictures or texts on the walls. These were not only in stark contrast to conditions in the workhouse infirmaries described in Chapter 3 but also compare favourably to those which were later created in St. Luke's House (Goldin 1981:396 Figs. 1, 2 and 8).

ILLUSTRATION 5.2 The Friedenheim: Albert Victor Ward, c. 1910

ALBERT VICTOR WARD.

London Metropolitan Archives, used with permission

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[36] Much of the furniture was supplied through the offices of a Mr. John Groom who donated the contents of his Hampstead house, delivered in four van loads. Groom's gifts furnished the, 'Staff Dining Room, Sitting Room, and Waiting Room, besides all kinds of useful furniture for other parts of the house.' UoL.StC/F RR Davidson, M.M. *Friedenheim*, 1893:14

ILLUSTRATION 5.3 The Friedenheim: Women's Day Room c. 1908

WOMEN'S DAY ROOM.

London Metropolitan Archives, used with permission

The extensive gardens of the Friedenheim were always a feature of the hospital, providing fresh air and pleasant views for the patients. As well as a vegetable plot which supplied the hospital, a tennis court and private garden were built for the nursing staff. Three witnesses who knew St. Columba's in the 1940s and 1950s particularly mentioned the grounds. One of these had, 'vivid memories…playing round the large mulberry tree and tasting its fruit'.[37]

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[37] Personal communications from Freda Rudall, Colin Rudall and Dr J.A. Clark Wilson, 13.12.2007, son of the Medical Director, Dr J. Clark Wilson.

Much of the newly constituted Executive Council's[38] time was occupied in managing and improving the fabric of the building.[39] In addition to regular maintenance such as cleaning,[40] decorating,[41] replacing gutters[42] or a boiler,[43] the Council was also constrained to incorporate the 'suggestions' of the King's Fund (see below) in order to assure that income source and the kudos of its support.[44] These suggestions invariably related to physical facilities and the King's Fund donations were allocated towards the cost of these improvements. The Fund suggested, for example, the purchase of fire fighting equipment in 1903,[45] a 'disinfector' for hospital bedding in 1910[46] and an electric lift.[47] One of their more disputed suggestions related to the situation of the mortuary described below (p 106).

There were originally two conservatories in the Friedenheim, a large one which was used as a men's smoking room and a smaller one attached to the men's ward on the ground floor. This collapsed in a storm in 1897 and, perhaps in recognition of the different care needs of cancer patients, was replaced by a new cancer ward, isolation ward and lavatories.[48] The converted conservatory housing the new cancer ward can be seen on the left of the building in Illustration 5.1.

Davidson and the Council wished to ensure that facilities for patients and staff were as agreeable as possible. This involved major investments such as the creation of long, wide balconies overlooking the garden so that bedridden

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[38] The constitution and activities of the Executive Council are examined in Chapter 6.
[39] See below and UL/SC/F RR 1893 AR and SMHA/CF/2, 8
[40] SMHA/CM/II:32
[41] SMHA/CM/I:166
[42] SMHA/CM/I:288
[43] SMHA/CM/I:294
[44] Details of the disbursement of funds were published in *The Times* newspaper, providing indirect advertising and, assuming the workings of the King's Fund were known, a guarantee of the institution's worthiness for support.
[45] SMHA/CM/I: 100
[46] SMHA/CM/II:30
[47] A/KE/531(3)10 It is interesting to note that by acting on the Fund's 'suggestion', the Council incurred costs of nearly £2,000, to which the Fund contributed £100 (A/KE/531(3)10,11,12,13)
[48] F/SC/AR 1897:10

patients could be wheeled out to enjoy the fresh air and view.[49] The first plans for these balconies had been mooted in April, 1914 and agreed by the Council in October that year.[50] Their construction, however, was only finished in October 1919, at the same time as major renovations on the top floor.[51] Fixed screens were added at either end of the balconies in 1920 to provide shelter from any wind. Photographs dating from the 1950s still exist of patients on these balconies,[52] taking tea with their visitors.

Facilities inside the Hospital were constantly improved and the minutiae of, for example, contracts with boiler engineers and pest control services or the purchase of fire extinguishers and buckets are all recorded in the Council Minute Books.[53] In 1906 an operating table and a dressings table were donated to the hospital.[54] Two 'Restiform' beds for the patients' greater comfort were received as a gift from Kingsley School for Girls in 1930.[55] Patients' entertainment was not neglected. In 1920:

> By the kindness of a new friend, Mr. Ronald Preston, an electrophone has recently been installed in the men's ward, by means of which we can be connected with almost all the places of amusement, and with quite a number of churches.[56]

This equipment was enhanced in 1924 with the gift from a patient's family of:

> …a wireless installation to her ward, which the patients have much appreciated. The Men's Ward had already been presented with a crystal

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[49] SMHA/CM/II:128-140
[50] SMHA/MBII:128, 140
[51] During these renovations, the hospital was closed for three months. Not only were the balconies erected, three upstairs rooms were thrown into one to make one ward. F/SC/AR/1920
[52] Author's collection
[53] SMHA/MBI:111
[54] SMHA/MBI:223
[55] F/SC/AR/1931
[56] F/SC/AR/1920

set earlier in the year by Father Hogan, the Roman Catholic Priest who was visiting a patient there at the time.[57]

By 1926, the Medical Officer, John Clark Wilson was able to report that, '… the ubiquitous wireless has been installed in all wards'[58] and in May, 1935, a '…new wireless installation' was donated by the Managing Director of *The News Chronicle*:

> It came just in time for the patients and staff to listen to the Silver Jubilee broadcasts and made us feel very closely linked with the Empire. Little did we think that in so short a time we should be listening in to the sad procession of His late Majesty's funeral and the sorrowful yet triumphant Service at Windsor.[59]

The mortuary

Given prevailing concerns about the treatment of dead bodies when the Friedenheim opened (Chapter 3:68), the importance given to the mortuary is not surprising.[60] Perhaps as a general reflection of this concern, in 1896, *The Nursing Record and Hospital World* published an article on hospital mortuaries,[61] including the facilities at the Friedenheim which were described as, 'clean and bright', creating the overall impression, 'that the dead were reverently cared for'.[62]   In 1897, the Annual Report included an extract from an article which appeared in *Mothers and Daughters* in November, 1896, and

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[57] F/SC/AR/1925
[58] F/SC/AR/1926
[59] F/SC/AR/1936
[60] Even in 1926, the Council members were still careful to avoid any possible perception of collaboration with undertakers and firmly refused a financial donation from a local firm following the death and interment of a patient. They directed that a letter be sent to the firm, suggesting that offered donation be given to the relatives of the deceased. SMHA/CM/III: 208
[61] Few of these had found favour in the eyes of the author, 'M.B.' as they were deemed mostly dirty, crowded or also used for post-mortem examinations.
[62] Available on line at http://rcnarchive.rcn.org.uk/ Vol.17 11 July 1896:25-28 keyword search mortuaries Accessed 25.01.10

which particularly praised the mortuary.[63] Following a visit in 1904, the Bishop of London also congratulated the hospital on its mortuary arrangements, saying, '…even the Mortuary in which rest the bodies of about 100 each year before they are carried to their graves is given that look of hope and rest which befits a Home of Peace.'[64]

ILLUSTRATION 5.4 The Friedenheim mortuary (undated)
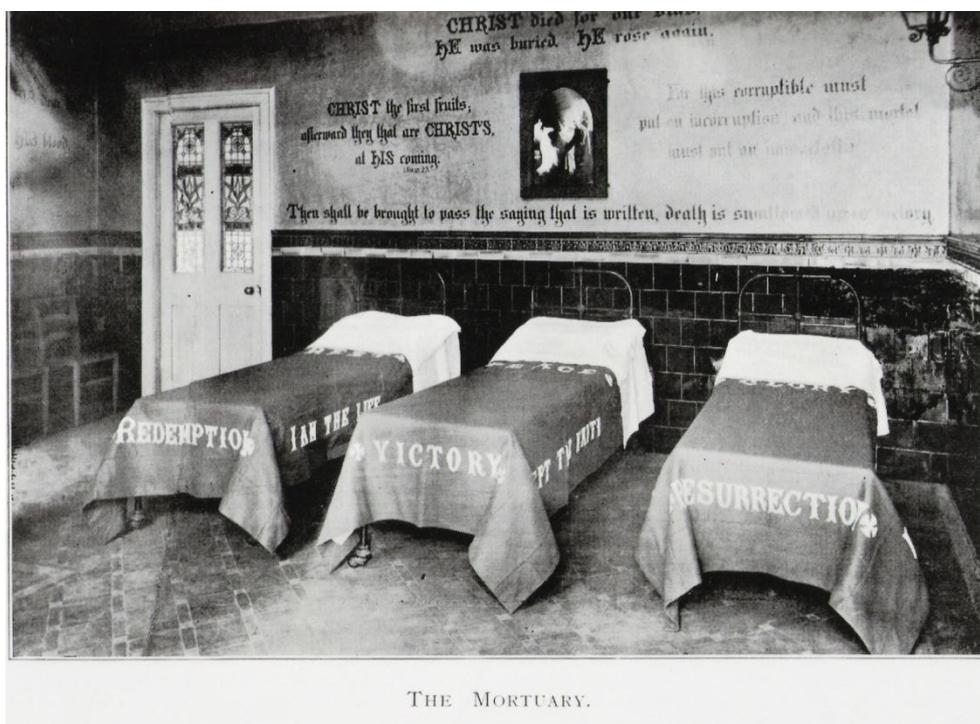
THE MORTUARY.

University of Lancaster. IOELC Used with permission

By 1925, however, these arrangements perturbed the official Visitors from the King's Fund who were concerned with the proximity of St. Columba's mortuary to the kitchens. According to them, this proximity, '…leaves an unsatisfactory

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[63] F/SC/AR 1897:14 The mortuary was described thus, 'Here the low beds were draped with violet cloth, and furnished with snowy linen, every detail giving evidence of the reverent treatment accorded to the inmates of Friedenheim from first to last'.
[64] SMHA/CMB/I:147

impression upon the mind of not too sensitive observers.'[65] The Council immediately commissioned the eminent forensic pathologist, Sir Bernard Spilsbury (1877-1947), to inspect and report on conditions there. His report, in a letter dated 27th March 1925 was unequivocal, 'In my opinion the construction of the Mortuary is admirable,' going on to describe alterations which, though he did not 'consider them to be necessary, would add considerably to the isolation of the Mortuary.'[66] Dr Clark Wilson, the Medical Officer, promptly wrote to the King's Fund, citing Spilsbury's report at length.[67]

The subject recurred, however, in 1936 when a 'Remark' was added to the disbursement of a maintenance grant by the King's Fund:

> Remark: I am directed by the General Council to ask for the observations of your Committee on the following paragraph in the Visitors' Report, viz: "Mortuary and Post-mortem room: There is no separate room for relatives to view the body."[68]

Again, the arrangements were defended by the then Matron, Olive Howlett, in a letter dated 27th January, 1937 to the Honorary Secretary of King Edward's Hospital Fund for London. This letter incidentally also provides insights into the arrangements for visitors to the hospital at this time:

> I am to say that when the relatives of a patient are attending either in cases of extreme crisis or after the death of a patient, the Hospital Council Room, which is a comfortable and cheerful room, is used as a waiting room by them. It is our experience that few ask to see their dead after removal to the mortuary, and if they do, and it should happen that there is also a body other than that of their own relative in there, we can

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[65] SMHA/CMB/III:179
[66] SMHA/MB/III:186 Letter to the King's Fund dated 30th March, 1925
[67] A/KE/257/1/4
[68] A/KE/531(3)/28

remove the other for the duration of their visit. This can be easily arranged, as the Post-mortem Room is very seldom used for Post-mortem examinations, and in the meantime can be used for this other purpose, as it opens out of the mortuary.

The Council are satisfied from their enquiries that every possible hospitality and consideration is shown to patients' relatives on these and all occasions.

I enclose a photograph of our Mortuary, from which you will see that it is carefully and reverently planned.[69]

The nurses' home

As was usual at that time and, indeed, throughout the life of the institution, residential accommodation was provided for the nursing staff. Nurses' rooms were originally in the main building, but Davidson felt they should have a dedicated Nurses' Home, in a separate building. The Medical Officer, Dr Percy Lush, supported her proposal:

I should like to repeat that the sleeping accommodation for our nurses is not adequate; and considering the class of cases [i.e. terminally ill patients] which fill the wards of the Home, and also the necessarily somewhat depressing character of the Nurses' work, it is highly desirable that the proposed Block – outside the present building altogether – should be proceeded with as soon as possible.[70]

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[69] A/KE/531(3)/30 Unfortunately the photograph of the mortuary is no longer attached.
[70] F/SC/AR/MR 1899:17

The roof and first floor of the new Nurses' Home can be seen to the right of Figure 5.1, showing its relative position, via a covered way, to the main hospital building.

The change of name

A serious crisis, potentially affecting public support and funding, was averted at the onset of WWI by changing the German-sounding name of the institution. The source of the name 'Friedenheim' is explained in an article published in the *Daily News* in 1892 which credits a Mrs Rundle Charles with its choice.[71] The anonymous author wrote:

> In Germany the word "Friedenheim" is sometimes employed to signify a place of burying[72] but here it is used to signify, not a resting-place for the dead, but a home of peace for the dying. The word was suggested to Miss Davidson by her friend Mrs Charles … who pictures [the Friedenheim of Mildmay Road] as a Home of Peace, and also a threshold of Hope.[73]

This is confirmed both in Davidson's *In Memoriam*[74] and in the 'Note', written by Mary Davidson, Frances Davidson's sister, as a postscript to Rundle Charles' autobiography, *Our Seven Homes* (1896). Mary Davidson wrote:

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[71] Elizabeth Rundle Charles (1828-1896) was a prolific Victorian religious author and friend of Davidson. Charles was best known for her historical romance, *Chronicles of the Schönberg-Cotta Family*, published in 1863. The novel is an account of the life of Martin Luther seen through the eyes of various members of the Schönberg-Cotta family, particularly a daughter, Else, and her brother, Friedrich. It is clear from the preamble that Charles had a good knowledge of German, having based the historical elements of her work on various writings of Luther in the original German and German-language historical texts (Rundle Charles 1871:8). It is, therefore, probable that Charles was sufficiently confident in her competence in the German language to create this neologism, 'Friedenheim'. The *New Schaff-Herzog Encyclopedia of Religious Knowledge* erroneously credits Charles with also having founded the Friedenheim in Hampstead [sic] as a home for incurables [sic]. www.ccel.org/schaff/encyc03.html accessed December 2006.
[72] This is linguistically inaccurate, see Footnote 76. The writer was presumably thinking of the word *Friedhof* (cemetery).
[73] *Daily News* 04.11.1892 Issue 14537
[74] F/SC/AR 1921:17

It was she [i.e. Charles] who chose the name of 'Friedenheim' for the 'Home for the Dying,' founded in 1885, now established in South Hampstead, and the delight she took in the work is expressed in the paper she wrote at the request of the Baroness Burdett Coutts,[75] for the Women's Convention at Chicago in 1893 (Rundle Charles 1896:219-220).

The word 'Friedenheim' ('home of peace'), while sounding authentic and perfectly comprehensible, does not however exist, as such, in received High German.[76] This apparent, but spurious, German connection occasioned a letter to the Council from a subscriber, a Miss Tate, in October, 1914[77] in which she reported that she had had to defend the hospital against accusations that it was run by Germans. Although Tate had contradicted such assertions, owing to the war, she felt that it might be advisable to change the name. The suggestion was adopted at the Council meeting of 15th October, 1914 and various new names were considered. With the agreement of their Patron, Queen Mary, Davidson proposed to name the institution 'St. Columba's Hospital' and the Annual Report of 1915 explained the reasoning behind the choice of this name. The passage opens with regrets that the name, '…so dear to many of us is no longer to be applied to this "Home of Peace"' and continues:

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[75] See Burdett-Coutts (1893:178-183)

[76] The word 'Friedenheim' does not appear in any of the following reference dictionaries: *Brockhaus Wahrig* (6 vols) Wiesbaden 1980-1984, *Duden* (6 vols) Mannheim 1976-1981, *Klappenbach und Steinitz* (6 vols) Berlin 1977 and most importantly Grimm's *Deutsches Wörterbuch* (32 vols) 1838-1961. There is, however, an area of Munich called the Friedenheim, the name derived from the property in whose grounds the housing estate was built. See the State Archives in Munich,
(http://www.muenchen.de/Stadtleben/Bildung_Beruf/Bibliotheken_Archive/stadtteile/geschich te/134468/bezirk25.html), accessed 15.03.2009 or Sonne 2005. The archives cite Albrecht, Dieter (1951) *Das Landgericht Starnberg: Historischer Atlas von Bayern, Teil Altbayern, Heft 3,* München.
In addition, I am indebted to Dr R.H. Watt, sometime lecturer in German Studies at the University of Glasgow for pointing out that the morphology of the word 'Friedenheim' tends to rule it out as a native High German word since all compound nouns based on 'Frieden' are constructed with '-s-', e.g. Friedensvertrag, Friedenshoffnung etc. Interestingly, Saunders, on at least two occasions referred to the linguistically correct 'Friedensheim Home of Rest' (Saunders 1993:3 and 2005b) although the hospital was never called such.

[77] SMHA/CM/II:139

The name of "St. Columba" is greatly venerated in Scotland, as the Missionary who brought the Gospel to that country in the sixth century… The original name "Home of Peace" is still retained, and it will be clearly seen how harmoniously the two titles blend, as the Dove with the olive branch is the symbol of the Messenger of Peace.[78]

Both name and symbol continued to be associated with the hospital until its closure in 1981.

The need for permanent accommodation

The Avenue Road premises had been taken on a fifty-year lease, and after Davidson's death in 1920, the Executive Council started looking for more permanent accommodation. Various discussions took place with the land owner, aimed at extending the lease or purchasing the property, but without success.[79] In 1938, therefore, the firm of Knight and Co. was approached to search for new premises, with the conditions that the total cost should not exceed £15,000, including any necessary alterations, and that it should be within 15 miles of their current site. The main criterion, however, underlined in correspondence, was that there should be easy access for visitors by public transport.

Early in 1939, a suitable freehold property was identified in Wimbledon.[80] Funding was now available (see Chapter 6), negotiations had begun and the Council would, 'in all probability have purchased [it]'[81] had not war broken out. The current lease on Avenue Road was extended for the duration of the war

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[78] F/SC/AR/1915
[79] SMHA/CM/III: 102, SMHA/CM/III: 176, F/SC/AR 1925, F/SC/AR 1937, F/SC/AR 1939, SMHA/CM/III:189, 194
[80] Ridgelands College, The Ridgeway, Wimbledon
[81] F/SC/AR 1940

and for six months thereafter.[82] In fact, St. Columba's continued at Avenue Road for some years after the end of the war, but records are not clear for the reasons behind this unexpected prolongation of the lease. The implication in the Minutes is that the building and grounds of St. Columba's Hospital, at some time during or shortly after the war, had been acquired by the Local Authorities. Presumably the hospital itself had either no longer been in a position, or no longer desired, to purchase them itself.

In the Annual Report for 1945, written in part during Victory Week, the Council nevertheless confronted:

> … the immediate problem [of]… where to find new premises as our present lease has expired, and the plans made before the war no longer avail…. It is unthinkable that such a hospital as this should be closed for lack of suitable premises, yet in these difficult days the problem is not easy of solution.[83]

By the next year, however, the Council faced not only the problem of being homeless, but was also confronting future uncertainty over their status under the new National Health Service. Given the confusion which reigned over the status of the hospital under the new National Health Service, the Local Authorities were perhaps willing to extend the lease, while their own post-war situation and that of the hospital itself became clear.

St. Columba's was eventually included within the NHS, administered by No. 21 Paddington Group Hospital Management Committee, but remained in the old premises for nearly ten further years until moved to a new site on Hampstead Heath. The Avenue Road building was demolished in July, 1958.

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[82] F/SC/AR 1942
[83] F/SC/AR 1945

5.3 The final phase at The Elms, Spaniard's Road, Hampstead (1957-1981)

Although chronologically occurring during the years after acquisition by the NHS and discussed later in Chapter 10, a review of the buildings and facilities of the Friedenheim/St. Columba's would not be complete without considering its final location. Following the decision to demolish the Avenue Road premises, the hospital moved to 'The Elms', Spaniard's Road, Hampstead in 1957, where it spent the remaining 23 years of its existence until its closure in 1981.

ILLUSTRATION 5.5 St. Columba's Hospital, Spaniard's Road, Hampstead

Source: Holborn Library. Used with permission

Although the North West Metropolitan Regional Hospital Board, Paddington Group (21) Hospital Management Committee left few records, some details of the problems associated with the purchase of this property are described in Chapter 10. The Elms was a large house, but the absence of a lift meant that

instead of its expected capacity of 40 to 50 patients, the hospital could receive only 35.[84]

An unattributed, undated paper held at St. Christopher's Hospice describes the operation and facilities at the hospital. This paper, labelled simply, 'St. Columba's Hospital',[85] describes the, '…intricately decorated ceilings, carved wooden panels and fancy marble toilets. It must be quite the best place to lie flat on your back and be ill because thus one can best savor [sic] the beautiful high ceilings'.[86] The general tone of the report is positive, describing weekly visits from a consultant geriatrician, Dr Sutchett-Kay[87] (who 'loves the place dearly') and daily visits from an unnamed local GP. Patients were reported to be, 'comfortable and happy' and although, 'the predominant age group was definitely elderly', there was no 'arid geriatric atmosphere'.[88] The only caveat to this was that in the 'large new airy dayroom' which had just been built, all the patients, '…were placed firmly around the walls'.[89]

Staff consisted of a Matron, two Sisters and otherwise, '…young Phillipino [sic] auxiliaries'. One other comment is noteworthy. The author reported that the 'Home does not apparently have a reputation as a terminal home. '"That is the responsibility of the medical staff." "Who told people St. Christopher's was for the dying?" I was asked'.[90]

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[84] CLSAC/SCH/362F/22-23

[85] Christine Kearney, Cicely Saunders' P.A. at the time (see p 40), thinks it may have been part of a survey on homes for the dying carried out for Saunders by an American doctor who came to St. Christopher's for training. Ms Kearney tentatively attributes the short (1½ pages) report to Dr Sylvia Lack and dates it at between 1970 and 1972. Attempts to make contact with Dr Lack have been fruitless.

[86] SChH/SCH first page

[87] Alan Ivor Suchett-Kaye (formerly Abram Icchok Suchecki), MD 1939 Paris, MRCP London 1950

[88] SChH/SCH first page. The implication here seems to be that the hospital had become, in fact, if not in name, an institution for the elderly.

[89] SChH/SCH first page

[90] SChH/SCH second page. I take this to mean that patients were not necessarily aware that the hospital was for the dying and that the nurses left the task of telling patients that their condition was terminal to the doctors. The author was then asked how 'bad news' was broken at St. Christopher's. A possible implication of this is that the report's author spoke only to nursing staff.

Many questions are raised by this report, not least how much reliance can or should be placed on it as it appears to be the result of one, possibly brief visit.

After a certain amount of local controversy, described in Chapter 10, The Elms and the 7.5 acres of land on which it stood on Hampstead Heath[91] were sold by the NHS for building development in 1981.

While this final location had been managed by the NHS, both earlier houses had been the responsibility of Davidson, either alone, or together with the management committee which later succeeded her. Relocation to Avenue Road, in particular, was an ambitious project and the management challenges, failures and successes there are described in the following chapter.

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[91] SMHA/CF/18

CHAPTER 6 - MANAGEMENT CHALLENGES AND ISSUES

6.1 Perspectives

This chapter examines the management and administration of the Friedenheim/St. Columba's from 1892 until its incorporation into the NHS in 1948, comparing it, where possible, to similar institutions in London. Recent academic work has revealed the economic and social importance, historically (Morris 2000, Robbins 2006) and currently, of the voluntary or so-called 'third' sector (Morris 2000, Muukkonen 2009, Salamon 1995, Salamon and Anheier 1992a, 1992b, 1997). The theoretical insights of these authors and the models they propose provide a structure for consideration of Davidson's institution and also go some way to explain its ultimate failure.

Early twentieth-century works on philanthropy (Braithwaite 1938, Macadam 1943), supported by more recent authors (Kendall and Knapp 1997), emphasise the pioneering nature of much voluntary effort. Braithwaite, for example, argued that 'new ideas and attitudes come first not to all but a few' (Braithwaite 1938:34) and then suggested that the general adoption of such services by the state can only take place once their usefulness has been established (Braithwaite 1938:21). Indeed, she argued that 'the State cannot act until the majority of the legislature are convinced of the desirability of a

measure' (Braithwaite 1938:31-32).[1] Davidson's pioneering work clearly failed to 'convince the majority' and ensure the long-term survival of either her premise that some needy people needed a place to die, or of the institution itself.

More recently, Salamon has suggested that the voluntary sector is usually perceived as a secondary system, filling gaps left by State provision. This view, he argues however, can usefully be 'turn[ed] …on its head', and government seen as the 'derivative institution' responding to 'inherent limitations of the voluntary or non-profit sector' (Salamon 1995:44). This concept is consistent with, and amplifies Braithwaite's description of philanthropic work as a pioneering endeavour which may later be adopted by the state. Both views contribute to an understanding of the Friedenheim/ St. Columba's foundation and evolution in the late nineteenth- and early twentieth century and the four limitations or 'failures' which Salamon attributes to voluntary effort: philanthropic insufficiency, particularism, paternalism and amateurism can be discerned in the operation of the Friedenheim described below.

The pioneering nature of the Friedenheim has been discussed elsewhere in this thesis, Davidson exemplifying an original idea coming to one of a 'few'. The following examination of the institute's management during the central years in Avenue Road[2] shows signs, however, of the amateurism characteristic of ultimate 'failure' described by Salamon.[3] Further, charismatic leadership such as

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[1] This is clearly of interest in the context of the modern hospice movement which has, by now (2011), gained acceptance with the majority of the population (see Chapter 1) and may be in the new phase of state-supported legitimacy following Saunders' pioneering efforts.

[2] Prior to this, Davidson appears to have managed the Mildmay Road premises single handed and afterwards, the hospital was absorbed into the NHS.

[3] The institution also selected its patients and was directive in their treatment, as will be seen in Chapters 8 and 9. Similar critiques about selectiveness are still made about the availability of specialised care for the dying and the perceived elitist nature of the provision of hospice care both in this country and the USA (Allen 2007, Campbell et al. 2009, Kessler et al. 2005, Koffman and Higginson 2001, Kwak et al. 2008, Zapka et al. 2006). Moves to make the provision of this, originally voluntarily provided, type of care available to all, and incorporate it within the State-run NHS are evident in the end-of-life care programmes described in Chapter 1 and place government as the 'derivative institution' responding to the 'failures' of the voluntary sector.

Davidson's brings with it operational problems regarding, amongst other things, empowerment of subordinates, as well as those of succession (Conger and Kanugo 1998, Rippin and Flemming 2006, Santora and Sarros 1995) and the institution's executive board demonstrated the weaknesses inherent in this style of operation. A further element of managerial failure, unaccounted for in Salamon's model however, is Davidson's character. As founder, her modesty, lack of desire to 'come forward' and personal unwillingness to take steps to create further homes must also have contributed to the organisation's ultimate weakness.[4]

6.2 Management and administration

The Friedenheim/St. Columba's was an independent home which, unlike other proto-hospices, did not enjoy the administrative, financial, staffing or moral support of a 'mother' organisation. Two major management issues became evident during the inter-war years: firstly that of leadership, exacerbated following Davidson's death, and secondly, the problem of funding which was never comprehensively addressed and which potentially compromised the institution's ability to care for patients in the conditions to which Davidson aspired.

These issues were factors in a long-lasting weakness in the organisation which can be ascribed to its dependence on individuals and their personal devotion to its cause. In spite of its Management[5] and Executive[6] Councils, set up around

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[4] 'Failure' is, of course, relative, in that the institution existed for nearly a hundred years and served many thousands throughout this time.

[5] See the front page of all Annual Reports. The Management council included medical men and both lay and medical trustees.

[6] The composition of the Executive Council inevitably varied over the years, but included Davidson, members of her family, Schofield, the current Medical Officer and a mixture of lay and medical men with one or more Chaplains. The Minutes disclose a core group among these members of Davidson, Schofield and the Medical Officer, who rarely failed to attend meetings and whose words were most frequently recorded.

1892 presumably to help administer the enlarged institution, the hospital lacked a strong corporate structure which could weather evolution in the economic environment, react to legislative change and ensure its ultimate survival. These Councils ran the hospital until July 1948, and the following examples, for the most part taken from the Executive Council Minutes, demonstrate the type and scope of matters they discussed.

From the Executive Council minutes, it is clear that Davidson's position was somewhat anomalous. She did not chair the meetings, but nevertheless held a privileged position as founder and Lady Superintendent, expecting her views and wishes to be complied with, and maintaining strict control over the management of 'her' hospital. These expectations extended beyond her retirement through ill health in 1916 with at least one extremely forceful memorandum being sent from Scotland[7] in 1918. Davidson's immediate family also participated in running the institution and both a sister, Mary Margaret Davidson, and a niece, Margaret Outram, were appointed Trustees.

Perhaps somewhat undermined by Davidson's personal control, the Executive Council was reduced to concentrating on mundane administrative details rather than the strategic direction of the hospital. An example both of the Council's tendency to micromanage the institution and Davidson's influence can be found in the Council minutes for 8th October, 1908 where discussion concerned the purchase of a new boiler. Estimates had been received:

> … that of Messrs Mackenzie and Marcus being £24.10.- that of Mr.
> Willett £20.5.- The Secretary was instructed to ascertain if Messrs
> Mackenzie and Marcus would reduce their estimate by £4, but in any

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[7] SMHA/CM/II:235-236. See Appendix B. This memorandum is included in full as an example of Davidson's grasp of details, appreciation of the problems of nursing, concern for patients' well-being and also her authoritative approach to questions concerning hospital management.

case the work was to be given to them because Miss Davidson wished it.[8]

Other discussions were on, for example, the best supplier of coal,[9] or the need for a new kitchen range.[10] In March, 1909, the Council considered tenders for various household goods including bread. They felt the price quoted for bread was too high at 5 1/2d per quartern[11] loaf. Another baker was offering bread at 1/2d less and the Secretary was instructed to send for samples so that Miss Davidson could judge the quality.[12]

Further examples abound of the Council's involvement in the minutiae of running the institution, whether the purchase of a new lawn mower,[13] the installation of a 'small water closet' in the garden for the patients' convenience at a cost not exceeding £35,[14] repairs to the roof of the potting shed[15] or the incident of the pilfering of nurses' clothing which occurred in 1910 when the Council was shown garments from which a name had been picked out and another substituted.[16] A further unlikely item for the Council's consideration, but nevertheless duly discussed and entered in the minutes was the decision to unite the words 'Hope' and 'Peace' over one bed, whereas previously they had been painted over two separate beds.[17]

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[8] SMHA/CM/I:294 At the next council meeting, it was reported that Mackenzie and Marcus had reduced their estimate by £2.

[9] SMHA/CM/I:32, 1902

[10] SMHA/CM/I:162, 1905

[11] A quartern-loaf: a loaf made with a quartern of flour; a four-pound loaf (Shorter Oxford English Dictionary 1987 Clarendon Press, Oxford)

[12] SMHA/CM/II:6 This example is perhaps not as insignificant as might initially be supposed. The King's Fund prepared annual comparison tables of hospitals' expenditures on food, broken down by such criteria as: topside of beef, legs of mutton, fowls (each), butter per lb., milk per gallon, potatoes per cwt., ale per barrel and bread per 4 lb etc. (LMA/A/KE/901/7) This evidence of effective (or otherwise) housekeeping management presumably fed into the calculation of grants awarded by the Fund.

[13] SMHA/CM/I:275

[14] SMHA/CM/I:239

[15] SMHA/MBI:111

[16] SMHA/CM/II:28-29

[17] SMHA/CM/II:230

Davidson remained involved in every aspect of the administration and management of the Friedenheim/St. Columba's until two years before her death in 1920, and with hindsight, it is clear that she failed adequately to provide for her succession at the head of St. Columba's.[18] She chose as the next Superintendent Miss Elizabeth Evelyn Macneill, a lady of uncertain health, whose frequent absences in warmer climates and prosaic writing skills cannot have advanced the cause of the hospital. In her introduction to the Annual Report of 1928, the main promotional vehicle for the hospital, Macneill wrote for example, 'In reviewing the events of the past year the outstanding feature seems to be its uneventfulness. There are no changes of any importance to relate…'[19]

Continuity was further affected after Davidson's death when Herbert R. Arbuthnot, Chairman of the Council for 11 years, resigned in September, 1921.[20] He was replaced by William McAdam Eccles (1867-1946) who, during the following decade, presided over possibly the most adverse financial years in the Hospital's history. On the verge of financial collapse, its survival appears only to have been due to the appointment of Sir Edward Midwinter[21] to the Council in 1930, first as Honorary Treasurer[22] then as Chairman.[23]

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[18] The problems of succession associated with charismatic leaders are recognised in the literature. See, for example, Bryman 1993, Conger and Kanungo 1998 or Santora and Sarros 1995,

[19] FSC/AR/1928 Macneill did instigate some changes which imply a subtle change in ethos. The implicit social criteria of the admission requirements (see Chapter 7) were now overtly stated: 'The Hospital is intended only for persons in the last stage of illness *and whose social position renders them unsuitable for admission to the Workhouse Infirmary*' (emphasis added) (FSC/AR/1921:2). This qualification was subsequently dropped in 1934 (FSC/AR/1934:9). Macneill was also responsible for the conflict which ensued when she actively 'converted' a young Jewish man to Christianity on his deathbed and which is discussed in Chapter 9:228.

[20] Davidson's niece, Miss Outram, resigned in the same year, following her aunt's death.

[21] Captain Sir Edward Colpoys Midwinter KBE, CB, CMG, CBE, DSO (1872-1947) had seen active service in Egypt in the Royal Engineers, resigning his commission in 1907 and then served as General Manager of the Sudan Government Railways and Steamers between 1906 and 1925. (*Who's Who* Adam and Charles Black, London 1946: 1884)

[22] FSC/AR/1932

[23] Midwinter's appointment was shortly followed by the resignation of Eccles (FSC/AR/1933) and Macneill was replaced by a new Matron, Miss A.H. Anthony. The post of Superintendent was abandoned.

Midwinter instigated the energetic and successful series of promotional efforts in parallel with financial and administrative checks and controls, described below. Having brought the hospital back from the threat of imminent closure, however, his sudden death in January 1947 left St. Columba's without a committed apologist and advocate at the time of its absorption into the NHS (see Chapter 10:259).

6.3 Public awareness 1892-1947

Prochaska has described the overwhelming need for effective advertising and public relations in Victorian philanthropic organizations (Prochaska 1988:36). As a voluntary institution which was largely dependent on the donations of individuals, the efficacy of the Friedenheim in this respect must be questioned given the precarious nature of the institution's finances for many years (see below).

An explanation for the apparently limited promotional effort during the early years can be found in an article entitled 'Friedenheim in London' in the *Daily News* of November 1892. The anonymous author wrote:

> The institution named Friedenheim … is emerging from the obscurity in which it has been purposely kept by its leading spirit, Miss Davidson. Her principle has been … to trust in Providence. She tells you with a smile that she never begs, she does not advertise, her attitude is one of faith, and instead of urgent appeals for public support she "has felt no wish to go forward until the Lord, through His stewards, sees fit to give the token for advance." In the report from which these words are copied will be found the following, written by a friendly hand; "She is ready to accept the larger responsibility should the Lord so indicate, but she

awaits His will."[24] That larger responsibility is now felt (*Daily News* 04.11.1892 Issue 14537).

That 'larger responsibility', particularly financial, meant however that contributions now needed to be encouraged by all appropriate means. The appearance at this time of various publications or reports, such as the above article, may be attributable to Schofield's interest in the Friedenheim.[25]

The most relied upon method of promoting the institution was word of mouth, through so-called, 'drawing-room meetings', church groups, prayer gatherings and sewing circles.[26] These were, presumably, followed up by the distribution of the Annual Reports, the institution's major marketing vehicle, as well as, at least on one occasion, by the publication of a brief history of the Friedenheim/St. Columba's.[27] It is unlikely, however, that these doubtless pleasant, though slightly passive occasions would ever have generated the large capital sums necessary to maintain an institution of the size of the 'new' Friedenheim.[28]

Davidson authored the introduction to each Annual Report from 1899 to 1918.[29] These were some fourteen pages long[30] and in them, she related anecdotes aimed to appeal to a wide readership. In conversational detail, readers were informed of patients' conditions, unusual cases, deathbed returns to faith and

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[24] This reflects the measured response implied by Ryffel (1890:214) and is in some ways similar to Saunders when planning the role of religion within the community at St. Christopher's '…I had not been thinking of going any further than pray for the right people to come, and wait for the leading of the Spirit should He want us to draw together more definitely.' (Saunders cited in Clark 2001b:356-357)

[25] See Chapter 5:97

[26] For example, SMHA/CM/I: 201

[27] Streetly-Smith, L.A. (1915) *The Story of Friedenheim* Privately published. See Chapter 2

[28] Some knowledge of how much money was generated by these occasions and an insight into how the, mainly female, attendees acquired and disbursed their funds would have been interesting, but no records survive.

[29] The Annual Reports regularly included two photographs of patients, facilities or rooms in the hospital until WWI. The use of photographs for promotional and marketing purposes had been pioneered by Dr Thomas J. Barnardo for the promotion of his Homes in the 1870s (Koven 2004:104-120).

[30] As an example, the Annual Report of 1908 contained 64 pages. Davidson's report therefore covered just over one fifth of the issue.

other events or activities during the preceding year. She not only tried to interest her readers in the life of the hospital but also pointed out on-going financial difficulties, while thanking benefactors by name,[31] particularly if aristocratic or royal.

From the outset, Davidson and Council were aware of the prestige and benefits which would accrue to the institution if they had the benefit of royal patronage[32] and the names of these patrons were prominently listed at the beginning of each report.[33] Royalty also visited the hospital, although the costs of these visits were apparently considerable. Some are listed in the Council Minutes for the 1902 visit of Princess Christian. Rental of the tent, chairs and platform came to £30 and the fee for the band playing for the visitors' enjoyment was £12.12.0d. In addition, tea was provided for 500, '…a detective in plain clothes [was] to be engaged' and 12 gentlemen invited to act as stewards. [34] Published accounts are insufficiently detailed to reveal the percentage of total costs represented by this hospitality or estimate the return on this investment.

Although advertising in Burdett's *Yearbooks*, the Executive Council nevertheless rejected suggestions to promote the hospital directly in the medical and daily papers.[35] More indirect means were preferred, such as the insertion in leading London newspapers of an extremely flattering letter of thanks and

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[31] A full list of benefactors and their donations, both financial and in kind, were printed at the back of each Annual Report.

[32] Then, as now, '…every effort is made to get favourable notices and glamorous backers, preferably with a title' (Prochaska 1988:16). See also Goldin 1981 and compare Saunders' desire to acquire a 'name' as St. Christopher's first Chairman (du Boulay 1984:121)

[33] The new building was opened by HRH The Duchess of Teck (mother of the future Queen Mary) and other royal visitors included her daughter HRH The Princess of Wales (the future Queen Mary, consort of King George V who remained as Patron after her husband's accession to the throne), HRH The Princess Christian of Schleswig-Holstein (the third daughter of Queen Victoria, SMHA/CM/I:32, FSC/AR/1908:3), HRH Princess Marie Louise Augusta of Schleswig-Holstein in 1907 (Daughter of Princess Christian (Helena). The Princess also addressed the Annual General Meeting later that year. SMHA/CM/I: 209) and the Princess of Wales in 1910 (SMHA/CM/II: 31).

[34] SMHA/CM/I: 32ff

[35] SMHA/CM/I:153 This may, of course, have been due to Davidson's dislike of publicity (see above).

congratulations written by the Bishop of London following a visit to the hospital.[36] Other letters were written to the newspapers,[37] and incidents were seized upon which might legitimately occasion a letter to the press, with its attendant publicity. In 1904, for example, it was erroneously reported that the Friedenheim had benefitted from an important legacy. As this was not the case, the Management Council wrote to *The Times*, *The Standard* and the *Daily News* detailing the work of the institution and explaining that donations were still needed. [38]

There were annual meetings of subscribers and donors, addressed by Church or medical dignitaries, and in the early years, interested parties could also visit the hospital and observe its facilities first hand.

These rather passive, reactive promotional efforts doubtless appealed to Davidson's temperament and were continued by her immediate successors. Once Midwinter became chairman, however, he stimulated marketing and promotional efforts to encourage donations, subscriptions and legacies in order to reverse the, by now, difficult financial circumstances of the hospital.

An appeal broadcast by the BBC on 9th April, 1933[39] by Canon Woodward,[40] for example, proved to be a potent, modern marketing tool which generated £3,150, 'in sums varying from £50 to sixpence'.[41] In 1935, a Jubilee Appeal to commemorate the 50th anniversary of the hospital's founding was launched[42] and the following year, a country-wide direct mailing campaign took place,

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[36] SMHA/CM/I:153
[37] See, for example, The Times 04.01.1892 issue 33525:3 Col B or 29.09.1892 issue 33756:2 Col F
[38] SMHA/CM/I127, SMHA/CM/I:138
[39] The date was possibly calculated by Midwinter as 9th April was the start of Holy Week that year.
[40] The Right Reverend Clifford Salisbury Woodward was, at the time of the broadcast, Chaplain to H.M. King George V and Rector of St. John's, Smith Square in London. The following month he was consecrated Lord Bishop of Bristol. (Crockford's Clerical Directory, Oxford University Press, Oxford 1938, under Bristol)
[41] FSC/AR/1934 The BBC no longer holds a copy of that recording, nor any correspondence with Canon Woodward.
[42] FSC/AR/1935

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managed by a professional, outside agency under a Captain Stavert.[43] The first wave of mail shots raised £509 and a further 25,000 [sic][44] were therefore issued. Six months later, in September 1936, approximately £2,200 had been received. This was obviously deemed a good return, as in April the following year Captain Stavert managed another appeal, this time issuing 12,000 mailings.[45] Records kept by the COS show a number of requests for confirmation of the hospital's bona fides around this time from recipients of the mail shot.[46]

The success of Midwinter's more aggressive marketing efforts can be shown by the income they generated, which is discussed below. Fund-raising efforts ceased, however, once the likelihood of absorption within the NHS became clear and the production of Annual Reports was discontinued.

6.4 Finance

Several factors militate against a comprehensive exploration of the financial situation of the Friedenheim/St. Columba's. The main surviving evidence is to be found in the income and expenditure statements published in the Annual Reports. Accounting conventions changed over the lifetime of the hospital and the appearance (and disappearance) of line items over the years prevents consistently following a particular type of income or expenditure throughout this period.

In addition, published figures do not give the full picture and may therefore obscure unsound practice or underlying weaknesses. In 1932, for example, it

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[43] FSC/AR/1937
[44] This number appears inconsistent with the following and a transcription error may have occurred in the original Executive Council Minutes.
[45] SMHA/CMB/IV:292
[46] A/FWA/C/D/160/2

became clear that the Management had for some time been drawing on capital to cover current debts and expenditure, rather than using income and attempting to improve cash flow, a fact not immediately evident from the Income and Expenditure accounts. Trends are further obscured by the erratic nature of the income, particularly the legacies, making them difficult to interpret. The lasting success of any institution, however, and particularly any plans for growth, depend on competent financial stewardship and therefore the available accounts must be interrogated for information on the events leading to the institution's successes and failures.

Income sources

The Friedenheim/St. Columba's income statements reveal five main sources of funding: legacies, donations, subscriptions, grants and patient payments, each element varying in size and importance over the years. From at least 1892, the hospital had hoped to generate income from fee paying patients or others making a contribution to care.[47] Regulations 5 and 6 stated:

> 5. While no charge for general patients is made, it is expected that they or their friends contribute according to their means. A few beds in the "Helena" Wards are reserved for paying patients.

> 6. Funeral expenses must be guaranteed, should death occur while in the Home.[48] An adjacent 'Memoranda' [sic] specified the hoped-for contribution: The General Wards are free; but when patients or their friends can afford it, contributions are received varying from 2/6 to 10/- per week.[49]

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[47] Davidson had imagined, for example, that families would be happy to support former members of their staff who were now dying.
[48] FSC/AR/1901:4
[49] FSC/AR/1901:5

In the early years however, direct, individual payments were never a significant source of income. In 1908, for example, they amounted to £186.2.6d (6%) out of a total income of £3,059.11.8d.[50] The picture becomes more confused in subsequent years as patient payments are sometimes conflated with payments from insurance and friendly societies, County Councils and even the COS. An attempt to increase patient-generated revenue was made however in 1934, when the hospital, contrary to its original mission and as a temporary measure, accepted for the first time a small number of (paying) chronic and incurable patients.[51] By 1942, however, patient payments from whatever source nearly equalled voluntary contributions.[52]

This solution to funding problems through diversification of income sources places St. Columba's very much in line with other hospitals which experienced similar financial difficulties during the inter-war period. Gorsky et al. (2002) have examined in detail the complex factors which influenced the generally severe funding problems of medical institutions at this time and concluded that '…while traditional modes of charitable giving played a key part in the recovery after the First World War, subsequent success depended on diversification of funding sources to include organized contribution and direct payment' (Gorsky et al. 2002:554). Further, Harris (2004) has pointed out that London hospitals are reported to have achieved near parity between charitable and patient-generated income between 1935 and 1939 (Harris 2004:230). This suggests that

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[50] The remaining 94% essentially came from private and Fund generated donations, sponsorship of beds, annual subscriptions and legacies with another small amount (£114.19.4d) from the dividends of investments. Outgoings in 1908 were £3,669.11.2d (FSC/AR/1901:55), causing a deficit of some £510. The negative implications of the fact that most of the gifted money came from occasional donations, rather than the more dependable subscriptions was recognised. Sponsorship of beds continued until 1947. In 1908, a bed could be named for £60 annually, £500 for the lifetime of the donor or £1,000 in perpetuity. By 1947, the hospital was asking for £500 for a named cot or £1,000 for a named bed.

[51] FSC/AR/1935 It is ironic that throughout the Hospital's previous history, Davidson had fought to preserve its distinctive nature as catering only for patients close to death and yet the admission of chronic, incurable patients was one of the contributory factors to the Hospital's survival. Presumably in reflection of this, deaths declined sharply between 1935 and 1940 (see Table 7.4), a situation exacerbated in 1939 when the hospital was also obliged to vacate a ward at the onset of war.

[52] FSC/AR/1943:8

by the immediate pre-World War II period, management at St. Columba's had recognised the economic and financial problems it was facing and, more importantly, was adopting similar strategies to the much larger hospitals to overcome them.

As implied above, arrangements were occasionally made with various bodies for the reception of patients at an agreed weekly cost. In 1912, after an initial reluctance to become an approved supplier of care for tubercular patients 'under the new Health Insurance Act',[53] the Council nevertheless decided in October that year to accept 'insurance cases' at a rate of 30/- per week.[54] In 1918, the hospital accepted patients recommended by the London War Pensions Committee, charging 5/- per day.[55] Rates had nearly trebled by 1922 when the Council agreed to reserve a bed or beds in the hospital for cases, 'in the last stages of tuberculosis' referred to them by the COS, at a cost of £3.10s per week.[56] In this year, patient contributions to costs provided £983.18.6d, some 12%, of annual receipts.[57]

The King's Fund, the Hospital Saturday Fund and Hospital Sunday Fund also made occasional grants to the hospital, although the amount varied from year to year and, while undoubtedly useful and appreciated, was rarely financially important.[58]

By far the most important sources of income were donations, subscriptions and legacies, which accounted for a significant proportion of receipts but were both

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[53] That is, Part 1 of the National Insurance Act 1911. The Council felt that their liberty to accept, refuse and discharge suitable patients might be curtailed (SMHA/CM/II:79-81)

[54] SMHA/CM/II:88 This decision was partially rescinded in May when, in line with the original intention of the Home, the decision was taken not to take in insured female patients but only uninsured women as their need was perceived to be greater (SMHA/CM/II:104) Certainly Smith reported that females were more numerous among the outdoor pauper sick in the 1870s, 'they were more deprived, and more of the males were in friendly societies (Smith 1979:353)

[55] SMHA/CM/II/251

[56] SMHA/CM/III:98

[57] FSC/AR/1922:11

[58] In 1900, for example, the Hospital Sunday Fund contributed £239.11. 8d and the Hospital Saturday Fund £10, which together represented some 7% of income FSC/AR/1901:54

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unpredictable and undependable.[59] Legacies, for example, varied between zero in one year (1939) to a never repeated £7,733 in 1924.[60] In most years, ordinary income was inadequate and the institution had to rely on extraordinary donations or legacies for their financial survival and growth. These frequently did materialise,[61] but in 1920 Arbuthnot, then Chairman of the Council, was constrained to advance a temporary loan, free of interest, of £600, 'in order to pay the tradesmen's accounts for the past month.'[62] By 1923, the Council reminded Hospital supporters that, '…they had been obliged to sell the larger portion of the small available Capital… At the commencement of 1924 there was a large overdraft at the Bank in addition to many outstanding accounts.'[63] The fortuitous arrival of a legacy of nearly £8,000 later that year prevented financial collapse.

These important but irregular income sources, along with generally rising costs, proved difficult to manage successfully, and by 15th April, 1932, as Chairman of the Executive Council, Midwinter gave a stirring address to attendees at the Annual General Meeting in which he clearly indicated the seriousness of the financial position.[64]

> … in the last three years we have overspent by £5,128. Legacies, £4,597,
> received in 1921-31 – all have been spent. Ordinary subscriptions have
> risen, but only owing to extraordinary gifts… Quite frankly, I do not see

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[59] Contrasting views on the impact that WWI had on the financial position of voluntary hospitals are discussed in Harris (2004:186).

[60] This generous legacy accounts for the spikes on both income and profit charts below.

[61] For example, in February, 1905, (SMHA/CM/I:165)the hospital received £3,000 from the Zunz Fund which had been set up by Jewish philanthropist, Siegfried Rudolph Zunz in memory of his wife Annie. Many hospitals, including the Friedenheim, Great Ormond Street, St. Mary's, the Royal Free, Bart's, King's, the Royal London and the Middlesex Hospital, benefited from his generosity and endowed wards in her name. A donation of £1,000 was also received from Otto Beit in 1917 (SMHA/CM/II:219-220).

[62] SMHA/CM/III:5

[63] FSCAR/CR/1925:11

[64] The remark in the Ministry of Health document (PRO MH 80/24, 1939) cited by Gorsky et al. (2002:535) should perhaps be remembered here, 'An overdraft is an asset for the purposes of collecting charitable contributions.' The available surviving figures do, however, suggest a serious situation following years of failing to balance accounts or provide for the future.

how without these special gifts and appeal we could have carried on, because even as it is we are living from hand to mouth. We have had to borrow £2,000 from one of our best friends and we have an overdraft at our bank varying from £1,000 to £2,000.

What does this all mean? If we closed down tomorrow we should have to draw on our Trust funds to pay our debts, and hand the rest over to the Charity Commissioners. I have felt it my duty already to consult the latter, who intimated plainly the concern with which they viewed the financial position of the Hospital…

… I must remind you that in 10 years' time the lease of these premises falls in and we ought to have been saving up money all these years to acquire new premises elsewhere, instead of spending every penny on running the hospital. In the past ten years we have received £28,000 in legacies, but it has practically all been spent on maintenance.[65]

He ended on an emotional note, pleading for support to maintain the work of the hospital:

Supposing we are beaten and have to close? Not only can we then no longer help the very poor, but even those in impoverishment and reduced circumstances will no longer be assisted. Our great spiritual work among those poor, sad, pain-stricken and dying folk will cease; the devoted members of our staff – nurses, servants, - dispersed and thrown out of work, with, I suppose, not even the dole available to help most of them. It's a grim and black picture that, is it not? Will you help? Will you see to it that the work started so many years ago is not for the need of a little self-sacrifice and a little more effort struck down and swept away in

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[65] FSC/AR/1933

the general depression of these troublous times – never to be revived or seen again?[66]

Expenditure was reduced by measures described in more detail below, but which involved the closure of some beds and, as noted above and contrary to the Home's original mission, the temporary admission of some paying, chronically ill patients. In addition, the success of the new marketing approach instigated by Midwinter was such that donations rose from £870 in 1935 to £2,875 the following year[67] and poorer, non-paying patients were again admitted.[68] The 1938 Annual Report recorded a further rise in donations to £4,055, investment in a general reserve fund now standing at £11,500, the opening of three of the closed beds and a further increased intake of impoverished patients.[69] It is, perhaps deliberately in the promotional literature, not clear how many patients had actually been refused on commercial grounds over this period of extreme financial difficulty and even the unpublished Minutes give no figures.

Expenditure and economies

Reported expenditures had risen, more or less steadily, until 1930 when Midwinter, in addition to his more aggressive measures to generate income, attempted to limit and control them. One floor of the institution was closed,

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[66] FSC/AR/1933
[67] FSC/AR/1937:9
[68] FSC/AR/1937:9 It is not clear from the reports how many (if any) non-paying patients had been admitted during this time.
[69] FSC/AR/1938 Midwinter appears to have been more successful than many hospital managers. Gorsky and Mohan chart figures showing 'there was a persistent risk of income shortfall throughout the period [1921-1942], with at least half of all hospitals in deficit in 1921, 1930, 1938, and 1939.' (Gorsky and Mohan 2001:251)

(reducing beds from 50 to 35) which had an impact on the number of patients who could be treated and admitted (see Figure 6.1).[70]

FIGURE 6.1 The Friedenheim/St. Columba's: patients treated and admitted 1908-1947
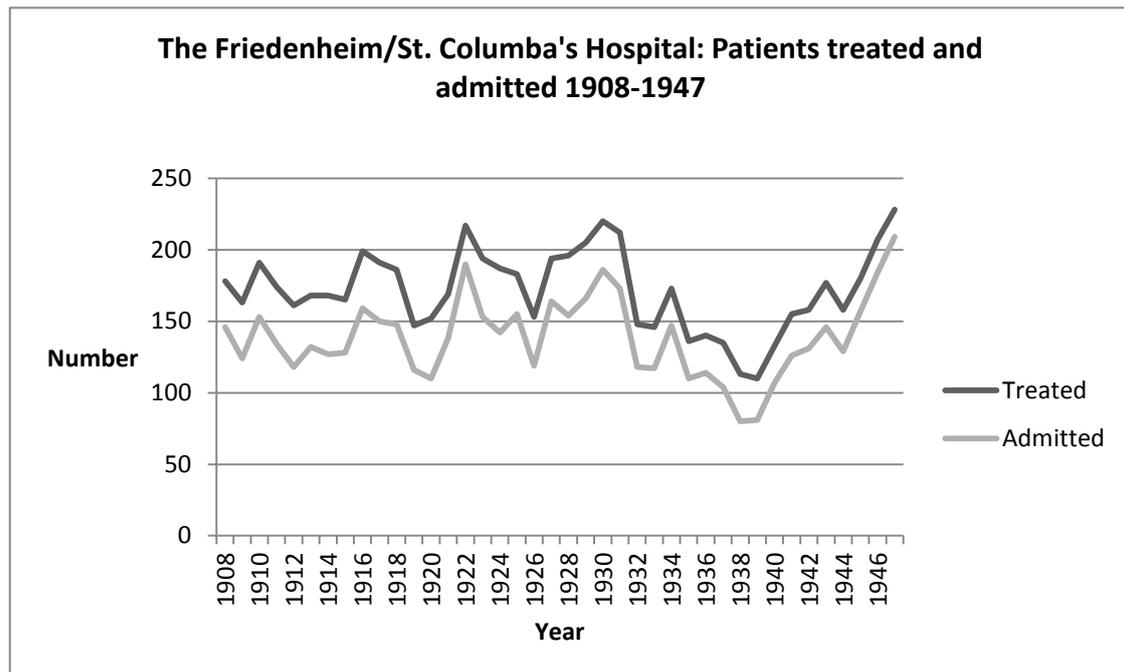
Source: Friedenheim/St. Columba's Annual Reports

In spite of the fact that a large number of patients with chronic conditions might be expected to affect the number of new admissions in any one year, the chart shows that the relationship between patients admitted and treated remained more or less constant.

Midwinter introduced other management controls and the new Matron, Miss Antony, encouraged '…an increasingly high degree of efficiency and economy'[71]

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[70] The trough in 1939/1940, however, can be accounted for by the compulsory ward closure at the beginning of WWII.
[71] FSC/AR/1935

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without, it was claimed, '…in any way impairing the comfort of the patients'.[72]

Council Minutes imply that there had been, in the immediate past, little

budgetary control and that incompetence, if not dishonesty[73], was rife in the

general hospital administration. Costs started to rise again, however this time

together with income, around 1934. In 1947, the final year of the institution

under the old management and also the year of Midwinter's death, figures

again show expenditure exceeding income, but it is unclear what, if any,

significance can be paid to these final numbers which immediately pre-date

absorption into the NHS.

By the beginning of the World War II, the hospital was operating at a profit with

a surplus of £3,626 over expenditure. Investments amounted to £38,275, of

which £15,000 were allocated for the purchase of new premises.[74] Accounts

from the war years continued to show the hospital running with a surplus and

further sums were added to the reserve fund.[75] It was recorded with

satisfaction in 1941, that due to the more stable financial situation of the

hospital, they were able to take in many poorer cases.[76]

Midwinter's success had been achieved at the cost of compromising one of the

core functions of the institution but must be seen in the national context.

Detailed analyses by Gorsky and Mohan (2001), as well as Gorsky et al. (2002) of

the financial situation of voluntary hospitals during the interwar period reveals

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[72] FSC/AR/1936

[73] Midwinter found evidence of mismanagement which not, however, publicised in the Annual Reports. In 1934, for example, it was discovered that the Secretary, a Mr. Vincent Cooper, had been, '…guilty of irregularities in the accounts under his control and a searching investigation by the Auditors had confirmed a deficiency of £148.9.0d.' SMHA/CMB/IV:194). His services were dispensed with forthwith. At the same time the, Miss Anthony, was charged with making a thorough investigation into the whole of the domestic administration. She discovered that the Porter, his wife and adult children had allowed their lodge to become so filthy, that it could be cause for a serious complaint by the Municipal authorities (SMHA/CMB/IV:202). Cleaning and redecorating material were supplied at no cost, and the Porter promised to make improvements. These did not materialise, however, and some twenty-four months later, under threat of legal proceedings, he was eventually persuaded to leave (SMHA/CMB/IV:250).

[74] FSC/AR/1939

[75] FSC/AR/1940, 1941, 1944, 1945

[76] FSC/AR/1941This implies that they were still receiving paying, though not necessarily chronic or incurable, patients.

that many were in financial crisis, due to a complex of issues including rising costs,[77] increasing patient numbers and static or reduced income from charitable sources, particularly in the 1930s.[78] Both large and small hospitals were at risk and demonstrated widely individual patterns of resources, management and financial competence (Gorsky and Mohan 2001:254-255).

The London-based homes for the dying introduce another variable into this changeable situation.[79] St. Joseph's Hospice and the Hostel of God were able to rely respectively on wealthy London Catholics or the Freemasons for their funding and remained financially viable during the interwar years. Care of the dying at St. Joseph's was also subsidised by its Nursing Home, and patients provided their own bed gowns and toiletries (Humphreys 1999:72). St. Luke's House, however, particularly after it separated from the West London Mission in 1911, encountered similar financial problems to the Friedenheim/St. Columba's (Humphreys 1999:68-73 and 131-152 *passim*), apparently without its temporarily successful resolution.[80] No details are given regarding the way in which St. Luke's staved off financial disaster, but it became 'increasingly dependent upon patient payments' (Humphreys 1999:72).[81] Humphreys argues that, like all voluntary hospitals, the homes for the dying lost their traditional philanthropic base and 'adopted a system whereby payment was received from patient charges, contributory schemes… and public authority funding' (Humphreys 1999:72).

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[77] Gorsky et al. state that fluctuating numbers of reporting hospitals prevent an accurate summation of expenditure, 'but it is clear that in absolute terms it rose sharply'; contributory factors including costs of provisions, staff , maintenance, equipment, increasing differentiation of services and facilities as well as more systematic and sophisticated administrative needs to manage them (Gorsky et al. 2002:543).

[78] These findings are of particular importance since such conditions led ultimately to the creation of the NHS, and may therefore indicate the period in time described by Braithwaite and Macadam or Salamon and Anheier (see p 117) when voluntary efforts 'failed' and the state assumed control.

[79] See Gorsky and Mohan 2001:248 and 267

[80] Unlike St. Joseph's Hospice, St. Luke's House was later incorporated into the NHS.

[81] This included charging all patients for laundry. Already in 1905, Sisters from the West London Mission visited patients' homes to assess their ability to contribute towards costs (Humphreys 1999:72)

Summary

The data and brief financial reports suggest that the hospital was in a precarious financial position through much of its life until the 1930s.[82] Between 1908 and 1947, total annual income (not adjusted for inflation) ranged from a low of £3,190 in 1911 to a high of over £14,000 in 1924. Expenditure consistently exceeded income, although with irregular, sometimes very generous, donations, legacies and loans covering the deficit. Given Prochaska's findings on the pervasive and important place of charitable, particularly Christian, giving during the late Victorian and early Edwardian periods (Prochaska 2008:1-1-27), the Friedenheim's managers might have felt able to place some reliance on public generosity and a more or less adequate income stream. They failed, however, either to amass reserves or adjust performance to accommodate changing social circumstances.

Isolating the annual profit or loss reveals that the institution rarely broke even, fluctuating widely in some years. It must be remembered, however, that capital was used to cover operating costs up to 1930/1932 and masks the underlying financial fragility of the institution. The positive effects of the financial measures undertaken by Midwinter after 1932 can be traced in the chart below, since, with the exception of 1947, the hospital essentially broke even or operated at a profit after his arrival.

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[82] See, for example SMHA/CM/I:162 or SMHA/CM/III:5 and 83

FIGURE 6.2 The Friedenheim/St. Columba's: operating profit and loss

The Friedenheim/St. Columba's Hospital:
Operating profit (loss) 1908-1947
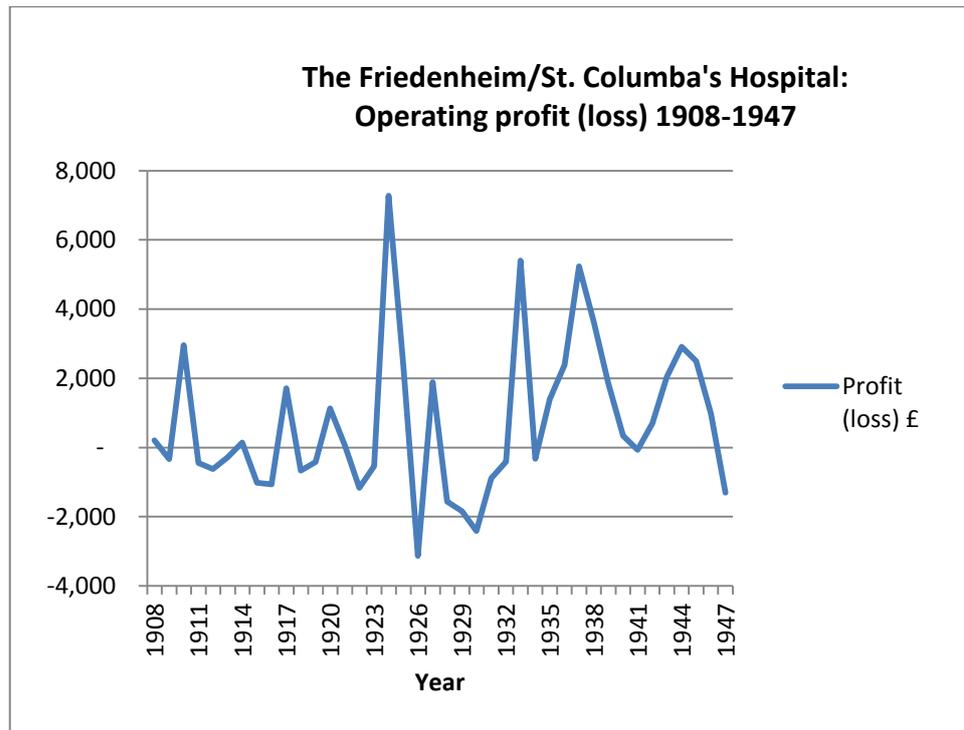
Source: Friedenheim/St. Columba's Annual Reports

FIGURE 6.3 The Friedenheim/St. Columba's: Income and expenditure 1908-1947

The Friedenheim/St. Columba's Hospital:
Income and expenditure 1908-1947

Source: Friedenheim/St. Columba's Annual Reports

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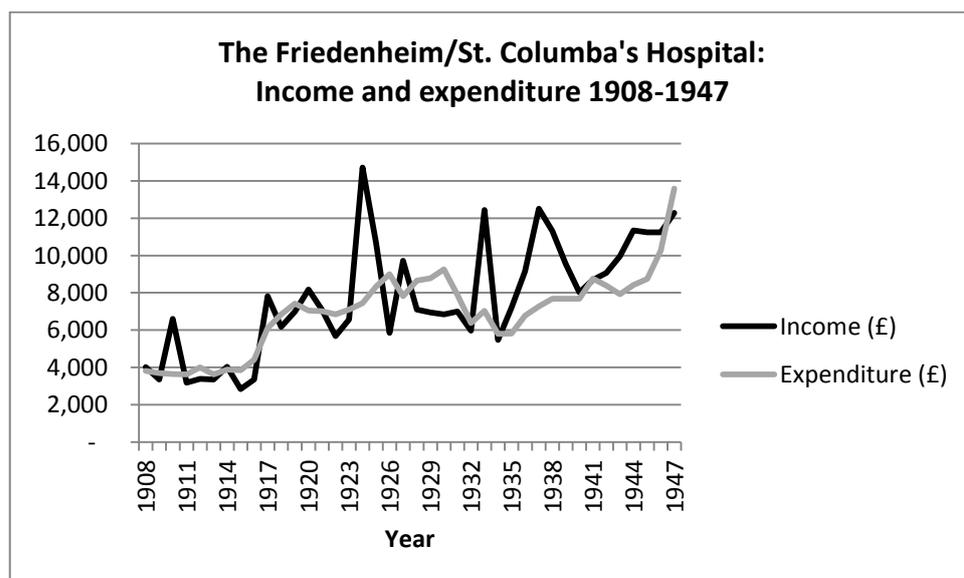
The irregular and unpredictable nature of the income stream, particularly legacies, makes analysis difficult, but by subtracting amounts received from legacies ('Extraordinary Income') from total income, a better idea can be reached of the efficacy of general financial management (Figure 6.4).[83]

This does, in fact, somewhat smooth the curve and reveals the considerable and developing negative discrepancy between income and expenditure between the years 1920 to 1932 when expenditure rose and income fell. This was addressed in 1932, although the years 1939-1942 were again difficult financially, but to a lesser degree.

FIGURE 6.4 The Friedenheim/St. Columba's: income (without legacies) and expenditure 1908-1947
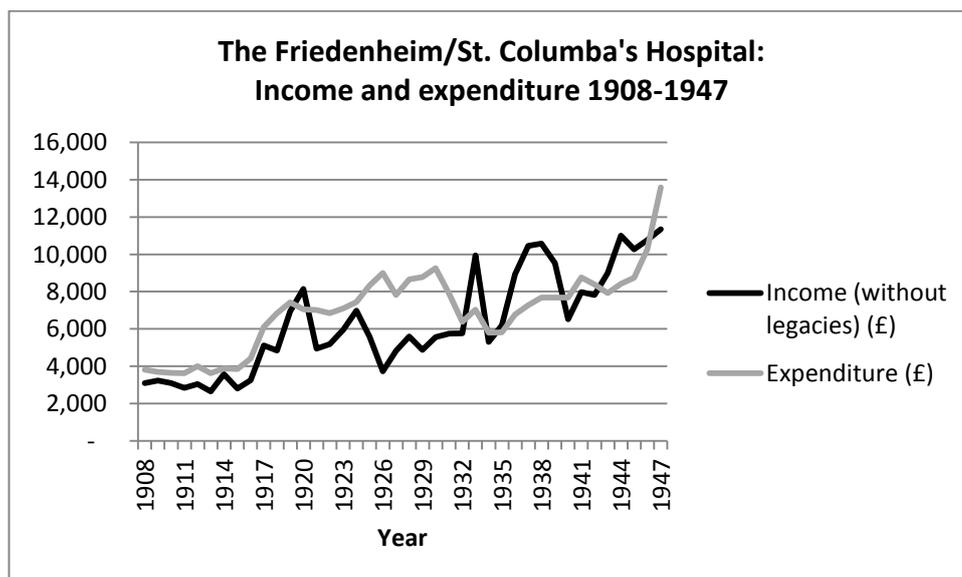
Source: Friedenheim/St. Columba's Annual Reports

N.B. The income spikes in 1933 and 1936/1937 correspond to respectively the appeal made through the BBC in 1933 and the two direct marketing campaigns described above.

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[83] In some years, 'Donations' are partially or totally included under 'Extraordinary Income'; in others it is not clear whether they have been included or not. Legacies are, of course, a reflection of successful marketing of the hospital among wealthy benefactors.

Midwinter's arrival in 1930, his assumption of the Chairmanship in 1932 and subsequent attempts to correct the financial situation were, however, successful and when the Hospital was taken over by the NHS, the accounts showed that under his leadership, it was again fulfilling its original mission to provide care for the homeless dying and, for the first time in its existence, was doing so without incurring debts or compromising standards. Sufficient provision had also been made for the purchase of suitable premises intended to ensure the permanent survival of St. Columba's.

Midwinter's success in reversing the declining finances of the hospital, albeit at the expense of temporarily compromising the core mission of the hospital, is of particular interest at a time when the prevailing economic climate among hospitals was variously described as 'parlous'[84] or 'severe'.[85] The financial history of the Friedenheim/St. Columba's provides an interesting insight into the way one manager addressed these problems and the close relationship exposed between philanthropic endeavour and successful marketing.

The following three chapters describe the patients for whom these efforts were intended and provide an overview of their medical and nursing care.

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[84] PRO MH 80/24, 'Finance' (1939) cited in Gorsky et al. 2002:533
[85] Lowe R (1993) *The Welfare State in Britain since 1945* cited in Gorsky et al. 2002:533

CHAPTER 7 – PATIENTS

This chapter delineates, in broad lines, the characteristics of the Friedenheim/St. Columba's patient base. These characteristics, including referral sources, admission criteria, patient profiles, numbers and disease types are, where possible, compared with the other early homes for the dying. Results complement earlier research to provide a fuller picture of those receiving end-of-life care in the proto-hospices, but reveal an essentially idiosyncratic institution with certain unique characteristics.

The Annual Reports were the main source of internally generated information about the Friedenheim/St. Columba's patient base. Copies survive for each year between 1886 and 1948,[1] when management of the hospital was taken over by the NHS. Each Report was examined in depth and together they provided a rich, detailed and distinctive picture of the home. Their format changed slightly over the years, with the earlier reports, in particular, providing much more comprehensive patient data than later ones.

Raw patient figures were supplemented, while Davidson was directing the institution (1885-1916), with her lengthy 'Introductions' covering around fourteen printed pages or more. These decreased in length as the public face of her successors (E.E. Macneill as Superintendent and then A.H. Antony as Matron), became less visible (see Chapter 6:122), so that by 1938, their

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[1] St. Columba's continued to publish Annual Reports containing all the basic data throughout WWII, though in attenuated form due to paper shortages.

contribution, by now only called a 'Report' covered one side. The authorship of the 'Introductions' passed to the Chairmen of the Council who, however, tended to write terser, more business-like documents lacking the rich detail, information and personal commentary of Davidson's accounts.

The numbers of admissions, discharges and deaths are available for the entire period pre-NHS. The internal consistency of these figures and patient diagnoses in general terms was assured by the fact that the institution had, between the years 1892 and 1948, only three Medical Directors: Doctors Percy Lush, John Clark Wilson and Norman Sprott.[2] Not only *ex officio* members of the Executive council, each also authored a lengthy section of the Annual Report, the Medical Report, which, as well as providing basic numerical data,[3] commented on medical aspects of the Home's operation and its patients. It was therefore possible, not only to chart variations in patient numbers, but also to gain insight into their underlying conditions and treatment.

7.1 Referrals

Many patients were referred to the Friedenheim/St. Columba's by the major London teaching hospitals.[4] These are listed by rank in the Medical Reports, i.e. according to the number of patients received, without specifying the actual figure. In all, over 180 different hospitals are mentioned as having referred patients over the years 1920-1938. Those which occur most regularly are the London Hospital,[5] which is ranked in first place seventeen times in nineteen

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[2] It is, of course, not improbable that progress in medical diagnostic criteria occurred over these years which may have influenced the doctors' definitions.
[3] Clark Wilson, while presenting the basic data, provided fewer breakdowns of these figures that his predecessor or successor.
[4] Some referring institutions are listed in the Annual Reports of 1904, 1915, 1917 and 1918, but from 1920-1938 and again in 1947 they are listed in greater detail. Did the Medical Officers, in particular Clark Wilson, wish to emphasise the professional credentials of St. Columba's?
[5] Now the Royal London Hospital

years. This is followed by St. Bartholomew's Hospital which is in second place for 15 years and third in three. The other hospitals which regularly occur in the top five sources of referrals are St. Thomas's, King's College, Guy's, University College, St. Mary's, Hampstead General and the Middlesex.

Figures for 1947 follow the same trend and show that in an intake of 209 new patients, 141 (67%) were referred from London hospitals. St. Bartholomew's supplied the largest number (13) closely followed by the Middlesex (12), London Hospital (11) and University College Hospital (10). Over 30% of the hospital admissions (although only 22% of total admissions) therefore came from the major London teaching hospitals. This argues that well into the twentieth century, the work at St. Columba's was recognised and used by the major London hospitals which had been referring their terminal patients there since at least 1904.

Hospital referrals were a source of pride to Davidson, who chose to see them in a positive light in spite of the fact that a compassionate doctor, forced to discharge a terminally ill, homeless patient might grasp at any adequate facilities:

> As usual, many of our patients have come from other hospitals; and we
> have been gratified by the way in which the doctors, nurses, and
> secretaries have applied for admission, showing they think highly of the
> care, attention, and kindness with which the inmates are surrounded.[6]

St. Joseph's close relationship to its religious foundation meant that initially patients were recruited through the work of the nuns and priest within the local Irish Catholic community. After WWI, however, the Hospice recorded more secular sources of patients.[7] St. Luke's House had a broader base of patient

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[6] FSC/AR/SR/1898
[7] Between 1905 and 1910, a total of only seven patients had come from the London hospitals, although this proportion rose to 14% by 1935 (Humphreys 1999:140-142)

sources, including war charities, county councils and the Jewish Board of Guardians (Humphreys 1999:143-146). Referrals from medical institutions varied there between 54% in 1895, 10% in 1910 and 79% in 1935 (Humphreys 1999:145). Although irregular and incomplete, registers for the Hostel of God indicate that the majority of patients also came from London hospitals; a fact tentatively attributed to the homes' consultant staff, many of whom were active in the London voluntary hospitals (Humphreys 1999:147).

In addition, there was some cooperation between the proto-hospices which occasionally exchanged patients or received them from another home when it, for example, was temporarily closed for renovations or redecoration (Humphreys 1999:149). St. Luke's is the only home specifically mentioned in the Friedenheim/St. Columba's literature,[8] although Davidson implied that the facilities there were inferior to those at St. Columba's:

> At St. Luke's it is not so much the rules, as the crowded beds, the nearness to other patients, and the consequent air-less-ness (or worse!) that patients have spoken of when they experienced the change to St. Columba's.[9]

The source of other referrals to the Friedenheim/St. Columba's is frequently obscure, although some patients were referred through local authorities as part of their provision for tubercular patients.

The source of referrals to the proto-hospices is of particular interest for the light it sheds on these institutions' place within the general medical establishment in London. Although referral patterns varied, it is evident that the work they were

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[8] FSCAR/MR/1903, FSCAR/MR/1924

[9] SMHA/CMB/II/235-236 This is confirmed from the illustrations in Goldin (1981) which show crowded rooms with little space between the beds. On Davidson's death, the Superintendent of St. Columba's received a letter of condolence from the honorary secretary of St. Luke's who wrote that, 'Miss Davidson's loss will indeed create a terrible blank in that section of Hospital work of which she was the honoured pioneer' (SMH/CMB/III/36-37). If any letters were received from the other homes, they have not been preserved.

doing formed an integral part of the London medical scene and many patients were referred from the major London teaching hospitals. Quite why this work with the dying should therefore have received such little recognition from the medical world in general is difficult to appreciate, but certainly their efforts went largely unreported until the advent of Saunders in the 1950s and 1960s. Humphreys suggests that St. Luke's House and the Hostel of God became 'integrated into the London hospital system, while St. Joseph's was incorporated into local government networks of provision' (Humphreys 1999:149).[10] No such delineation between the hospitals and local government can be made in the case of St. Columba's which continued until 1948 to receive patients from both sources. The cooperation between St. Columba's and St. Luke's is of interest as demonstrating basic unity of purpose, in spite of their perceived individuality. Had there perhaps been more cooperation, a more influential 'weight' of power might have been generated.

7.2 Admission criteria

Admission criteria to the Victorian homes for the dying exemplify the two conflicting ethical foundations for much philanthropic work: the religious imperative to view all, especially the poor, as equal in God's eyes and worthy of respect, and the moral or ethical dilemma which sees some elements of society as being more worthy of help than others, in other words, the 'deserving poor'.[11] In addition, Prochaska's finding that, '[g]iven the pressures of population growth and the dislocations caused by industrialisation, the supply

[10] Humphreys' text implies that these patients were 'advanced cases', referred for medical rather than social reasons (Humphreys 1999:141).
[11] See, for example, Harris 2004:59-75, Forsythe and Jordan 2002:848-853, May 1995:230-232, Rose 1988:18 and passim. See also Loseke's (2007) analysis of the general cultural criteria necessary for sympathy to be expressed with a sufferer, summarised as a) the sufferer is not responsible for his/her condition, b) s/he is a morally upright person and c) s/he finds him/herself in a 'troublesome condition'. Only once these criteria have been met, will expressions of help follow. Observers care because 'good people are unjustly harmed' (Loseke 2007:79 and 76-88).

of charitable relief struggled to keep up with demand' (Prochaska 2008:15), indicates that some sort of triage was a practical, as well as ethical, necessity. Examination of how this conflict was resolved at the Friedenheim/St. Columba's contributes to an understanding of Davidson and her successors, as well as the nature of the home and those who lived there.

The Friedenheim's selection criteria encapsulate the home's mission towards the dying, the friendless and the poor. It was avowedly:

> *only* for those *in the last stages of illness* when rejected or dismissed as incurable by the General Hospitals; *not for chronic invalids or aged and infirm persons*. It is for those whose insufficient means and friendless condition prevent their being properly nursed and cared for to the end.[12] (Italics as original)

These criteria are similar to those at the other proto-hospices, where all were supposed to be both poor[13] and dying[14] although St. Luke's also imposed geographical restrictions, limiting patient intake in the early years to 'the poor of London and its immediate environs'.[15]

This did not mean, however, that all people in this position were necessarily admitted. From the beginning, Davidson imposed some financial and social criteria on future patients.[16] Although treatment in general was free of charge, funeral expenses had to be ensured before admission, 'should death occur

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[12] F/SC AR 1901:5

[13] St. Luke's deemed unsuitable those patients for whom provision was made under the Poor Law and, it is implied, rejected those who had been in receipt of parish relief or an inmate of a parish infirmary (Humphreys 1999:133).

[14] The extent to which these selection criteria were applied did, however, vary, particularly in the Hostel of God and St. Joseph's where some long-term patients were the norm, see below.

[15] Humphreys 1999:131-135, 151

[16] This is a possible precursor to the racial and social inequalities of access to, and uptake of, current hospice care (Allen 2007, Campbell et al. 2009, Kessler et al. 2005, Koffman and Higginson 2001, Kwak et al. 2008, Zapka et al. 2006). On a different level, Froggatt elaborates on the philosophical necessity for clinical admission criteria to hospice to ensure that entrance to this liminal space between life and death remains reserved for those dying (Froggatt 1997:128).

while in the home.'[17] This regulation, although a practical necessity, must have excluded those completely without means. The two financially better endowed homes, the Hostel of God and St. Joseph's, did not make this stipulation, but St. Luke's went further than the Friedenheim, requiring a deposit on admission towards the removal of the body and imposing a time limit within which it should be removed. Later, fines were also levied there on relatives if the deceased were not removed within the time allowed (Humphreys 1999: 131-135).[18]

Friedenheim Regulations stipulated that 'Patients are admitted solely on their merits, preference, however, being given to those who are least suitable for the Workhouse Infirmary.'[19] This left the interpretation of 'least suitable' to those controlling admission: Davidson herself, Schofield and the Medical Officers. In a private memorandum written after she retired, Davidson wrote, 'One of the foundation reasons for this Hospital was to provide a place where women of the upper-middle classes, (the class that needs it most) should be able to die in quiet, privacy, and happy surroundings'.[20] This sentence suggests that the home was intended only for genteel patients, in spite of the general implication in promotional literature that it received the 'deserving poor' of all classes. [21] This paradox can be resolved by an examination of the available occupational data of the patient body which reveals that, in spite of Davidson's assertion, like the workhouses, the Friedenheim recruited the majority of its patients from the broad working class, although including a certain number of professional patients.

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[17] F/SC AR 1901:4

[18] St. Luke's appears to be the only home which also required character testimonials before admittance, particularly for labourers, charwomen and laundresses. Those who had benefited from parish relief were also excluded, as were those who could afford to pay for their own care (Humphreys 1999:131).

[19] F/SC AR 1901:4

[20] SMHA/CM/II:235-236 Memorandum reproduced in Appendix B.

[21] The definition of 'deserving' appears, however, to have been highly personal and it is perhaps surprising to note the inclusion of criminals, drug addicts, syphilitics and alcoholics among the patients.

7.3 Profiles

Davidson's rich introductory accounts in the Annual Reports, together with those of the medical officers who were in daily or twice daily contact with the patients have provided a vibrant picture of residents and the atmosphere inside the home.

Ages

According to her niece, Davidson's decision to open the Friedenheim came from witnessing the difficult death from tuberculosis of a young girl (see p 87). An overview of patient ages reveals the relative youth of those dying there in the early years, which would be expected given the preponderance of tubercular cases (see below). A detailed breakdown of ages is available only for the years 1899-1914 and is fairly stable during that period. Consolidated age data are available for the years 1914-1917 enabling the chart to be extended by three years. These figures show that in 1899, 85% of patients were under the age of 50, with 50% in the age range 21-40 years.

Figure 7.1 Patient percentages by age 1899-1914
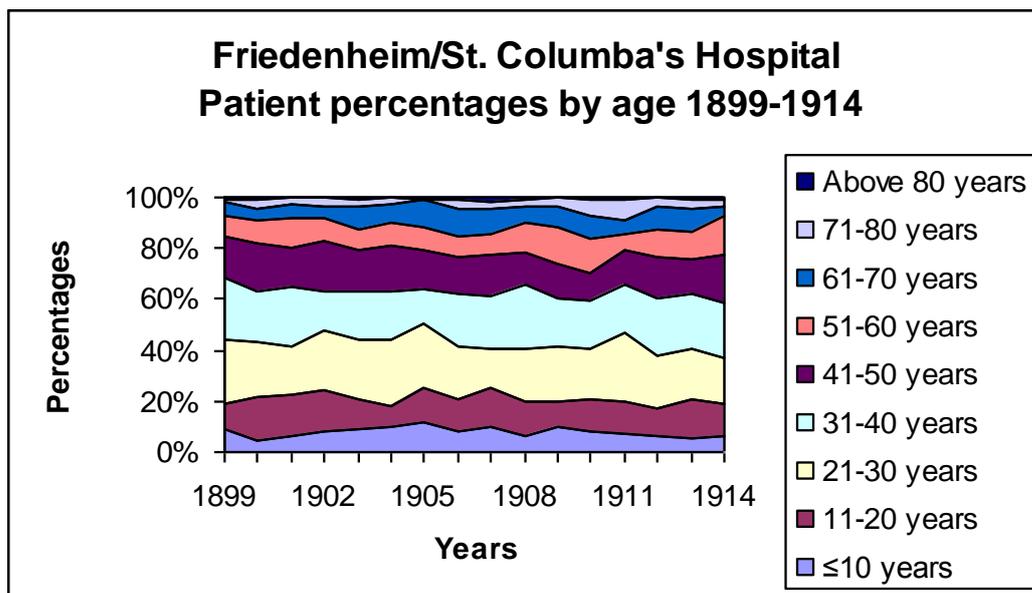
Source: The Friedenheim/St. Columba's Hospital Annual Reports

FIGURE 7.2 Patient percentages by age group, 1899-1917

The Friedenheim/St. Columba's Hospital
Patient percentages grouped by age 1899-1917
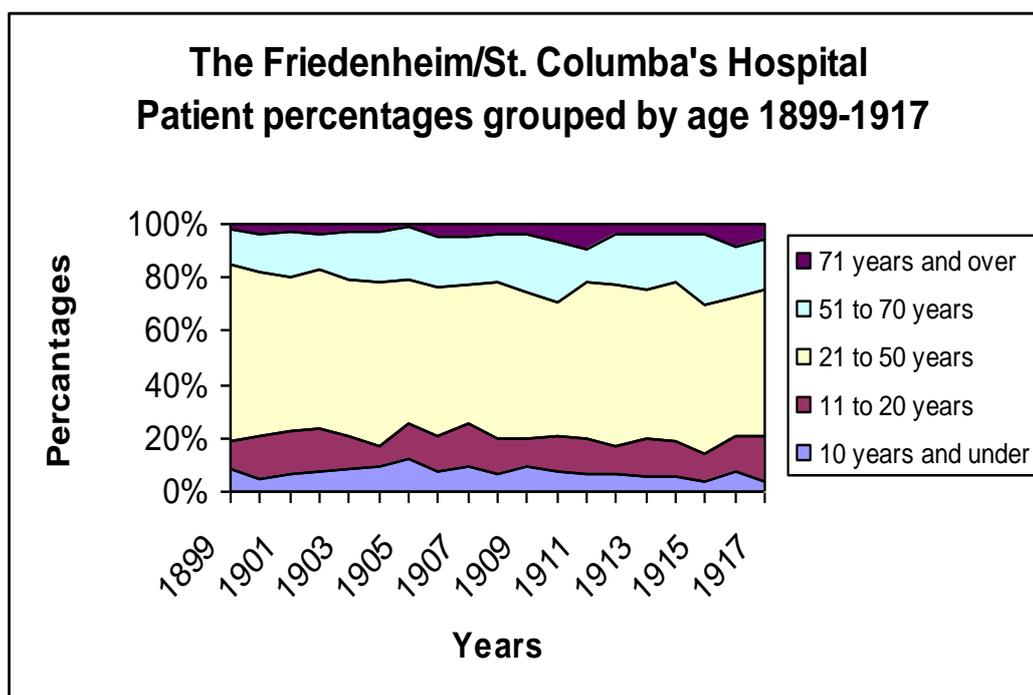
Source: The Friedenheim/St. Columba's Hospital Annual Reports

Given the age profile of tubercular patients discussed elsewhere, and the prevalence of that condition among its patients, it is not surprising that in the year 1901, for example, 42% of the Friedenheim patient body was under 30 years old,[22] and by 1918, 79% of patients were still under the age of 50.[23] It would have been informative to follow the trend of patient ages throughout the change in primary admission condition from tuberculosis to cancer (see below), but following the death of Lush in 1918, fewer statistics were published in the Annual Reports.

Not unexpectedly, similar trends were found in the other homes although, perhaps surprisingly, the continuing prevalence of tubercular patients at St.

[22] This figure is not directly comparable with the figures from the ONS given below as the Friedenheim numbers include patients at both end of their age spectrum, those under 5 and over 25 years.
[23] For comparison, figures from the Office of National Statistics show that the under-50 age group, including infants and children, accounted for only 57% of deaths in England and Wales in 1918. (Source: National Statistics Online)
http://www.statistics.gov.uk/statbase/xsdataset.asp?More=Y (accessed 07.05.2010)

Joseph's does not appear to have been reflected in patient ages which remained substantially higher than in the other homes, an anomaly which has been noted in the literature (Humphreys 1999:160, 169).

Patient Occupations and the National Census 1901

Appeals for financial contributions to the Friedenheim tended to stress the inappropriateness of the workhouse infirmary as a place to die, particularly for those who had known better days or were especially 'deserving' of the donor's compassion. These included, for example, those who had worked for a living, but could not afford the specialist care now needed, or lived in surroundings where this could not easily be delivered. This perceived inappropriateness of the Workhouse was linked, in Davidson's appeals for funds, to the fact that the Friedenheim and later St. Columba's could provide a suitable 'home' for these worthy cases, who did not 'deserve' to end their days in the squalor and degradation of an Infirmary ward. This section examines the patients' previous occupations, and, in order to test Davidson's premise, compares them with that of the local workhouse inmates. Any similarities between the two populations would be of interest as showing the potential accuracy of Davidson's claims and also go some way to discover the extent to which Davidson restricted admission to those of the 'upper-middle class'. Changes in financial or social circumstances, if shown to exist, might indeed have resonated with the Friedenheim's donor base and elicited their sympathy.

There are two main sources for information about the occupations of patients before their admission to the Friedenheim/St. Columba's: the Annual Reports and national census data from 1901. These should help clarify the social status of the institution's residents, although both have to be interpreted with caution; the Annual Reports record only the more unusual or exotic patients and the census provides a snapshot of only one night, Sunday, 31st March, 1901. Census

data from the Hampstead Workhouse and Infirmary (HW&I)[24] have been examined to provide a comparison.

Unfortunately for statistical purposes, there were exceptionally few patients at the Friedenheim on the night of the census; only 27 out of a potential 48, and the figures cited below are therefore shown for illustrative purposes, although some ancillary details can be deduced.

The first, and not unexpected, difference between the two Hampstead institutions is that of the ratio of staff to patients/inmates. Not forgetting that the HW&I inmates included some of the allegedly able-bodied, even with a full complement of patients (48), the Friedenheim would have had the far more generous ratio of one member of staff to every two patients and one nurse to four patients.[25] Average age of nursing staff can be calculated from the census data. The nurses at the HW&I were, on average, slightly older than those at the Friedenheim (range: 24 – 45 years, average age 32.5 years); certainly not, or no longer, the elderly infirm described by the *Lancet* reports of 1865 -1866.[26] The range was narrower at the Friedenheim: from 23 to 31, with an average of 25.4 years.

The ages of the patient populations differed considerably. Thirty per cent of the HW&I inmates were under 50 years of age, compared with 81% at the Friedenheim. Indeed 60% of the Friedenheim patients were under 30 years of age. As the hospital at that time catered mainly for tubercular patients, this finding is not unexpected. Although 59% of the Workhouse population was over

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[24] The Hampstead Workhouse and Infirmary was chosen for its relative geographical proximity to the Friedenheim which overcomes some of the difficulties in comparing census data. It was also of manageable size (307 inmates) although it does, of course, include the able-bodied as well as the infirm.

[25] Current hospice practice recommends a ratio of one nurse to every 1.5 patients. http://www.hospicecare.com/gs/page4.htm (accessed 30 July 2008)

[26] See Chapter 4 for a detailed description of the Lancet reports.

60 years of age, only 3.7% (one person) in the Friedenheim fell into this category.[27]

Both institutions show a preponderance of the single and widowed, approximately 80% in both cases. This is fully in line with the likelihood that both institutions cared for those without other support.

Higgs (1989:78-96) and Woollard (1999) have described the potential pitfalls inherent in collecting occupational data from census records, particularly the problems associated with compiling comparative figures country-wide. As respondents at the HW&I and the Friedenheim were likely to have been elderly or terminally ill, however, occupational information was particularly useful in this study, as the 1901 census included, for the first time, details of the previous employment of those who had retired. Comparative figures are shown in Table 7.1, followed by occupations listed for the inmates of the HW&I in Table 7.2

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[27] Cf. Humphreys' charts 1999:159-161

TABLE 7.1 Hampstead Workhouse and Infirmary and the Friedenheim

Hospital: Comparative data from the 1901 census

	HAMPSTEAD WORKHOUSE AND INFIRMARY	THE FRIEDENHEIM HOSPITAL
ALL OCCUPANTS	342[a]	52[b]
Inmates/patients	307	27
All staff	34	24
Ratio staff to inmate/patient	1:9	1:1
Nursing staff	23[c]	11[d]
Ratio nursing staff to inmate/patient	1:13	1:2.5

INMATES/PATIENTS				
Ages	Number	%	Number	%
0-10	24	7.8	2	7.4
11-20	9	2.9	5	18.5
21-30	15	4.9	8	29.6
31-40	22	7.2	4	14.8
41-50	23	7.5	3	11.1
51-60	32	10.4	4	14.8
61-70	84	27.4	1	3.7
71-80	71	23.1	-	-
> 80	27	8.8	-	-
Total	307	100.0	27	100.0
Marital status				
Single	124	40.4	16	59.3
Married	59	19.2	5	18.5
Widow/widower	124	40.4	6	22.2
Total	307	100.0	27	100.0

Inmates/patients' place of birth				
Britain (inc. Ireland)	300	97.7	23	85.2
Non-British	7[e]	2.3	4[f]	14.8

Notes: [a] Includes the thirteen-year-old son of the Workhouse Master. [b] Includes one visitor
[c] Staff styled 'Sick nurse' (20) and 'Lunatic attendant' (3). [d] Staff styled 'Hospital nurse'.
[e] Canada (3), Italy, Germany, France and New York, USA. [f] Australia, West Indies, Canada, Russia

TABLE 7.2 (Previous) Occupations of inmates of the Hampstead Workhouse and Infirmary as given in the 1901 Census

Occupation	Number	%
None listed (adult)	71	23.1
None listed (child)	26	8.5
Domestic Servant	25	8.1
General labourer	25	8.1
Charwoman	19	6.2
Laundress/washerwoman	15	4.9
Gardener	14	4.6
Carpenter	10	3.3
Needlewoman/shirtmaker	9	2.9
House painter	8	2.6
Cook	7	2.3
Bricklayer	6	2.0
Coal porter	4	1.3
Shoe/boot maker	4	1.3
Cab driver	3	1.0
Clerk	3	1.0
Coachman	3	1.0
Dressmaker	3	1.0
Sick nurse	3	1.0
Stableman/groom	3	1.0
Tailor	3	1.0
Butler	2	0.7
Road sweeper	2	0.7
Other	36	11.7
Illegible	3	1.0
TOTAL	307	100

Source: National Archives, 1901 Census RG13/129/45-54 Schedule no. 2

The category 'Other' included thirty-six disparate occupations represented by a single inmate. They ranged from the professional (one lawyer) to the commercial (one newsagent) and from the artisan (one commercial flower maker) to the unusual (one exhibition cricketer).

Comparative data for the Friedenheim show that the only occupation among the patients which had more than one representative was that of cook domestic. The others are listed below in Table 7.3

TABLE 7.3 Previous occupations of patients of the Friedenheim given in the 1901 Census

Occupation	Number
None listed (adult)	3
None listed (child)	4
Cook domestic	2
Electric engineer	1
Farm labourer	1
Wheelwright	1
Postman	1
General labourer	1
Journeyman tailor	1
Shop porter	1
Brewer	1
Boilersmith (ex soldier)	1
Cab driver	1
Gardener	1
Stick stainer	1
Plasterer	1
Ex-marine	1
General domestic servant	1
Waistcoat machinist	1
Needlewoman	1
Board school teacher	1
TOTAL	27

Source: National Archives, 1901 Census RG13/123/177/53 Schedule no. 2289340

In order to establish the similarities or dissimilarities of the occupations of the patient/inmate base in both institutions, some kind of grouping had to be

essayed, bearing in mind all the caveats expressed above.[28] Results can be seen in Table 7.4.

TABLE 7.4 Hampstead Workhouse and Infirmary and the Friedenheim

Hospital: Comparative inmate/patient occupation data from the 1901 census

Occupation Group	HW&I		Friedenheim	
	Number	%	Number	%
Members of army and navy			1	5.0
Teachers (+ Nurses)[a]	4	1.9	1	5.0
Merchants, brokers, clerks and shopmen	17	8.2		
Manufacturing trades	5	2.4	1	5.0
Miners	1	0.5		
Engineers	1	0.5	1	5.0
Artisans and mechanics	47	22.7	7	35.0
Domestic servants	88	42.5	4	20.0
Messengers, porters and labourers	43	20.8	5	25.0
Other [b]	1	0.5		
Total	**207**	**100**	**20**	**100**
None listed + illegible	100		7	
TOTAL	**307**		**27**	

Notes: [a] The nursing profession is not mentioned in the 1881 groupings, but for convenience is here included with teachers. [b] An exhibition cricketer.

Although numbers are too small to be of significance, patients at the two

institutions showed similar proportions (approximately 80%) in the three

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[28] The 1901 census antedated Stevenson's first consistent model of socio-economic groupings by ten years (Higgs 1989:130) and later models proposed by Armstrong have been criticised on the grounds that, 'it is inappropriate to use a twentieth-century social classification to order nineteenth-century data' (Higgs 1989:94). A simple classification system has therefore been adopted here based on the instructions appearing on the reverse of the householders' schedules for the 1881 census (Woollard 1999:18). In spite of its date, it nevertheless represents a pragmatic way of grouping the few occupations listed in the two establishments in 1901. Only occupations mentioned in either or both institutions have been included. See Woollard 1999 for a more exhaustive list of definitions and occupations.

categories: 'artisans and mechanics', 'domestic servants' and 'messengers, labourers and porters' i.e. the large category of manual working class.

Conclusions can be drawn only with circumspection from such limited data, but, broadly speaking, the local workhouse population showed many of the same occupational characteristics as the patients at Davidson's institution. Marital status is also similar, showing a preponderance of the single, and therefore possibly unsupported. Within these limited data, the age profiles between the institutions are very different however, and in line with, for example, Longmate (Longmate 2003:136-147), they suggest that the workhouse in Hampstead had become a repository for the elderly. The Friedenheim, however, had the younger age profile which might be expected with its high number of tubercular patients.

Occupational information drawn from the Friedenheim census can be complemented by that from the Annual Reports. Most reports mention a few patients' occupations, but in some years, fuller lists are printed. Table 7.5 is taken from the Annual Report dated 1901. It is noteworthy that of the 170 patients treated that year, only 64 (38%) are deemed to have had occupations worth mentioning. The majority remained unclassified.

TABLE 7.5 Patient occupations 1ˢᵗ January – 31ˢᵗ December, 1900

7.5.1 Men

Brickmaker	Journalist
Butcher	Labourer
Carman	Manufacturing goldsmith
Carpenter	Page Boy
Caretaker	Photographer's assistant
Chemist's assistant	Plate-glass fitter
Clerk	Policeman
Commercial traveller	Porter
Coachman	Postman
Compositor	Seaman
Dental surgeon	Sheep farmer
Draper	Shoemaker
Drayman	Shop assistant
Farm labourer	Soldier
Fireman	Stableman
Footman	Sweep
French polisher	Warehouseman
Gardener	Waterman
Hairdresser	Watchmaker
House decorator	Working engineer
Joiner	Writer

7.5.2 Women

Board School Teacher	Lady Clerk
Book folder	Laundress
Boxmaker	Machinist
Charwoman	Maid Attendant
Cook	Mantle Cutter
Domestic Servant	Milliner
Governess	Monthly Nurse
Housekeeper	Needlewoman
Housewife	Trained nurse
Instrument Maker	Waitress in A.B.C.
Ironer	Ward Maid

Source: Friedenheim Annual Report 1901

Occupations singled out for specific mention in the Annual Reports tend, as mentioned earlier, to be either exotic or susceptible of eliciting particular sympathy from the reader. A typical example can be found in Davidson's report for 1903, where the fate of a 'sailor boy' is discussed along with that of a patient's blind husband and the tragic death of a child.

> Some of the cases have been especially sad. A sailor boy, who had been in His Majesty's Navy, came from Brompton Consumption Hospital; had had no home: and we have had several soldiers in the same condition. A woman was nursed here for some weeks whose husband had become blind, and as there was no family, he had to find someone to bring him to visit his dying wife. A baby of a year old was brought to us suffering from cancer in one eye. The parents were so devoted to him that they were thankful to have him nursed where more could be done to ease his pain than was possible in their own home. Their sorrow when he died was very great, and when they came to see the little body, as it lay covered with flowers which hid all that was painful, the poor mother said she could hardly believe that lovely infant was her own.[29]
> (Punctuation as original)

The diversity of patients referred to the Friedenheim/St. Columba's to die is demonstrated by an overview of individual patient characteristics mentioned in the Annual Reports. This heterogeneous group included those from many different countries and conditions.

Professional patients included occasionally lawyers and doctors together with school teachers, nurses, governesses and clerks as well as one 'lecturer on Economics'[30] and a stipendiary magistrate from British Guiana.[31] There was also a fishmonger, the son of an Italian organ grinder, a cinematograph operator, a

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[29] FSC/AR/SR/1904 Punctuation as original.
[30] FSC/AR/1929
[31] FSC/AR/1918

billiard marker, a linen room maid at Sandringham and a masseuse. The entertainment profession was well represented throughout the years by actors, actresses, orchestral players, music hall stars and one 'dresser for music hall artistes'.[32] Some of the more unusual occupations included a female long-distance swimmer and a female navvy both in 1912, a naturalist's assistant, a seaman from the Trinity Yachts and a steward on the Canadian Pacific Railway. Three other patients given special mention were a keeper of performing dogs,[33] the nanny of Peter Scott, 'whose father died "beneath the Antarctic snow"'[34] and perhaps the most intriguing; 'A man well known to art connoisseurs, into whose history we were warned not to enquire too closely'.[35] It must be remembered that in any given year, those occupations mentioned represented only a very small fraction of the patients treated. The majority was made up of small tradesmen, domestic servants, policemen, railway workers, labourers and their families, or as described by Clark Wilson: 'working men in almost every trade, and those belonging to them'.[36]

These results are very much in line with the more general findings of Humphreys, who found, for example, that virtually all patients at St. Joseph's came from the 'lower middle or working classes' as did those at St. Luke's (Humphreys 1999:152). Of the occupations she analysed for the year 1905 at St. Joseph's (n=51) and at St. Luke's (n=62), for example, the majority were domestic servants, labourers, craftsmen and tradesmen. The exceptions were one patient at St. Luke's that year who was a Fusilier, and one at St. Joseph's who was described as a 'distressed lady' (Humphreys 1999:153). The Hostel of God, which did not record a patient's previous occupation, nevertheless had a different profile which gave priority to members of the middle classes and also

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[32] FSC/AR/1919
[33] FSC/AR/MR1917
[34] FSC/AR/MR1914
[35] FSC/AR/MR1912
[36] FSC/AR/MR1928

set aside beds for the family and members of the army and navy as well as Freemasons.[37]

Patients at the Friedenheim appear to have held more diverse occupations than those at the other proto-hospices, but the literature shows only one year in detail and this may not necessarily be representative (Humphreys 1999:152-154). The findings which are specific to the Friedenheim can, therefore, be added to, although not assimilated into, occupational data from the other proto-hospices (Humphreys 1999:152-154).

Nationalities

The patient base of the Friedenheim/St. Columba's was drawn from many countries, as was that of the HW&I, and may reflect the fact that non-nationals were intrinsically less likely to have family to care for them. The country of origin of patients in the Friedenheim/St. Columba's are variously listed as: South Africa, France, Germany, Italy, Switzerland, Sweden, Armenia, Canada, Egypt, the West Indies, Argentina, India, Ceylon, Russia, Central America, New Zealand, Denmark, Hungary and the Straits of Malacca. It is not always clear whether the patient was a native of the country or had spent his/her life there. The obviously transplanted patients, such as the missionary from China, have been excluded from the above list, but some of the other countries, particularly the European ones, are mentioned several times. The spread of countries represented is of interest, but not too much weight can be placed on information which was not collected systematically or comprehensively.

Unlike the other proto-hospices studied, the Friedenheim patients' home addresses have not been saved, although occasionally Davidson notes that a particular patient was admitted because s/he was too ill to travel to his/her

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[37] The 'Waterloo', 'Nelson' and 'Clarence' beds respectively (Humphreys 1999:153)

family either in Britain or abroad. In this context, it is of interest to note that the Friedenheim, Hostel of God and St. Joseph's admitted those of all nationalities and areas, whereas St. Luke's House was restrictive in the geographical scope of its admissions, requiring prospective patients to be 'the poor of London and its immediate environs' (Humphreys 1999:151).

7.4 Patient numbers

As was shown in Chapter 1, the Friedenheim remains largely unknown and unreported in the literature of death and dying and it was therefore important to establish the size of the undertaking. Comparative bed numbers (shown in Table 7.6) drawn mainly from *Burdett's Hospitals and Charities Yearbook* show that no similar institution was numerically of such significance in the early years.

TABLE 7.6 Comparative figures on bed availability in the London homes for the terminally ill c.1905

Home/hospital/hospice	Year	No. of beds
Friedenheim	1905	42[a]
St. Luke's House	1905	35
The Hostel of God[b]	1905	28
Home of the Compassion of Jesus	1918	30
St. Joseph's Hospice	1905	12[c]

Notes: [a]Rising to 50 by 1921. [b]Then known as the National Free Home for the Dying. [c]This rose to 27 by 1907. Sources: Figures from 1905 from *Burdett's Hospitals and Charities Yearbook*, 1907 :947-8. Figures for the Home of the Compassion of Jesus from *Burdett's Hospitals and Charities Yearbook*, 1920:813. St. Joseph's figures from Winslow and Clark 2005:10, 11.

This raises the question of number of patients actually admitted to each of the homes. The numbers of admissions, discharges and deaths at the

Friedenheim/St. Columba's exist for the years 1885 to 1947 (see Table 7.7) and reveal the scale of the organization during its first sixty-two years. Admission numbers fluctuated widely, however, with low numbers reported in 1892 when the institution moved from Mildmay Road to Hampstead and again in 1919/1920 when renovations and a shortage of nursing staff led to ward closures. Patient numbers were also affected during the financial crises in the 1930s (see p 131), and again in 1939 when complete wards were held in readiness for possible air raid casualties. From the admission figures for 1939,[38] the lowest since before the removal to new premises in 1892, admissions gradually increased until, by 1946 and 1947 over 200 patients were being treated annually, among the highest recorded. By the time the hospital was incorporated within the NHS, the hospital had received 7,536 patients, including readmissions, of whom 5,545 (74%) had died. Table 7.7 shows the complete Friedenheim figures for admissions, discharges and deaths.

FIGURE 7.3 Patients treated 1885-1947

The Friedenheim/St. Columba's Hospital
Patient Numbers 1885-1947
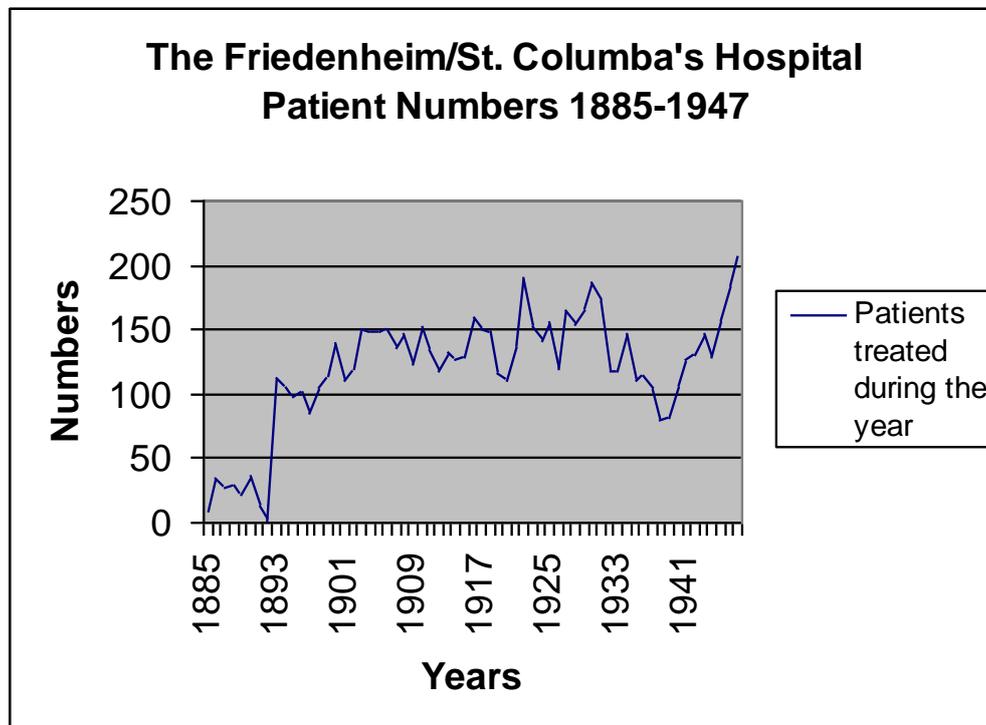
Source: The Friedenheim/St. Columba's Annual Reports

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[38] At the outbreak of war, the hospital was instructed to keep beds free for possible air raid casualties.

TABLE 7.7 The Friedenheim/St. Columba's: Admissions and deaths 1885-1947

Year	In hospital on 1st Jan.	New admissions	Patients treated	Discharges	Deaths
1885		9	9	2	1
1886	6	34	40	20	16
1887	4	27	31	15	11
1888	5	29	34	13	16
1889	5	22	27	11	12
1890	4	36	40	13	18
1891	9	12	21	12	9
1892	0	1	1	0	1
1893	0	112	112	21	68
1894	23	105	128	21	76
1895	31	97	128	21	77
1896	30	101	131	18	80
1897	33	85	118	28	63
1898	27	105	132	24	75
1899	33	114	147	36	80
1900	31	139	170	37	99
1901	34	110	144	29	84
1902	31	119	150	31	82
1903	37	150	187	51	98
1904	38	149	187	45	100
1905	42	149	191	45	102
1906	44	150	194	31	121
1907	42	136	178	39	107
1908	32	146	178	42	97
1909	39	124	163	33	92
1910	38	153	191	46	105
1911	40	134	174	34	97
1912	43	118	161	41	84
1913	36	132	168	24	103
1914	41	127	168	26	105
1915	37	128	165	32	93
1916	40	159	199	37	121
1917	41	150	191	34	119
1918	38	148	186	43	112
1919	31	116	147	39	71
1920	37	110	152	29	85
1921	32	138	169	28	115
1922	27	190	217	50	126
1923	41	153	194	49	100
1924	45	142	187	48	111
1925	28	155	183	37	112
1926	34	119	153	44	79
1927	30	164	194	43	109
1928	42	154	196	47	110
1929	39	166	205	51	120
1930	34	186	220	52	129
1931	39	173	212	53	129
1932	30	118	148	20	99
1933	29	117	146	24	96
1934	26	147	173	40	107
1935	26	110	136	45	65
1936	26	114	140	28	81
1937	31	104	135	32	70
1938	33	80	113	23	61
1939	29	81	110	29	55
1940	26	107	133	29	75
1941	29	126	155	17	111
1942	27	131	158	28	99
1943	31	146	177	26	122
1944	29	129	158	24	111
1945	23	157	180	21	136
1946	23	184	207	26	162
1947	19	209	228	29	174
1948	25				
TOTALS			7,536	1,966	5,545

Source: The Friedenheim/St. Columba's Hospital Annual Reports 1885-1947

Humphreys' figures for patient admissions at St. Luke's show selected years between 1893 and 1922. They are compared with the Friedenheim/St. Columba's figures in Table 7.8.

TABLE 7.8 Selected admission figures, 1893-1922, the Friedenheim/St. Columba's and St. Luke's House

Year	Friedenheim/St. Columba's admissions	St. Luke's House admissions
1893	112	38
1896	101	53
1900	139	37
1905	149	77
1910	153	171
1915	128	150
1920	110	138
1922	190	139

Sources: Friedenheim/St. Columba's figures from the Annual Reports, St. Luke's figure from Humphreys 1999:138

Although interesting, these figures show no sustained trend in either home and may reflect internal developments (for example, the creation or decommissioning of beds, the numbers of soldiers admitted during WW1 or loss of beds reserved for them) rather than any meaningful, sustained parallel between the two establishments and their relative bed usage and admissions.

Long-stay patients

A major and on-going cause of concern for the Friedenheim's administrators related to patients who, in spite of rigorous medical admission criteria,[39] defied their prognosis[40] and, perhaps with the better care, food and surroundings in the hospital, stayed longer than expected or were discharged. The 'problem' of long-stay or discharged patients was one which was shared in particular with St.

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[39] See Appendix A for a facsimile admission form
[40] See Glaser and Strauss (1968:1-15 passim) for a discussion of the difficulties in estimating both an accurate time of death and the length of the dying trajectory.

Luke's, and many of the same reasons were reported: homesickness, misdiagnosis and patients' misunderstanding about the nature of the institution.

Barrett, on behalf of St. Luke's, showed many of the same tensions as the Friedenheim's report writers when discussing long-stay patients. In 1905, for example, he expressed himself particularly forcefully, saying that long-stay patients represented a 'misappropriation of our funds'.[41] It is not clear, however, to whom these strictures were addressed since he was, himself, largely responsible for setting and applying admission requirements and restrictions.[42] One resident, indeed, stayed over two years in spite of the hospital policy of admitting only those within four months of death (Humphreys 1999:182).

The Hostel of God and St. Joseph's, however, had even less success in controlling the 'problem' of long-stay patients, and the literature reports on two at St. Joseph's who stayed for 39 and 15 years respectively, while one at the Hostel of God stayed there for seven years (Humphreys 1999:177-182).

One reason for the difference between the Friedenheim and St. Luke's on one side, and the Hostel of God and St. Joseph's on the other may lie in the Homes' different modes of funding. Both the Friedenheim/St. Columba's and St. Luke's were heavily dependent on donations from the public, and in order to differentiate themselves from other charitable institutions, particularly those for the chronically ill, subscriptions and donations were solicited on the basis of their patients' dying status. In addition, as the financially relatively well-endowed mother orders of the Hostel of God or St. Joseph's were catering to the needy in general, there may have been less urgency to apply the strict

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[41] Barrett, cited in Humphreys 1999:189

[42] He was also responsible for discharges on moral grounds, including some patients who were 'spoilt', exhibited 'bad behaviour' or two in 1914 who were 'most objectionable men of the infirmary class …quite unable to appreciate the kind of relief we offer' (Humphreys 1999:196).

admission criteria necessary in a more focussed and financially fragile Home such as St. Luke's or the Friedenheim.[43]

The disturbing moral dilemma posed by long-stay patients was described by Davidson:

> One woman is left of last year's patients: she has, I fear, become a "chronic", but as she has *no* friends and *no* money, what can we do but retain her – at all events till we can find a suitable home for her? It would break her heart to propose the [Workhouse] Infirmary. It is strange how many absolutely lonely young women there are who, when health fails them and they are unable to earn their living, have none to care for them.[44] (Italics as original)

Her Medical Officer could reassure donors, however, that those who decided on patient admissions did refuse some, even when the workhouse infirmary was the alternative:

> The… case was a pathetic one – a consumptive Father who left the [Workhouse] Infirmary, where he had taken refuge, in order to sit with his daughter dying of the same disease in Friedenheim. When the poor girl had passed away, we gave the Father a bed for a few days until he went back to the Infirmary. He was not sufficiently advanced to be a suitable case for us.[45]

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[43] In 1931, the Hostel of God even opened a home on an adjacent property to accommodate their long-stay patients (Humphreys 1999:182).

[44] FSTC/AR/1908 This problem appears to be common to homes of this type. Nurse Tutor Mick Coughlan at St. Joseph's Hospice said about that institution as late as the mid-1980s: 'Then it wasn't a palliative care unit, it was more of a nursing home. I remember patients who were meant to be palliative, but were here for months…' (Winslow and Clark, 2005:97)

[45] FSCAR/MR/1913 It is interesting to speculate on how the daughter of this apparently indigent man qualified for acceptance, given the admission criteria, but it is clear that he, the father, was also considered for admission though apparently refused on medical grounds rather than financial.

High proportions of new admissions as well as a relatively speedy turnover in bed occupancy were necessary to maintain the identity of the institution as a home only for 'advanced cases' and prevent it becoming, *de facto*, another home for incurables.

In spite of the clearly stated terms of admission, the extent to which the purpose of the Friedenheim was recognised within the medical community is unclear, and unlikely to be widespread. Certainly, as an institution, the Friedenheim was of a type previously unknown and no specific term for its activity had yet been coined. Dr Percy Lush, Medical Director 1892-1918 expanded on the problems this posed as early as 1904:

> Every care is taken to admit only dying patients – that is, as we interpret it, such as are not expected to live more than two or three months – and thus relieve the General Hospitals and enable them to admit more patients. This is not yet generally understood; hence we receive a great many applications on behalf of the sadly large class of chronic incurables, which we are obliged to decline. For it will be at once recognised that every patient who occupies a bed for, say, twelve months is preventing the admission of three or four really dying ones.[46]

Some patients, however, were admitted, who proved to be 'long cases' and he continues with, perhaps, some honesty:

> At the same time I am bound to say that it is a great relief to have a proportion of Patients [sic] who are not actually dying; and not only is it a relief to us who have charge of them, but it must also tend to inspire

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[46] FSC/AR/MR/1904

new-comers with hope. It is not desirable that "those who enter here" should "abandon hope." [47]

Clark Wilson wrote in somewhat harsher terms however. When discussing the temporary closure of the hospital in 1926 for decoration and the installation of a new lift he wrote:

> It must be admitted that the closing served the very useful purpose of enabling us to clear out a considerable number of unsuitable cases which, in an institution like St. Columba's have a way of accumulating, and start fresh again. Some of those unsuitable cases return to us later on – sometimes much later on. One who was admitted in October, 1919, as being within three months of the end, and discharged as so much improved as to be unsuitable in May 1920, returned to us in November last [1926], by then only too suitable; and there is now waiting admission a woman who was a patient for many months in the children's Ward nearly 20 years ago. [48]

Discharge after stabilisation of symptoms, followed by re-admission as the person's condition worsened was not unknown at the Friedenheim/St. Columba's although it was not a deliberate policy. [49] In 1928, no fewer than nine of the new admissions had been admitted to the hospital on previous occasions, one for the fifth time. [50] Conditions at St. Columba's apparently compared favourably with those elsewhere, as Clark Wilson wrote '[They had] been so comfortable during their previous stay, that as soon as any recurrence of symptoms shewed itself they made great efforts to return.' He continued by conceding that most of the returning patients had been '…quite unsuitable when [originally] sent in, and were admitted more or less on false pretences.

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[47] FSC/AR/MR/1904
[48] FSC/AR/MR/1926
[49] See, for example, Hockley 1999:86
[50] The implication in the text is that this was a particularly high number (6%) of re-admissions and therefore worthy of comment and explanation.

This sort of thing happens over and over again, and is very difficult, if not impossible, to avoid'.[51]

Discharged patients

In a similar way to the long-stay patients, the number of discharged patients was also a constant source of concern to the Medical Officers at the Friedenheim/St. Columba's and the other proto-hospices, as too large a percentage of discharges might be badly perceived by the hospitals' supporters and donors.[52] The Friedenheim was, after all, a home for the dying who were, according to those who ran the hospital, homeless or for whom no proper provision was possible. If a substantial proportion of patients were being discharged, support had clearly been going to some who were either not in the terminal stages of illness or did have appropriate accommodation.

As with the other proto-hospices, the Medical Officers therefore took great pains to explain the varying reasons behind discharges. This was clearly a potential problem and in the Medical Report for 1903, Lush was particularly defensive, extensively justifying keeping the so-called 'long cases' and writing as much about the discharges as he did about the patients who died in the hospital.[53] Some patients apparently did not know the nature of the

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[51] F/SCAR/MR/1929 This raises an interesting issue about the referral, or, as is hinted, self-referral of patients to a home for the dying when in fact they were not moribund, together with its implications about other available accommodation.

[52] Glaser and Strauss suggest that nowadays, a factor in self discharge and some patients' preference to die at home may be, '…not because of the familiar surroundings, but because then they can minimize interference with their own management of death' (Glaser and Strauss 2005:93). This phenomenon may also have been a contributory factor in the early twentieth century.

[53] One patient who discharged himself, for example was a sweep, '…who wearied of the ceaseless use of water which nurses delight in (FSC/AR/MR 1904). Another left in 1904, ostensibly, because he did not appreciate the food, meriting the terse comment from Lush, 'It is to be hoped that he obtained better food at home' (FSC/AR/MR 1904).

establishment[54] and others wished to die at home, however unsuitable.[55] Requests for discharge were sympathetically received, but again, needed justifying to donors:

> It is hardly surprising that out of 161 patients, ten… should desire to leave, because, as a rule, the patients themselves do not know they are coming to a Home for the dying… One can sympathise with such feeling, as with the strong desire that others have to die at home – however poor that home may be – and one need not describe their feeling as discontent.[56]

The hospital was, of course, also reliant on the opinion of the referring physician and then as now, prognosis, and to some extent even diagnosis, could be an uncertain art. Lush, writing in 1910 took a slightly cynical view of this:

> These chronic cases are a serious difficulty for the Friedenheim. In former days, before the hospital was so well known, a medical man recommending a patient would take the most favourable view of his prospect of life, as ordinary Hospitals are chary of admitting a patient who is likely to die within its walls. But now that the object of Friedenheim is generally known, the medical attendant inclines to a pessimistic view of the patient's prospects of life![57]

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[54] This implies that some patients did know the nature of the institution and is in contrast to practice at St. Luke's Home where the Director, Dr Barrett, always suppressed the purpose of the hospital (Goldin 1981:400). By the 1950s, patients at St. Columba's were always, though gradually, told the truth about their condition (see Appendix C). References to the desirability, or otherwise, of telling patients about the truth of their condition could not be traced with any consistency through the source material, though see Appendix C for the mid-twentieth century approach. Lush remarked in 1900 that he felt it his 'duty' to tell patients when their end was near, adding 'It is not always easy to do this, although it is very rarely resented by the patient' (FSC/AR/1900:18). There is no indication of why this was felt to be a 'duty', though he may have thought it necessary for a temporal and spiritual preparation for death.
[55] These remarks were, of course, written by officers of the hospital who may not always have been aware of, or recognised, the true reason behind a patient's criticism.
[56] FSC/AR/MR/1913
[57] FSC/AR/MR/1910

FIGURE 7.4 Deaths and Discharges 1885-1947

The Friedenheim/St. Columba's Hospital Deaths and Discharges
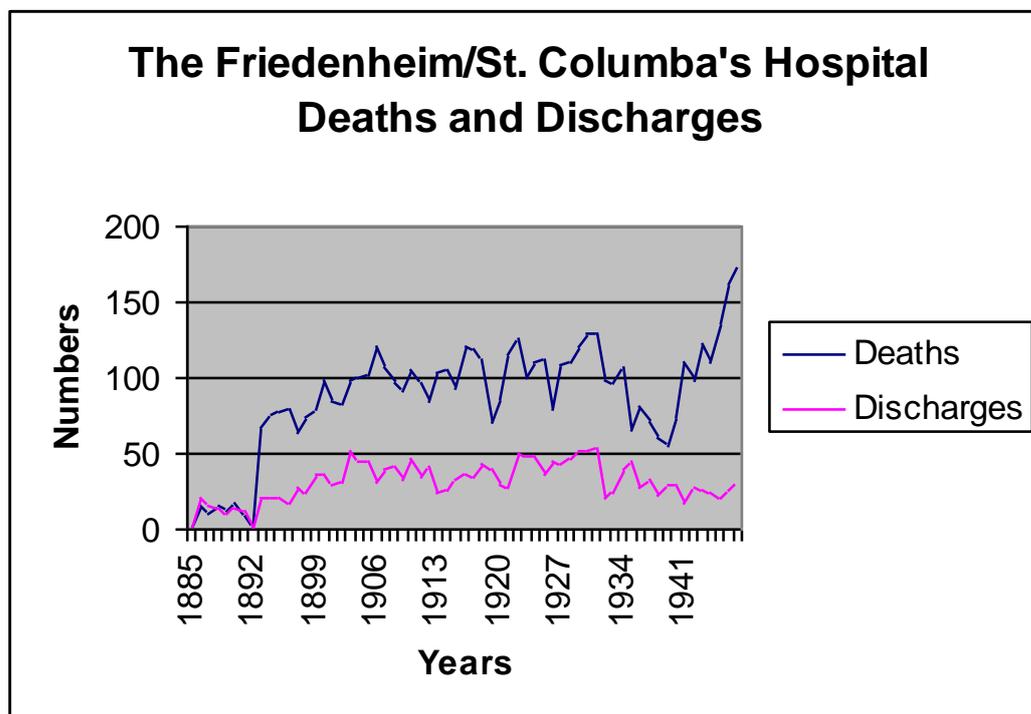
Source: The Friedenheim/St. Columba's Hospital Annual Reports

A graph charting both deaths and discharges (Figure 7.4) shows a general consistency between the two sets of figures during the first part of the twentieth century. The ratio between them, however, narrows during the 1930s when fee-paying, chronically ill patients were admitted for financial reasons (see p 133). By the 1940s, however, numbers of discharges remained constant or sinking while deaths increased, showing an unprecedented rise in number during the final years. These changes were probably due to the replacement of chronically ill residents by cancer patients (see Figure 7.5) whose prognosis was more certain and generally shorter. The picture is confused by the outbreak of World War II in 1939, when a ward was kept in readiness for possible air raid casualties, '…much to the detriment of numbers admitted'.[58] Once these beds were released sometime in 1940, admissions started to rise and continued to do so until 1947.

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[58] FSC/AR/MR/1940

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7.5 Disease types

Humphreys cautions against the 'temptation of retrospective diagnosis' (Humphreys 1999:167), but Hardy makes it clear that in spite of uncertainty in the art of diagnosis and vagaries of the recording systems, 'by the later nineteenth and early twentieth century, …it is probable that registered tuberculosis mortality approximated to reality' (Hardy 1994:490), implying improved diagnosis and post mortem recognition of the disease. Even the diagnosis of malignancies became more accurate around that time through information gleaned from more frequent surgical procedures to detect internal tumours and post mortem examinations (Hardy 1994:491). These were the two main presenting conditions[59] at the early homes for the dying and the relative and changing numbers of admissions of each of these can be traced up to c. 1945 at the Friedenheim/St. Columba's. A parallel cannot simply be drawn between national incidence and patient admissions, however as the Friedenheim continued to favour tubercular over cancer patients for a variety of reasons and for a longer period than might have been expected. Some of this was due to the institution's historical bias towards these patients, who were also easier to nurse than those suffering from cancer. Pragmatically, as well, the home was able to make financial arrangements with some Urban Councils for the reception of their TB sufferers which provided a useful source of income.[60]

At the Friedenheim, and for many years at St. Columba's, tuberculosis (TB) remained the major presenting condition. Based on the Registrar General's *Decennial Supplement* for the years 1881 to 1890, which includes the year the

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[59] Recorded patients' conditions were those diagnosed on admission, and not necessarily the cause of death.

[60] The extent and amount of this financial input cannot, unfortunately, be traced with any accuracy. Referring councils and bodies changed and there is no record of the numbers involved. Humphreys found an even more extended pattern of intake of tubercular patients at St. Joseph's, which in its case, however, she tentatively assigns to the fact that many of their patients were referred by Sisters 'on mission' who were more exposed to home conditions where TB might have flourished. A greater proportion of hospital-generated admissions there, she felt, might have led to a preponderance of cancer cases (Humphreys 1999:169, 173).

Friedenheim opened, TB was numerically the single most important cause of mortality in England and Wales accounting for nearly 13% of all deaths. Twenty years later, between 1901 and 1910, deaths from TB had dropped to 11% of the total. Cancer deaths, however, showed the opposite tendency, doubling from 3% in 1881-1890 to 6% in 1901-11. These divergent trends continued and, by 1948, the proportion of deaths attributable to all forms of TB had fallen to 5%, whereas the proportion of those attributed to cancer had risen to 17%.[61]

Originally planned to cater primarily for tuberculosis sufferers,[62] the early Friedenheim Medical Reports carefully distinguished between admissions for simple, complex or acute pulmonary phthisis,[63] as well as tuberculosis of the vertebrae, abdominal organs, glands, sternum and knee joints.[64] In spite of self-imposed selection criteria which might favour tuberculosis sufferers, the changing morbidity pattern in the general population is nevertheless reflected in admission figures to the institution. Figure 7.5 shows how the trend of conditions on admission evolved between 1900 and 1938.

Notwithstanding the home's bias towards tubercular patients, the chart also shows that at least from as early as 1900, patients with illnesses other than tuberculosis were admitted to the hospital and that already in those days, cancer was an important cause for admission. In spite, therefore, of having been founded primarily for tubercular patients, by 1947, the institution was

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[61] Registrar General 1881-1890, 1901-1910 Central Statistical Office 1948, 1949. In 1920, the Executive Council, under the leadership of the newly appointed Medical Officer, Clark Wilson, rationalised patient accommodation and accepted more applications for the admission of patients suffering from cancer, see Chapter 7:176. By 1980, the year before the Friedenheim closed, cancer accounted for 22% of deaths in the UK. (Yuen 2005:45).

[62] See Appendix B for Davidson's view on that matter and also p 176.

[63] Although the term 'tuberculosis' existed by 1840, the terms 'phthisis' or 'consumption' continued to be used until the beginning of the twentieth century (Dubos and Dubos 1953:5).

[64] See, for example the Friedenheim Annual Report dated 1901:28. Figures published by the Friedenheim/St. Columba's refer to condition on admission, not to cause of death as it appeared on the death certificate, and cannot, therefore, be directly compared with mortality data. They do, however, give an indication of the underlying cause of death.

Figure 7.5 Primary diagnoses on admission, 1900-1938

The Friedenheim/St. Columba's Hospital
Primary diagnosis on admission (%) 1900-1938
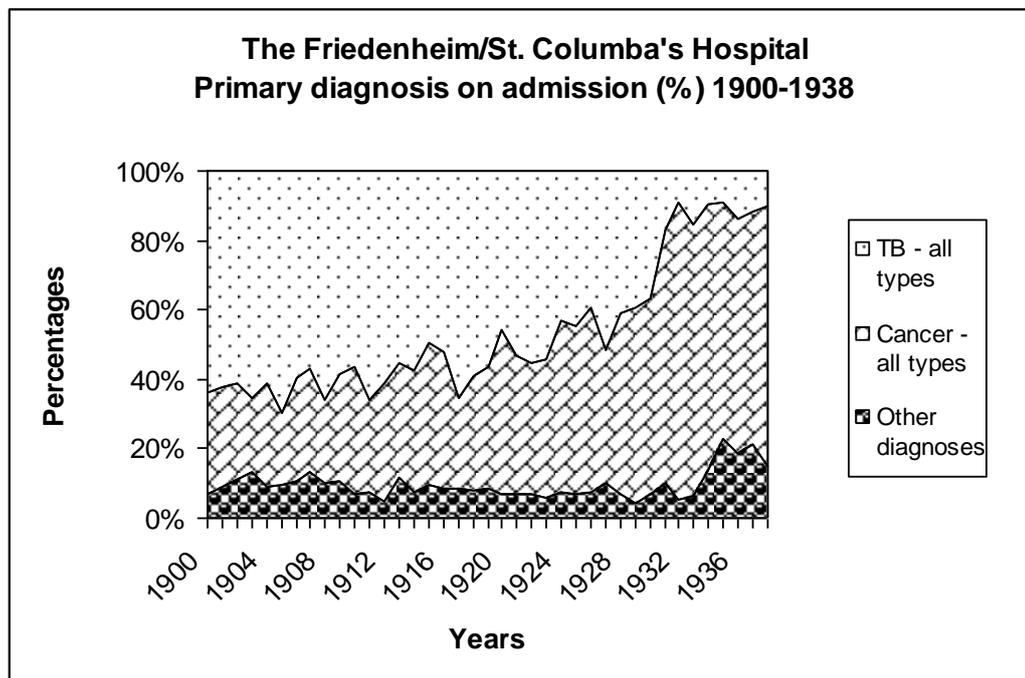
Source: The Friedenheim/St. Columba's Hospital Annual Reports

mainly treating patients with cancer. The figures here show this change over a period of 38 years and it is unfortunate that more detailed patient data are not available for the years 1938-1947 to complete the picture. Five-yearly admission data from the other proto-hospices, show a similar trend, with the exception of St. Joseph's where some 50% of patients were suffering from TB in 1938 (Humphreys 1999:170).

In addition to the growing predominance of cancer patients, another factor to emerge from Figure 7.5 is the consistent evidence of care being provided for disease groups other than TB or cancer, such as heart or liver disease; a situation which continued until 1948. The independence enjoyed by the hospital allowed it to impose its own medical selection criteria, accepting, therefore, those patients who were close to death and in need of care, rather than necessarily suffering from a specific disease condition.[65]

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[65] See Humphreys 1999:176

The rise in numbers of cancer cases

As incidence and mortality from tuberculosis declined, it can be seen that the number of admissions of patients suffering from terminal malignant conditions increased. Davidson had already retired to Scotland late in 1916, but, under instructions from the Council, Macneill informed her of a project to increase the number of cancer beds which required some structural alterations to be made to the upper floors. Davidson, however, resisted the admission of too many such patients:[66]

> As Dr. Lush [the Medical Officer] knows, <u>I have always tried to keep down an undue proportion of Cancer cases</u>, as 'Friedenheim' was mainly intended for consumptives, for whom there is so little provision made in London, whereas there are Homes and Hospitals for dying cancer cases.[67] I feel that there are now as many cancer cases at St. Columba's as should be for its accommodation and nursing staff.[68] (emphasis as original)

Davidson was by now in her late-70s and in failing health. The Council Minutes, perhaps as a matter of courtesy, record that, 'although adhering to their former opinion [they] decided to let the matter drop for the present'.[69] After her death in 1920, however, these structural alterations were undertaken and the middle floor became entirely devoted to cancer patients.

Clark Wilson, who followed Lush as Medical Officer (see Chapter 8), confirmed that the decision to alter the focus of their patient base was the correct one in 1924:

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[66] SMHA/CM/II:235-236 This is the same memorandum in which she revealed her grasp of the practicalities of nursing and the needs of the patients (see Appendix B).

[67] Davidson is presumably referring to specialist hospitals such as the Royal Marsden which had wards dedicated to their dying patients.

[68] SMHA/CM/II:235-236 This is the same memorandum in which she revealed her grasp of the practicalities of nursing and the needs of the patients (see Appendix B).

[69] SMHA/CM/II:235 Figure 7.5 (p 175) shows that Davidson's insistence on trying to restrict the number of cancer cases did not, in fact, greatly alter the rising trend of such admissions.

...it is happily the case that the figures for tubercle all over the country shew latterly a decrease: but it is alas! also true that the figures for cancer shew an even greater increase; and our experience at St. Columba's is in accordance with both findings.[70]

This changing balance in presenting conditions, which sometimes overstretched the available nursing capacity, was to be a matter of concern in the Annual Reports of 1927 and 1930 but by 1932, twenty-five of the thirty[71] total available beds were given over to cancer patients. By 1945, Sprott was able to write, 'We do not usually admit non-cancer cases',[72] although he then goes on to detail the non-cancer cases: 5% of admissions that year and as many as 15% in subsequent years.

The growing incidence of cancer among the homes' patients suggests the lack of provision in general for those who, by then, were possibly most in need of medical care: a shortfall which was specifically recognised nationally in the Marie Curie Memorial report of 1952 (Marie Curie Memorial 1952). St. Columba's figures show a disproportionate number of cases of that disease compared with the population as a whole. In 1938, for example, cancer accounted for only 14.8% of deaths nationally,[73] whereas some 75% of St. Columba's patients suffered from the disease.

At St. Columba's, no detailed diagnostic data are available for the years 1939-1941, but between 1942 and 1947, tuberculosis as a presenting condition had disappeared from the figures. Non-cancer patients, however, mainly with

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[70] FSC/AR/MR/1924

[71] St. Columba's was going through the major financial crisis described in Chapter 6 and had closed some wards in a drive for economy. These numbers suggest, however, that the intake of paying, chronically ill patients in this year at least, was fairly low.

[72] FSC/AR/MR/1944

[73] Office of National Statistics (1997) *Twentieth Century mortality database: 95 years of mortality in England and Wales* HMSO London

cardio-vascular conditions, continued to be admitted and accounted for between 5% and 15% of patients.

All the early homes for the dying, therefore, present similar, though nuanced trends in patients' conditions on admission which in general reflect the national decline in tuberculosis and rise in cases of cancer. Nevertheless, every home also accepted those dying from conditions other than tuberculosis or cancer. However many social restrictions there might therefore have been, medically, admission was ultimately based on a person's dying condition, and was not disease specific.

7.6 Summary

Characteristics of the Friedenheim/St. Columba's patient body reveal an eclectic mix of people filling the wards with different backgrounds, nationalities, languages and ages,[74] and whose main common denominator was their poverty in the face of death; whether financial, in housing, or of family and friends.[75] As well as being close to death, however, certain pragmatic criteria, such as the ability to pay for funeral expenses, had also been imposed, thus excluding the very poor. In addition, some social standards were applied as the home was intended for those 'least suitable for the workhouse infirmary'. In spite, however, of Davidson's claim that the home had been intended for 'upper-middle' class women, occupational data in fact suggest a preponderance of working-class groups. The comparison with census data from the local Workhouse and Infirmary revealed two occupationally similar groups, which differed mainly in age.

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[74] It should be remembered that, unfortunately, detailed data on patients' ages are only available up to 1917.

[75] It should also be remembered, however, that for a period of time some chronic, paying patients were admitted to support the institution financially (see p 132).

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The numbers show that on average, after 1893, over 130 patients were received annually and there were some two deaths every week, mostly from tuberculosis or cancer. Diagnoses on admission reflect the changing patterns in society and, as tuberculosis was brought under control, so subsequent numbers of cancer patients rose. Figures also show the constant admission of a small number of patients with other conditions but nevertheless needing some kind of specialised care or symptom relief towards the end of their lives. The youth of its patients in the early years reflects the original aim of the Friedenheim to provide a shelter for tuberculosis sufferers while this was the major condition on admission.

The available records for each of the proto-hospices vary in quantity, quality and depth, precluding sustained significant cross-analysis. Complementing, in particular, Humphreys' research on the patient body in her 1999 work, the Friedenheim data show some similarities and shared concerns with the other homes but essentially reveal another unique institution catering for the dying poor of London.

The following two chapters discuss different aspects of the care given to these disparate people and the staff who provided it.

CHAPTER 8 – STAFF AND CLINICAL CARE

The Friedenheim/St. Columba's existed for nearly one hundred years, during which time the medical environment underwent major changes. By 1885, the date it opened, Laennec's analytical work and the development of equipment such as stethoscopes and microscopes at the beginning of the nineteenth century had ushered in an era of improving diagnosis pre- and post-mortem. The pharmaceutical and surgical means to treat and sometimes cure or alleviate morbid conditions evolved only later, however, after World War II (Porter 2003, 2006, Shorter 1986). By the time St. Columba's closed in 1981, not only was 'postmodern', drug-based medicine the norm during life (Porter 2003, 2006, Shorter 1986), but Saunders was actively involved in defining and refining the specific nature of medical, spiritual, psychological and social care needed by the dying.

Another major evolution can be discerned over the lifetime of the Friedenheim/St. Columba's in the role played by clergy at the bedside of those dying. As early as the thirteenth century, Porter identifies a clear division of labour in the Christian world between the physician, who dealt with a person's body and the cleric, who dealt with a person's soul (Porter 2006:76). These responsibilities necessarily converged at a deathbed and, at the time the early homes for the dying opened, both professions played an important role in assuaging the distress of those dying. The next hundred years, however, were to see the gradual secularisation of society and medicalization of the death bed.

This chapter confines itself to clinical issues at the Friedenheim/St. Columba's, situating them in the contemporary medical environment and comparing them, where possible, with the other proto-hospices. The spiritual and religious responsibilities and environment of the hospital are discussed in the following chapter.

8.1 Clinical background

An overview of contemporary writing about dying towards the late nineteenth century indicates the resources and thinking of the doctors who treated the Friedenheim's first patients. Mid-nineteenth-century physicians, such as C.J.B. Williams[1] and William Savory,[2] followed Bichat's[3] experimental and analytical approach to their investigations of dying and death. By attempting to establish disease-specific 'modes of dying' based on the organs and diseases involved, they sought to introduce analytical structure into their 'imperfect art' when facing the 'ultimate inevitability of death' (Williams 1862:345). In parallel with his mainly laboratory work, Savory also briefly considered the mental situation of the patient, averring that there was 'a widespread error that the moment of death... is one of agony... usually it is not so.' Rather, the 'time of greatest mental distress is perhaps when the conviction first dawns on us that we are about to die' (Savory 1863:173). A different attitude and opinion is apparent in the writings of the American Silas Weir Mitchell,[4] however, who described dying patients as 'horrible', generally 'with few of their wits about them' and prescribed drugs only as necessary (Weir Mitchell 1887:73).

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[1] 'The successes and failures of medicine' *The Lancet* 1862

[2] 'On Life and Death' Smith, Elder & Co. London 1863

[3] Marie François Xavier Bichat (1771-1802), French anatomist, pathologist and physiologist, whose work 'Physiological researches upon life and death' (*Recherches physiologiques sur la vie et la mort* Brosson Gabon, Paris 1800) became the cornerstone of forensic and analytical medicine.

[4] 'Doctor and Patient' Lippincott, Philadelphia and London 1887

An evolution in thinking can be seen in William Munk's seminal work, *Euthanasia[5], or medical treatment in aid of an easy death,* published in 1887. Although starting with analysis of physiological phenomena like his predecessors, Munk amplifies this by, virtually for the first time, introducing the patient as a person into these discussions and considering practical details for the medical and physical management of the death bed.

Through his comprehensive recognition of the needs of those dying, Munk essentially creates a protocol to inform those caring for patients at the end of their lives. Their main aim, he says, is to promote 'an easy, gentle and placid death' (Munk 1887:4). An important contributor to the peace of mind this implies is hope, extending to the belief in an afterlife:

> To the dying there is no greater solace and cordial than hope… The retrospect of a well-spent life… is a cordial of infinitely more efficacy than all the resources of the medical art, but a firm belief in the mercy of God, and in the promises of salvation will do more than anything in aid of an easy, calm and collected death (Munk 1887:22-23).

Although individual needs vary and '[e]very case requires its own considerations' (Munk 1887:30), preparation for death will also ease the patient. He or she should not 'leave the world unprepared to meet his Creator and Judge, "with all his crimes broad blown"' (Munk 1887:29) nor be 'made miserable by solicitude for those [s/he] will leave behind' (Munk 1887:30-31).

Having established these principles, Munk continues by examining the ways death arrives, and details the contribution medical and nursing methods can make to promote the desired 'easy, gentle and placid' death. Appropriate nutrition is stressed, as is the correct position in bed, the weight of bedclothes

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[5] 'Euthanasia' here is used in its original meaning from the classical Greek of an easy, peaceful and painless death.

and, aimed at enhancing the patient's comfort, Munk recommends 'the fewer drugs and the less of medicine we can do with in the treatment of the dying the better' (Munk 1887:85). Recognising that this is not always possible, he then discusses the use of ammonia, alcohol in various forms,[6] ether, oil of turpentine and opium in symptom relief.[7] The dose, he says, although kept as low as possible to avoid mental confusion, 'is to be governed solely by the relief offered' (Munk 1887:80).

Munk provides the scientific rationale behind his recommendations, whether the lightening of heavy bedclothes or, say, the administration of port rather than brandy for relief, thus describing and establishing best practice at the time. Due, perhaps to the specificity of its content for those at the end of life, and the comprehensive nature of matters covered under this heading, Jalland has described Munk's work as a 'landmark in the Victorian history of medical care for the dying' and as an 'influential textbook' (Jalland 1996:82).

A breakthrough in symptom control occurred some years later, when Dr Herbert Snow recognised the relief that strong opiates could bring to painful malignant conditions. He suggested that opium and cocaine, when used together, provided pain relief and 'sustain[ed] vitality' in cancer patients (Snow 1896:718). The so-called Brompton cocktail,[8] based on this mixture of opium and cocaine, but with the admixture of other drugs, came into widespread use in the 1920s and was still used well into the late twentieth century (Clark and Graham 2008:1018). Also in the 1920s, an attempt was made to use nascent psychoanalytical theory in an effort to understand and relieve the mental distress of the dying. J. N. Glaister[9] wrote of the 'phantasies' of the dying, describing a case study where, by analysis of a patient's dreams, he had been

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[6] Munk distinguished between the use of sherry, brandy, Tokay, port and Madeira in their efficacy in combatting various symptoms.

[7] Various injectable alkaloids of opium were isolated in the nineteenth century; morphine in 1806, codeine in 1832 and heroin in 1898 (Shorter 1986:93).

[8] The 'Brompton Cocktail' is a mixture variously of morphine, cocaine, cannabis, gin or brandy and chloroform (Clark and Graham 2008:1018).

[9] 'Phantasies of the dying' *The Lancet* 1921

able to ensure her peaceful death. He attributes his success solely to the dream analysis, and, although recognising the woman's isolation from society brought about by her character, dying state and subsequent loneliness, appears not to have realised that his daily meetings with her and intense interest in her condition may also have played a part in her 'cure'. Glaister is important, however, for explicitly recognising the loneliness of the dying and calling for a united effort by those treating them to make 'the best possible use of the remainder of life, with all the help that the surgeon, the radiologist, and the psychologist can give them' (Glaister 1921:317).

Among later medical texts, published during the lifetime of St. Columba's but before the advent of the modern hospice movement (Barber 1948, Gavey 1952, Glyn Hughes 1960, Hinton 1963, 1967, Leak 1948, Marie Curie Memorial 1952), perhaps the one offering the most direct, practical advice for the physician or nurse in care of the dying is that of Worcester, *The care of the aged, the dying and the dead,* first published in 1935.[10] No longer analysing 'modes of death', Worcester concentrates on physicians' responsibilities, patients' physical needs and mental comfort, as well as consideration for the family.

There is no direct evidence of the extent to which the Friedenheim's Medical Officers recognised this evolution in medical theory of care for the dying. Early Medical Reports in particular recall the intertwined, yet separate, themes of medicine and religion and contain not only numbers of patients, sometimes detailed tables of conditions with occasional descriptions of individual cases and treatment, but also Biblical texts, religious verse and references to the ever-present Almighty. It is perhaps symptomatic, however, of the gradual

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[10] Alfred Worcester (1855-1951) was an American family physician whose mother, an old time neighbourhood nurse, had actively involved him in her work from childhood. An interest in nursing, including nurses' training, stayed with him throughout his life. Following extensive trips to Europe, where he visited Kaiserswerth, the Augustinian Sisters in Paris and met Nightingale, in 1935 he published *The care of the dying and the dead* which became a major text on the care of terminally ill patients. Worcester was appointed Professor of Hygiene at Harvard Medical School and continued writing articles on nursing and care of the dying until his death (Kerr 1992).

medicalization of the death-bed and growing primacy of the doctor over the spiritual adviser that these religious references decline over the years. By the time of the last Medical Officer of this central period at St. Columba's, Norman Sprott (see below), all religious references have disappeared from the Medical Reports, although he specifically recognises the spiritual comfort that religion can bring to the patient.

The Friedenheim and later St. Columba's aimed to provide physical conditions and medical support in order that a patient might die at peace with his/her conscience, in comfort and, where possible, free of pain. Examining the doctors and nurses who offered this care clarifies the character of Davidson's 'Home for the Dying'.

8.2 Doctors

Honorary Consultants

Administratively marking its evolution from the 'entirely small and very private'[11] Islington days, the new Hampstead establishment boasted a range of honorary consultants, including physicians, various specialised surgeons and anaesthetists. Although theoretically supplying a clinical resource for the medical staff, their role may also have been to bestow credibility on the hospital on a professional and social level. Despite being regularly thanked in the Annual Reports, these honorary appointees, unlike some of the other early homes for the dying (see, for example, Humphreys 1999:221), appear to have had little to do with the daily running of the establishment and minimal intervention by them in clinical matters is recorded. There is a clear division of practice between these honorary appointees and the Medical Officers who were in daily, or twice

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[11] A/FWA/C/D161/1 letter to Loch dated 08.02.1887

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daily contact with the patients. In comparison, while the Hostel of God, like the Friedenheim/St. Columba's, also retained the services of a Medical Officer, medical attendance at St. Luke's was covered by Visiting Physicians who each came one day a week, usually in the afternoons. At St. Joseph's, Humphreys notes that several of the visiting honorary physicians who assured medical cover at St. Joseph's had trained in Ireland, and would have been 'familiar with the work of the Sisters and their primarily spiritual agenda' (Humphreys 1999:221).

Two honorary consultants, however, played an active role at the Friedenheim/St. Columba's. The honorary dental surgeon, in 1914 a certain Ernest H.L. Briault, sent one of his assistants, a Mr. Scobie, on a regular basis to treat the patients and A.T. Schofield, (see Chapter 5:97) who in the early days advised on the suitability or otherwise of prospective patients, but whose contribution to the work of the Friedenheim was wider reaching than simply the medical.

Medical Officers: Percy Lush, John Clark Wilson and Norman Sprott

In his 1996 paper, Woods examined the work of Victorian medical statisticians which revealed the physical vulnerability of young doctors and 'a medical profession subject itself to poor health and diminished life chances' (Woods 1996:2). Mortality among doctors was, 'not only "far in excess" of that among other professions, but it was also higher than that in "most trades and industries"' (Woods 1996:1).[12] The Friedenheim/St. Columba's was therefore lucky in that it had the services of only three Medical Officers between 1892

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[12] Internal citations are from Ogle, W. Statistics of Mortality in the Medical Profession, *Medico-Chirurgical Transactions*, (1886) 69:217-137. Doctors' life expectancy compared to the male population in general gradually improved from the start of the Edwardian era, though again briefly declining in the 1930s (Woods 1996:28).

and 1948.[13] The last of these in fact stayed with the hospital under the new NHS management, retiring in the 1950s. Medical coverage was thus assured for a period of over 60 years by only three men, all of whom demonstrated commitment both to the care of the terminally ill and the institution.[14] It must be recognised that while such continuity of care at the Friedenheim/St. Columba's might be expected to promote a depth in professional expertise, it might also, if prolonged too long, encourage stagnation in practice. As members of the Executive Council, however, and responsible for an important, and public, section of the hospital's Annual Report, these men held a crucial position in the life, continuity and public perception of the hospital. This appears to be in marked contrast to the other Homes which experienced a rapid turnover of both medical officers and nursing staff (Humphreys 1999:219, 223, 238).

Percy Lush (1858-1918), the first of the Hampstead physicians, was in office from c.1892 until his sudden death in November, 1918. He had been the first Nonconformist to hold a scholarship at Christ Church, Oxford and had had a life-long connection with the Baptist church and its work, serving as the honorary medical officer of the Baptist Deaconesses' Home and the Baptist Union Annuity Fund. A Fellow of the Royal Society of Medicine and the Medical Society of London, he had a general practice around the corner from the Friedenheim in Maresfield Gardens. He died of influenza during the epidemic of 1918/1919 and a ward at St. Columba's was subsequently named in his honour.

His obituary[15] recorded that:

> He made a point of being as thorough and as careful in the examination
> and treatment of the inmates of Friedenheim as is the case in the best

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[13] In this respect, the Friedenheim/St. Columba's appears to have more in common with tuberculosis sanatoria where, Bryder reports, 'most medical superintendents …typically remained in the post for thirty years or more (Bryder 1988:213). These were, however, full-time posts, unlike the Medical Officers of the Friedenheim/St. Columba's.
[14] Medical provision had been assured in Mildmay Road by the services of, 'our friend Dr Huggins of Islington, the honorary physician' (UofL/FSCAR/1888:7), who visited regularly.
[15] See St. Columba's Annual Report for 1919

organized hospitals in the land. He set a very high standard of medical work, and we can trace certain definite results to this fact. It established St. Columba's as a hospital of first-rate rank – it is universally recognised as such… his daily morning visit was always a prolonged one, and he frequently supplemented it with a second visit late in the afternoon to see patients who were especially ill, or in much suffering.[16]

Lush was remarkable, the reader was told, for his courtesy and kindness, addressing all the patients by their first names and, 'his care was to make it a home, not an institution'.[17]

Given that an early twentieth-century obituary is unlikely to be overly critical of its subject,[18] particularly in the Annual Report of the institution he served, it is nevertheless interesting to consider two points singled out for mention. The anonymous writer emphasised Lush's professional standards vis-à-vis the patients, and also his concern to establish a homely atmosphere in the hospital, which included acknowledging each patient by name. These two factors alone would be enough to differentiate the Friedenheim from the workhouse infirmaries and are indicative of the care ethos that prevailed.

The detailed morbidity figures and data on patient ages from the early Hampstead years were produced when Lush was Medical Officer and are in accord with the general attempts among physicians in the late Victorian era to analyse and codify their profession.

Lush's succession was assured by John Clark Wilson who, in the early years of the century had acted as Lush's locum. He was then appointed pathologist and

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[16] FSC/AR/1919
[17] Ibid.
[18] See the work of Nigel Starck (for example Starck 2009), for the significance and rhetoric of published obituaries.

in 1908 had been appointed Registrar, under Lush.[19] John Clark Wilson (1870 –

1948) was born in Ayr, educated at George Watson's Academy in Edinburgh[20]

and graduated from that University before going on to University College,

London and Paris. He was an F.R.C.S (Edin.), M.D. (Edin.), M.M.B.C.M., M.R.C.P,

with a Diploma in Public Health from Cambridge.[21] He was an Elder of St.

Columba's Presbyterian Church, Pont Street and retired to Edinburgh in 1941.[22]

Following his appointment to the post of Medical Officer, the style of the

Medical Reports changed, becoming shorter, less expansive in content, more

business-like and providing fewer patient data. Clark Wilson wrote his last

Medical Report for St. Columba's in the Annual Report dated 1941, ending an

association of nearly forty years with the institution. Wartime paper restrictions

had, by then, reduced the size of the reports and there is only a brief

appreciation of his work in his obituary.[23]

The third Medical Officer at the Hampstead location was Norman Sprott

(c.1890-1979), who held an M.A., an M.D., an M.B., BCh and B.A. (Hons Nat. S.

Physiol.). He was also an F.R.C.S., M.R.C.S. and L.R.C.P. Sprott was the Medical

Officer in charge when Cicely Saunders visited the hospital and he continued

corresponding with her after his retirement to Jersey in the 1950s. He is the

only one of the medical directors to have written in the professional journals

about the care of the terminally ill (Sprott 1949, 1955), where he provides

direct, detailed evidence of care practice in the hospital. It is perhaps

symptomatic of the disassociation of medical practice from religion and the

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[19] FSC/AR/1909/MR

[20] I am indebted to Dr J. C. Wilson, his son, for some of these details. (Provided in December 2007).

[21] Clark Wilson practised in College Crescent, Hampstead where he lived with his wife, a former nurse from St. Columba's, and their seven children. His only published work appears to have been an article entitled 'Case of Scurvy with well-marked Purpura' in the *British Journal of Dermatology* in 1902.

[22] Clark Wilson's published Medical Reports are couched in significantly blunter terms than those of Lush. On his retirement, the Council, however, alluded to '…his life's labour of love' (FSCAR/1941:8) and he himself described his work as 'a pleasure and an inspiration' 9FSCAR/MR/1937:11) later recording that he had 'many precious memories of happy work and ever increasing admiration for it – for the noble devotion of the Matron, sisters and nurses, and for the courage and heroism of the patients.' (FSCAR/MR/1941:10)

[23] FSCAR/SR/1928 It is known that he, too, visited patients daily or more frequently if needed.

latter's decline in management of the death bed, that Sprott, alone among the hospital's medical officers, held no avowed religious beliefs.

Coincidentally, Sprott started working at St. Columba's at the time that major advances in pharmacology were, at last, giving doctors the possibility of curing certain conditions, as well as more successfully palliating symptoms. Although direct comparisons cannot be sustained as the one was writing about dying in general and the other about dying from cancer, the fourteen years between Worcester's work (cited earlier) and that of Sprott, nevertheless exemplify a transition in writing about the dying. Worcester, for example, writes in general terms about position, oral hygiene using water and 'sour wine', nutrition, the use of opiates and 'watchful waiting' (Worcester 1940:37, 46). Sprott in addition however, discusses disease processes and the appropriate relief to be afforded through the careful use of drugs and administration techniques.[24] Although aimed specifically at the treatment of terminal cancer, Sprott's 1949 paper introduces for the first time a recognisably modern approach to the use of drugs and surgical procedures in the palliation of his patients' symptoms.

Sprott's interest in his profession was widespread and continued after his retirement. One of his later letters to the British Medical Journal (BMJ) is of particular interest in the context of St. Columba's. Opposing a proposed ban on the medical use of heroin, he points out the relief that drug can bring to some terminal sufferers from cancer.

> Of course [at St. Columba's] we were familiar with all the pain-relieving
> drugs. For some of our patients the less potent ones were sufficient, at

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[24] Sprott compares the use of various morphia derivatives including morphine hydrobromide, codeine phosphate, protocaine and diamorphine. He also discusses the use of hyoscine hydrobromide, atropine sulphate, allonal veramon, nepenthe, physeptone, the 'Brompton Cocktail', and pethedine. The drugs are mainly analgesics, but include, for example, anti-emetics and drugs used to inhibit the production of excessive secretions. To further relieve symptoms, he suggests 'tapping' the abdomen, drawing fluid from the pleural cavities, laminectomy, active management of bowels and bladder and is particularly concerned about the treatment of anorexia, vomiting, anxiety, sleeplessness and pain (Sprott: 1949:188-190).

any rate for a time; but most of them required either morphine or heroin to make life at all bearable… By trial and error and individual study of each patient… we found out how best to bring relief' (Sprott 31 December 1955:1621).

He bases his remarks on his thirteen years' experience in charge of St. Columba's, where, he says, 200 new patients were admitted yearly. He points out that very few doctors, including consultants and specialists are likely to have had much experience of the 'management and care of patients towards the end' (Sprott 1955). Indeed, he includes himself among that number, suggesting that apart from the patients themselves:

> the people best qualified to know the truth in this matter [the use of heroin] are not doctors at all, but nurses – the matrons and ward-sisters of the special institutions where cancer patients go to die. A doctor who merely visits the hospital, however frequently, cannot have the same intimate understanding of the individual patient's reactions to different drugs as the nurses who… are with the patients day and night (Sprott 1955:1621).

The work of these three doctors spanned sixty years which saw the development of the physician's art from the diagnostic, analytical and curative insufficiencies of the late nineteenth century to the scientific, rigorous development of medical skills supported by extensive drug research achieved in the mid-twentieth century. It is notable, that during this period, perhaps as the doctors themselves became more adept at assuaging the physical distress of their patients, references to faith and the afterlife diminish and ultimately disappear from the medical reports.

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8.3 Clinical concerns

Medical records

It is clear from the Annual Reports that detailed patient records were maintained and, while Lush was Medical Officer, the analysis and presentation of these records for the Annual Reports was one of Clark Wilson's tasks whilst acting as Registrar. When Clark Wilson became Medical Officer himself, he ceased publishing more than the most basic data.[25] Sprott did not publish the comprehensive tables favoured by Lush, but nevertheless did leave some breakdown of the patients' conditions described earlier in Chapter 7. Other and subsequent records appear to have been destroyed in the years following acquisition by the NHS. Without detailed patients' notes, the minutiae of treatment cannot be established, but a general picture of the clinical aspects of symptom relief emerges.

Surgical procedures and pain relief

With no institutional religious pressure to perceive pain as anything but an enemy which inhibited the peace Davidson sought for her patients (see Chapter 9), active measures were undertaken to relieve symptoms, some of which even demonstrate a certain level of clinical sophistication. The hospital was, for

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[25] No reasons are given for this change in data presentation. It is possible to hypothesise that Davidson may have been the driving force behind the comprehensive publishing of patient data and Clark Wilson's appointment occurred at a time when she became less involved with the hospital. Alternatively, a general need for economy, particularly during a national economic crisis, might have suggested curtailing the reports. It may, of course, have simply been that whereas Lush had had a junior (Clark Wilson) to prepare the data, Clark Wilson himself may not have had that luxury or the time to prepare them himself for publication. The records do not provide an explanation.

example, equipped to carry out minor surgical procedures,[26] although Davidson wrote:

> We do not have many operations, as most of the Patients who require them had them performed before coming to us – but we sometimes have them for the relief of suffering, and it greatly assists having the proper appliances at hand.[27]

Lush also occasionally describes such procedures which were carried out at the hospital for symptom relief including tracheotomies and gastrostomies.[28]

The Report writers rarely mention treatment explicitly for pain relief and prefer general remarks, for example, '…from the advanced nature of the diseases most can only be eased and the suffering, as far as possible, alleviated.'[29] The administration of morphia is occasionally mentioned, however, and in one Medical Report Lush specifies the dose, writing that one patient needed eight grains of morphia per day in order to control his pain.[30] As early as 1906, it is made clear that medication and dosage were adjusted to ensure the individual patient's comfort, '…for many, indeed the great majority, a frequent change of medicine is called for to relieve the distressing symptoms as they arise.'[31]

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[26] In 1906, they were given an operation table and a surgeons' dressing table by the Chairman of the Council, Mr. John Langton SMHA/CM/I:201

[27] FSC/AR/SR/1907

[28] FSC/AR/MR/1905

[29] FSC/AR/SR/1907 Dr Herbert Snow had developed the 'Brompton Cocktail', a mixture variously of morphine, cocaine, cannabis, gin or brandy and chloroform for pain relief in the 1890s (Clark and Graham 2008:1018). There is, however, no indication of when the cocktail was first used in the Friedenheim/St. Columba's, though its use there was noted in Saunders' diary of 1954. Acquaintance with the works of early writers on care of the terminally ill, such as Munk (1887) or Worcester (1940) is, perhaps understandably, not mentioned in the Annual Reports or Executive Committee minutes.

[30] FSC/AR/MR/1913 This equals approximately 520mg. Without knowing how, or in what form the morphia was administered, it is impossible to make direct comparisons with current practice, however the British National Formulary for 2007, under the section Palliative Care suggests that, 'Although morphine in a dose of 5-20mg is usually adequate, there should be no hesitation in increasing it stepwise… up to 500mg or higher if necessary' (BNF, BMJ Publishing Group, London 2007:14).

[31] FSC/AR/MR/1907:22

A later indication of practice in pain relief, and apparently normal daily practice, can be gleaned from one of the reports issued by the official Visitor from the COS in 1936. N. Hugh Smith reported to the central office that he:

> ….was impressed by the way that one patient who had a sudden attack of pain and began to groan was given an injection at once as a matter of course, without any of the usual, "waiting to see if the pain went off".[32]

Otherwise, oxygen appears to have helped some cases. Lush felt the need to justify the expense of the treatment and wrote:

> Included in the Drugs' Account is one item that should be mentioned, and that is a sum of about £18 for Oxygen. Of this amount, over £15 was expended on two patients in the course of two or three weeks in the summer. These two patients lingered in a quite unexpected and very distressing way, and oxygen was the only thing that gave them relief, and we could not withhold it.[33]

These five lines provide an informative vignette as this sum is a significant amount. Nevertheless, they 'could not withhold it' – relief of the patient was paramount.

The strict rules which forbade alcohol[34] and formed part of the admission criteria might also be relaxed towards the end of a patient's life:

> …others again are disgusted because stimulants [i.e. alcohol] are not given under ordinary circumstances. It is only fair to add, however, that

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[32] LMA/A/FWA/C/D160/2 1898-1943 17.03.1911
[33] FSC/AR/MR/1914
[34] Alcohol use and abuse was thought to be a contributory factor in the development of tuberculosis (Bryder 1998:24, 25, 99, 128) which may, along with the general teetotalism within Scottish Protestant and non-conformist church practices, partially explain the 'dry' policy at the Friedenheim. Munk, however, advocates the use of various types of alcohol in symptom relief.

when the end is seen to be drawing near, and weakness and weariness prominent, alcohol in some form is never withheld if desired.[35]

Expenditure on dressings was another item which Lush felt it necessary to justify in several annual reports, using such phrases as, 'the nature of the cases we have to deal with demands a very free use of them. It is no uncommon thing to use a pound of cotton wool *inter alia*, upon one patient in a day,'[36] or that, some patients' lesions required, 'pounds of cotton wool or other more economical absorbent material in a day.'[37]

The literature reports that in the other early homes for the dying, the physicians had the sole responsibility for patients' medical care (Humphreys 1999:219) and there was a clear division of responsibilities between care for the soul and care for the body (Humphreys 1999:230). There is some slight ambiguity here however, particularly at St. Joseph's, where the physician's responsibility might have 'extended into the spiritual domain and that it was part of his task to recommend to the patients… the comfort provided by the Catholic faith. Humphreys also stated that:

> The regulation of morphine and alcohol by the staff of the Homes, together with their belief that pain should ultimately be accepted because it had a role to play in the patient's spiritual life, was underpinned by the belief that God would provide the necessary strength for enduring suffering (Humphreys 1999:229).

As at the Friedenheim/St. Columba's, opiates were used to relive pain although morphine use was closely monitored and controlled. Nuances in symptom relief and pain control can be discerned, however, within each home and over the period of time studied (Humphreys 1999:224-231). St. Luke's patients, for

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[35] FSC/AR/MR/1899
[36] FSC/AR/MR/1907
[37] FSC/AR/MR/1914

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example, participated in trial treatments for cancer and tuberculosis (Humphreys 1999:224-225) and the diverse specialists among the Visiting Physicians[38] who participated in patient care must have meant that patients benefited from the latest thinking and treatment of the day.

Dying of Cancer

The only surviving direct and detailed description of the ethos and content of care, particularly as regards pain relief, at the Friedenheim/St. Columba's was an article by Sprott published in *The Medical Press* in February, 1949.[39] In the introductory paragraphs, he lays out the basis for medical care at St. Columba's:

> At this stage, cure of the disease is out of the question and what is needed is medical nursing and spiritual care. From the patients' point of view, kindness, encouragement and bodily comfort are much more important than frequent medical examinations, scientific investigations and useless attempts or pretences to cure. A friendly, homely atmosphere, both of which prevail at St. Columba's, are all important (Sprott 1949:187).

His findings are, he says based on clinical and empirical observation, rather than being 'strictly scientific' (Sprott 1949:188) and goes on to provide a comprehensive picture of the palliative treatment offered at St. Columba's which is still in many ways current over sixty years later.[40] The paper is divided

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[38] These interests included arteriosclerosis, bronchitis, dropsy and rheumatoid arthritis as well as phthisis and cancer (Humphreys 1999:226). One physician of particular interest is Sir Alfred Pierce Gould, a cancer specialist, who was a Consultant Surgeon at both the Friedenheim/St. Columba's and St. Luke's. Unlike the records from St. Luke's, however, he is rarely mentioned in either the Minutes or Annual Reports of the Friedenheim/St. Columba's. Humphreys discusses Gould's work and opinions on pp227-228 of her 1999 thesis.

[39] A facsimile copy of the full text of this article is to be found in Appendix C. See also above.

[40] I am indebted to Dr Gareth Evans, Senior Partner, Stockbridge Surgery, Hampshire and his partners, as well as Dr Christine Wood, Lead Clinician and Head of Service, Salisbury Palliative Care Services, Wiltshire for their comments on Sprott's paper.

under four headings: treatment of the body, relief of pain, treatment of the mind and administrative points.

'Treatment of the body', contains many suggestions for patient comfort similar to those of Worcester (Worcester 1940:33-43),[41] and then describes the posology and administration of opiates and other drugs for symptom relief.

Sprott recommends that:

> Drugs should be freely given, the amount and frequency depending on the patients' symptoms and often on their wishes rather than on any preconceived idea of what should be necessary. Only the patient knows the extent of her [sic] suffering (Sprott 1949:189).

Sprott lays equal importance on the psychological management of the dying patient and encourages complete confidence between patient, doctor and nursing staff. He suggests that patients should not be kept isolated:

> They become familiar with the approach of death, which when it comes quietly to a suffering mortal behind the curtains in a neighbouring bed seems not so terrible as a few weeks previously they would have expected… It is much easier to face misfortune and death when you are one of a community of people similarly afflicted (Sprott 1949:190).[42]

The different personality of each patient is stressed and, arising from that, the necessity to approach him or her as an individual.

In spite of being a 'home for the dying', Sprott calls the social life of the wards busy, and describes daily life in the wards where there are, 'generously lax'

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[41]Unfortunately Sprott did not mention any writers, such as Munk (1887), Snow (1890) or Worcester (1940) who might have informed his practice.

[42] See Walter 1994:124 *passim* for more recent support of this view and Saunders 1959b:18.

visiting hours, religious services, entertainments, books and earphones as well as sewing and knitting for those who are able to do so (Sprott 1949:191).

On the administrative side, he recommends a homely rather than an institutional atmosphere which, in his opinion, can best be achieved by limiting patient numbers to around fifty, situated in a number of convenient hospitals scattered throughout the community.[43] Wards should, he feels, be 'medium sized' (Sprott 1949:191) with a few small wards of one, two or three beds for special cases and, though gardens are desirable, the hospital should not be 'buried in the country' but near activity and offer easy lines of communication for relatives and friends.

As has been previously noted, Sprott's paper is remarkable in that it bridges the clinical gap between writers such as Worcester with his, to modern eyes simple, though sound, practical advice on patient care and the sophisticated pharmaceutical and psychological symptom relief available today. Sprott's recommendations for symptom relief are wide ranging, though surgically minimally invasive, and suggest the importance these interventions must have assumed during a resident's day. It is notable that by the time of his paper, in which he acknowledges that to many, a religious atmosphere is important, medical expertise at the death bed has clearly taken over from spiritual.[44]

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[43] Compare this statement with the suggestion made in Anon 1887 that, 'others might undertake something of the kind in their own neighbourhoods' (Anon 1887:65), Burdett's '…it would be a great thing to have a home of peace for the dying in every poor district of every large town' (Burdett 1894:lxx) and Charles' 'Two similar homes have been lately begun, suggested by it [the Friedenheim]; one in Holland and another in London'. (Rundle Charles 1893:179-180).

[44] Sprott 1949:295. He is also, of course, writing in a medical publication, but this accords with Mrs Rudall's memory that Sprott had no particular religious views (Conversation with Freda Rudall 24.05.2007)

Care under the NHS

Some limited clinical information has survived from the final years of the hospital in Hampstead Heath (see p 114). The anonymous author documented the use of the Brompton[45], Diconal[46] and Sparine[47], although s/he documented:

> one strange practice [which] was that of not keeping patients on their transfer drugs. Even digoxin[48] and diuretics were stopped on admission. Dr. Kay's view was that patients were grossly overmedicated and they invariably do well with nothing.[49]

Antibiotics were used only for symptoms. There was 'No physiotherapy, no occupational therapy, no medical social worker, no volunteers, no home care.'[50] The implication here is that, in the visitor's eyes, practice at St. Columba's had become idiosyncratic and somewhat dated.

8.4 Nursing staff

Following pioneering work at St. John's House (1848), King's College Hospital (1856) and the Nightingale Training School (1860) (Abel-Smith 1979:19, Moore 1988:3-5), the years in the latter half of the nineteenth century can be characterised by the struggles of 'Lady Nurses' to create and define the nursing profession. Perceived as work uniquely appropriate to women, a certain success had been achieved by the end of the century, and nurses were regulating training, creating professional associations and endeavouring to assert their

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[45] The Brompton cocktail, see footnote 8 p 184
[46] Opioid used for moderate to severe pain relief
[47] Low potency anti-psychotic drug
[48] Used to treat congestive heart failure and associated shortness of breath
[49] SChH/SCH (undated:2)
[50] SChH/SCH (undated:2)

authority, not only on the management of their own staff, but also on those aspects of hospital work to which they contributed (Moore 1988:11-39).

One way to create exclusivity, control practice and assert the unique nature of any professional work is through the creation of boundaries to admission, such as certification, to be achieved through recognised training (Locker 2000:122-139). Contemporary accounts testify to the importance of training schools to these women in their nascent profession, and detail admission requirements, curricula and the importance of final examinations. Literacy, for example, had to be proved before admission to a nursing school, and probationary nurses received theoretical and practical instruction in basic hygiene, anatomy, physiology, dressings and dietetics before qualifying (Baly 1977, 1982, 1986, Burdett c.1914, Davies 1982, Glasgow Royal Infirmary 1893, Maggs 1982, 1983, Seymer 1960, White 1982).

In spite of Nightingale's dictum that to scour is a waste of power (Nightingale 1969:22), general nursing duties, particularly those of junior staff, also included domestic tasks such as tidying, dusting and cleaning around the beds and lockers (Maggs 1983:93, Seymer 1960:73).[51] Such importance was given to dietetics as part of patient care management, that nurses were also expected to master the preparation of special dishes which would be suitable and appealing to their patients.[52]

Responsible for the physical comfort of their patients, the tasks of nursing staff included making and changing bed linen, assistance with personal hygiene, changing of dressings, provision of ice bags, application of poultices, prevention

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[51]Responsibility for these domestic tasks is confirmed by a survey carried out by Burdett in 1913. Describing nursing duties in Guy's hospital, he reported that Probationers daily '…clean lamps, inkstands, spatulas, etc., thoroughly; dust the ward, wash lockers and doctors' tables; wash windowsills' in addition to their contacts with the patients (cited in Maggs 1983:93).
[52]Every week, *The Nursing Record,* for example, included a selection of recipes suitable for invalids. Maggs reports that although much nursing training was medically informed and geared towards caring for the patient, '…parts of the syllabus owed more to contemporary domestic science than medicine', a proposition confirmed by the '…ease with which some nurses apparently became teachers of domestic science subjects' (Maggs 1983:99).

of bedsores and, in some establishments, massage which pre-dated the work of physiotherapists.

A key role of a nurse, however, was that of observer and intermediary between doctor and patient. Nurses were expected, while carrying out their tasks, to observe and report on such things as 'colour of skin, condition of nails, mouth, breath etc.' (Maggs 1983:106) and gradually took over some of the tasks previously undertaken by doctors, such as taking temperatures and administering medication (Maggs 1983:106).

In spite of frequent visits by the Medical Officers, the nursing staff were inevitably responsible for the majority of personal contact and physical care of the patients. Although, therefore, the minutiae of the nursing care offered at the Friedenheim no longer exist, their professional training suggests the details of daily ward life in the institution, when nursing staff would be busily engaged in the domestic, clinical and personal care of the patients in their charge. In the early years of the Friedenheim, however, any supplementary information or training specifically concerned with nursing dying patients was limited.

Nightingale's *Notes on Nursing* published in 1859 contained many useful suggestions for the care of dying patients. It must be remembered that, as with the doctors, many, if not most of the nurses' charges would have been dying, since the means to cure them surgically or through drug therapy did not exist (Porter 2003, 2006, Shorter 1986). It is therefore not surprising that *Notes on Nursing* contains much advice on nursing seriously ill patients who were not expected to recover as well as advice specifically aimed at nursing those close to death.[53] Nightingale's work includes recommendations on position, nutrition, the patient's mental state and the death bed itself, concluding that the nurse may be the only person in the position to recognise impending death.

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[53] See, for example, Nightingale (1969 edition) pp: 17, 45, 49, 58, 60, 62, 63, 72, 84, 92, 96, 98, 99, 101, 103, 105, 117, 119, 121, 123, 126, 129, 133

In addition, Munk's work contributes to the picture, not only of the tasks of the professional nursing staff, but also of the way dying was experienced within the institutions. Following his and Nightingale's dicta, the wards would have been well-lit, well-aired, warm and cheerful. Nurses would have been encouraged to speak in normal tones, neither too loud, not too hushed and might have busied themselves with cooking special dishes which would have appealed to a patient or were particularly digestible and appropriate for his/her condition. In particular, Munk's descriptions of symptom alleviation, implies the realities of death from the various conditions, particularly tuberculosis, which the staff at the Friedenheim would have encountered: dryness of mouth, pain, excessive oral secretions, coughing, dyspnoea, agitation, haemorrhage and exhaustion.

By the later nineteenth century, however, perhaps symptomatic of increasing medical awareness, competence, or complexity, some works were published specifically on nursing the dying. Amongst these, Mrs Dacre-Craven, writing in 1889, included a section on 'The best positions for the dying according to the ailment' (Dacre-Craven 1889:100-107) in her manual on district and home nursing, while the works of 'A hospital nurse' (1890), [54] Oswald Browne (1894) and Weeks-Shaw (1896) were specifically aimed at nursing the dying and laying out the dead. These works draw heavily on Nightingale, each other and particularly on Munk's monograph, offering little original insight into the specifics of caring for the dying, except for the procedures which follow a death, laying out the body and comportment towards relatives. Concentrating on positions to relieve symptoms, appropriate nutrition and demeanour in the sick

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[54] This work must have been published at or around the time the term 'euthanasia' started to acquire its modern meaning of causing or actively enabling death rather than its original meaning of good death. 'The word Euthanasia has almost become, owing to the works of fiction written on the subject, synonymous in the public mind with 'putting people quietly out of the way when from one reason or the other their demise seemed desirable to themselves or their friends. The word really means 'a good death' and it is the medical treatment in aid of the Euthanasia that is so helpfully considered in Dr Munk's book' (Hospital Nurse, A 1890:17). See also Stolberg (2007) for an account of the early practice of euthanasia (as it is understood today) among nursing handy women in pre-modern society. Unfortunately there is nothing in the Friedenheim/St. Columbia papers which can contribute to current debate on euthanasia.

room, much that was written was a reflection of good nursing practice, palliating discomfort both in those dying and those expected to recover. They were, however, written for nursing staff and perhaps because of that, recognised the importance of these women's role at the deathbed. Their existence is also the first sign that nursing those dying might require a particular approach and concern for the mental attitude of patient, family and attendant.

The evolution of nursing practice during the life of the Friedenheim/St. Columba's can be characterised less by changes in practice,[55] but rather by increasing responsibility, when observations and procedures, previously the task of medical men, were transferred to nursing staff as their competence and professionalism were recognised.

Nursing at the Friedenheim/St. Columba's

Davidson's choice of title, 'Lady Superintendent', was one which had been used by the first nursing sisterhood, St. John's House, in the mid-1800s for the woman in charge of 'domestic arrangements and the appointments of the nurses' (Moore 1988:4). The exact nature of Davidson's relationship to the nursing staff remains, however, obscure. The title of Superintendent was assumed by Macneill following Davidson's retirement in 1916, but was abandoned around 1929, when Alice Hilda Anthony was appointed Matron.[56]

Some idea of what was involved in Davidson's personal concept of appropriate conditions for the dying and her grasp of practicalities can be gleaned from the memorandum, partially cited above, sent to the Council in 1918 (see Appendix B). This demonstrates concern not only for the physical and psychological well-

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[55] An exception should be made here about domestic work and cooking which eventually were no longer the responsibility of the nurse, although supervision and advice on cleanliness, personal hygiene and nutrition remained one of her/his tasks.

[56] FSC/AR/SR/1930 Anthony trained at Derbyshire Royal Infirmary, obtaining her certification in 1909. The post of Superintendent was abandoned.

being of the patients, but also the practicalities of nursing.[57] The arrangements of the beds suggested by the Council would, for example, have meant that patients could no longer talk to each other comfortably or see out of the windows. At the same time, nurses would not have access to all sides of the beds to deliver care. Davidson was also very concerned about dealing with toilet arrangements and offensive odours under the new plan. She deplored the fact that, under the proposed new arrangements, cancer patients, who often had 'disagreeable' symptoms, would be placed next to the nurses' kitchen, and access to the lavatories (there do not seem to have been separate sluices) would involve passing other patients and be in full view of the main staircase.

The last Matron in Avenue Road, Olive Howlett[58], retired from St. Columba's c.1957. She had been appointed in 1941 after working in the hospital for eight years previously as Sister[59] and, after St. Columba's was absorbed into the NHS, sat on the Nursing Sub-Committee of the No.21 Paddington Group Hospital Management Committee which administered it.[60] Howlett was one of the key staff at St. Columba's who was to know and correspond with Cicely Saunders in the 1950s, a role which will be discussed in Chapter 10.

The Annual Reports occasionally give an idea of the number of nursing staff employed.[61] In the report dated 1894, following the first full year in the new premises, Lush lists a Sister, four Charge Nurses, three Assistant Nurses and five

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[57] The full text of this memorandum is included in Appendix B and serves as an example of Davidson's continuing desire, although in her 78th year, to control conditions at St. Columba's as well as a demonstration of her knowledge of the practical essentials of nursing the dying.

[58] Howlett trained at the Uxbridge Union Hospital, Hillingdon and received her certification 1920-1923.

[59] FSC/AR/CR/1941

[60] See Wildman and Hewison 2009:1655, however, for discussion of the marginalisation of the matrons in the new administrative structures of the NHS, particularly those from the smaller hospitals, who had no access to the governing authority and whose sphere of authority was gradually eroded.

[61] A few names of the Friedenheim's nursing sisters have survived: a Miss Begg (trained at the Friedenheim and the Middlesex hospitals), Margaret M. Meldrum and Dora Borland (trained at The London Hospital), Frances E. Burch (trained at the Middlesex) and Mary Kimmond (trained at the Royal Infirmary, Dundee). *The Nursing Record* 1909-1919

Probationers on the staff, as well as the dispenser, Sister Jessie,[62] in charge of possibly forty patients at any one time.[63] Staff numbers are not recorded throughout the life of the hospital, but the figures, including those from the 1901 census, suggest there was usually one nurse to every four patients.[64]

A shortage of nurses in the early 1920s led to a closure of some beds,[65] partially remedied by publishing an article in the *Nursing Mirror and Midwives' Journal* of 3rd December, 1921 promoting the work of the hospital and designed to encourage recruitment. This article described the work of the hospital and detailed pay, conditions and living arrangements for the nursing staff.

Referring in particular to the Matrons in St. Luke's House but also other lay staff, a high turnover of nurses was reported at the other early homes (Humphreys 1999:238). It is interesting therefore to note that in contrast, many nurses at the Friedenheim/St, Columba's were, like the physicians, in post for many years. Sister Ethel Cox, for example, retired in 1935 after thirty years at the Friedenheim/St. Columba's, meriting a eulogy in the Annual Report[66] and Howlett was on the staff for some twenty-five years.[67] The Kings' Fund Visitors' Report of 1952 also comments on the nursing (and domestic) staff 'who seem to stay for a long time'.[68] Whether this loyalty was for personal, spiritual or professional reasons can only be guessed.

The Superintendents, Council and Medical Officers all appeared aware of the physical and emotional difficulties of the nurses' work, including the 'heavier'

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[62] Her name implies that Sister Jessie was a dispensing nurse, rather than a religious. Deaconesses are usually styled Miss or Mrs followed by their last name. If called 'Sister', this, too, is followed by their last name.

[63] FSC/AR/MR/1894

[64] This falls short of what is now considered the 'ideal' staff:patient ratio (International Association of Hospice and Palliative Care: http://www.hospicecare.com/gs/page4.htm , accessed 20.06.2008), but disease profiles and nursing needs were very different from those expected in a modern hospice.

[65] FSC/AR/CR/1922

[66] FSC/AR/MR/1936

[67] See also the report of the King's Fund Visitors in 1952, cited in Chapter 10:243.

[68] A/KE/735/41/1:61:5

duties involved in nursing cancer patients. [69] The nurses were thanked and praised, some by name, in nearly all the annual reports. Clark Wilson, for example, wrote that, 'the nursing staff have a much harder task than in most hospitals, and their devoted work deserves our utmost admiration'.[70] This appreciation of the nurses' work seems to have led to generous conditions of employment. In a 1911 letter to the King's Fund, whose Visitor had apparently commented on the high salaries paid to staff, the Hospital Secretary, Morton, was charged to defend expenditure on salaries and food in view of the difficult nature of the work:

> …the Council see to it that the patients and staff are well fed, and the staff must be well paid in view of the extremely trying character of the work they have to do.[71]

There were approximately two deaths every week between 1892 and the 1930s, therefore when some chronic cases were admitted to the hospital in 1934,[72] it was felt that there was a beneficial side effect for the nursing staff:

> The number of chronic cases… [has] proved a welcome change…, the psychological effect of a few less seriously ill being beneficial to the others, besides making the task of the nurses – a very severe one in a Hospital like this – considerably easier.[73]

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[69] FSC/AR/MR/1920 Unfortunately the Medical Officers do not define 'heavier'.

[70] FSC/AR/MR/1939

[71] LMA/A/KE/257/1/3 Figures are not consistently available for comparison, but Council Minutes record that in 1904 Sister Margaret's salary was to be raised to £85 p.a. and increased by £5 p.a. thereafter until reaching £100 (SMHA/CMB/I:134).

[72] These were chronic, paying cases, introduced by Midwinter as part of his efforts to create a financially viable institution (see Chapter 6). Clark Wilson may well be supporting this move by providing additional justification to donors for this departure from the Hospital's original mission, although Lush had made similar remarks about the patients who inadvertently proved chronic in 1904 (see p 165). This does not, however, appear to have prompted any thoughts about the advisability or not of having an institution exclusively devoted to dying patients.

[73] FSC/AR/MR/1937

The situation regarding any emotional support for the nursing staff is not clear.[74] Butler's suggestion that the '…solicitude of Miss Davidson for the well-being of her nurses reminded of that of a mother for her elder daughters'[75] was echoed in Davidson's *In Memoriam* which also suggests that she acted almost as a parental presence for the nurses. Her:

> …"upper room," bright with flowers and sunshine or firelight, could tell of many confidences, of joys revealed, and burden lightened, as friends came for a talk, or nurses looked in to say "Goodnight" to the motherly woman in the big armchair, with her welcoming smile and understanding heart'.[76]

No other mention is made in the published material of any formal or informal emotional care for the staff, although Baker described a supportive community which carried the staff through the difficulties of caring for so many terminally ill patients.[77]

The Nurses' Home

One of Davidson's first actions on arrival in Hampstead was to generate funds to build a Nurses' Home, separate from the main building. In 1899, Lush had written:

> I should like to repeat that the sleeping accommodation for our nurses is not adequate; and considering the class of cases [i.e. dying] which fill the wards in the Home, and also the necessarily somewhat depressing character of the Nurses' work, it is highly desirable that the proposed

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[74] Although, see below for a description of the nurses' home, deliberately separate from the main hospital building.

[75] Butler/UoL/St.C/F/RR/undated, c.1903:30

[76] FSC/AR/1921:17

[77] Conversation with Doris Baker 06.11.2007

Block – outside the present building altogether – should be proceeded with as soon as possible.[78]

The new home was eventually opened in 1903 and conditions there were described as 'admirable' by Lush.[79] A floor plan of the building shows at least thirteen bedrooms intended for the nurses, a pantry, sitting room, two (later four) bathrooms and a lift between floors.[80]

Facilities were refurbished with, for example, new chairs, a new carpet and bookcases in 1905.[81] The provision of good living quarters for the nurses continued when the hospital came under NHS management. A photograph exists, probably dating from the 1960s, of the nurses' common room in the final location of the hospital on Spaniard's Row. It shows a spacious room with modern furniture and television.[82]

Training

The Friedenheim intended to play its part in the London, if not national, medical world and for some years included a training school for nurse probationers.[83] Lush maintained:

The training which the nurses receive [here] is in future to place them in as good a position as those who are trained in any other hospital: a

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[78] FSC/AR/MR/1899

[79] FSC/AR/MR/1906 Again, the direct testimony of the nurses themselves would have been interesting.

[80] Undated document c. 1902 in Scrapbook in author's possession

[81] FSC/AR/SR/1906

[82] SMH/CF/24

[83] Humphreys reports that, in the early part of the twentieth century, lectures were given to the nursing staff at St. Luke's House. She concludes that this 'suggest[s] that at St. Luke's there was the beginning of a recognition of the need for a more specialist training for nurses working with dying patients' (Humphreys 1999:235). There is no suggestion that this is the case with the nurses' training at St. Columba's where they were rather given a generalist nursing training to prepare them for work in any medical establishment. This would support the view that nursing the dying was an integral, possibly major, part of the nursing experience at the time.

scheme being in course of arrangement by which one year out of the necessary three year's course is to be spent at a general hospital, the other two years being spent in the Friedenheim. This will enable them, after passing the necessary examinations, to register themselves as qualified nurses under the regulations of the British Nurses' Association. To this end I am giving a course of weekly lectures, in addition to which they are receiving systematic instruction from Sister Jessie [the Dispenser]. We intend our nurses to take as good a place in the nursing world as those of any hospital.[84]

The following year, Lush was able to report that, 'all five passed very creditably, to the complete satisfaction of the Examiners, and they have received their certificates accordingly.[85]

The training school continued for some years. In 1899, a Sister Caroline is named as the new nurses' instructor[86] and training continued, supplemented by weekly lectures given by Lush.[87] Medical and surgical books to the value of £8 were bought in 1910 to start a Nurses' library,[88] and in the same year, Lush made arrangements with '…a General Hospital to take our Nurses for a portion of the three years required for a full Certificate. In this way we hope to "turn out" as well-trained and efficient Nurses as any Association may desire'.[89] The nurses had a 'good opportunity' to practise nursing acute disease when two patients in the children's ward contracted typhoid in 1911.[90] By 1913, however, fewer probationers were applying to the Friedenheim and the experiment was dropped during WWI.

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[84] FSC/AR/MR/1895 Unfortunately no details have survived of the nurses' training, particularly the extent to which it prepared the nurses for the specific challenges to be faced in nursing the dying.
[85] FSC/AR/MR/1896
[86] FSC/AR/MR/1899:15
[87] FSC/AR/MR/1904
[88] FSC/AR/SR/1911
[89] FSC/AR/MR/1910
[90] FSCAR/MR/1912

As a body, it is clear from the Medical Reports that the nurses played a valued, recognised and important role in patient care. The hospital had links to the London teaching hospitals through its London-trained nursing staff and those who worked in them during their 'away' years (see above), which implies a certain degree of professionalism and competence. This continued to be acknowledged up to Sprott's time:

> A doctor who merely visits a hospital, however frequently, cannot have the same understanding of the individual patient's reactions to different drugs as the nurses who carry out the treatment and are with the patients day and night (Sprott 1955:1621).

8.5 Household staff

Lush described the Home as an 'organism', not a machine, in which Matron, Sisters and Nurses all played their part,[91] and Davidson's Report of 1912 demonstrated her appreciation of the fact that no one profession was responsible for the well-being of the patients, 'These few [sic] selection [of letters of appreciation] will suffice to shew how the ministrations of Chaplain, Doctors and Nurses are appreciated'.[92] However, there are also several references in the Minute Books and Annual Reports to the contribution made by the household staff, directly or indirectly, to the well-being of the patients. Perhaps unusually, this was also recognised publicly, in print. In the Annual Report dated 1905, for example, Davidson specifically gave, '…words of praise and thanks to the servants and Ward Maids, without whose hearty cooperation and help things could never move so smoothly as they do.'[93]

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[91] FSC/AR/MR/1914
[92] FSC/AR/SR/1912
[93] FSC/AR/SR/1905

In 1915 she reported that in addition to the work of the Sisters and Nurses:

> The household department has also been satisfactory: many of those in the service of the Institution have been with us for years, and the wellbeing of the Hospital is very near their hearts: and when all are working in sympathy the burden becomes lightened.[94]

Published appreciation of the household staff and the contribution they made to patients' comfort continued over ten years after Davidsons' death, but virtually ceased by the 1930s, while the work of volunteers is mentioned more frequently.[95]

Doris Baker, although employed as a Ward Maid, nevertheless participated both indirectly and sometimes directly in the care of the patients. It is perhaps also significant that she mentioned that nursing staff, even the Sister, would cheerfully do the washing up, normally Baker's job, if she herself were too busy.[96] While the boundaries between domestic, nursing and medical personnel probably remained, nevertheless the work of all, including the domestic staff, was appreciated for the contribution it made to the care of the patients and was also publicly recognised in print.

8.6 Dissemination of ideas

Davidson's original hope was that the Friedenheim should provide a template for similar homes to be established within local communities (Anon 1887, Burdett 1894:lxx). Rundle Charles[97] mentioned two Homes in England and Holland, which, she implied, were started in emulation of the Friedenheim, but

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[94] FSC/AR/SR/1915
[95] See, for example, the Annual Reports from 1938, 1939, 1940, 1944 and 1946
[96] Conversation with Doris Baker 06.11.2007
[97] Rundle Charles 1893:179-180

she gave no names and this research has failed to identify them. Some success is also implied in the Annual Report of 1901, where Davidson wrote, 'Another feature of the work to be specially noted is that similar Homes are springing up in other places, both in the metropolis and provincial towns.'[98] Davidson's tombstone also records her as 'Foundress in 1885 of the first Home of Peace for the dying, now called St. Columba's Hospital, London', implying some connection between the Friedenheim and other homes for the dying. The recognition of the need for further such homes continued to Sprott's day when he terminated his paper with the recommendation for 'a number of scattered hospitals at convenient points' (Sprott 1949:191).

Some awareness of the Friedenheim's work reached an international audience and a report on the work of the hospital, written by Elisabeth Rundle Charles, was included in the series of congress papers on the philanthropic work of women, which was edited by the Baroness Burdett-Coutts for the Royal British Commission for the Chicago Exhibition of 1893.[99] It is also interesting to note that Davidson was asked to provide nurses for mission stations in China, Japan, Palestine, and India, presumably in recognition of their particular strengths.[100]

Little direct attempt appears to have been made to promote the medical and social insights into terminal care gained at the institution to a more general public, however, whether lay, political or professional. Both Clark Wilson and

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[98] FSC/AR/1901:8. Although not called a Friedenheim, Lockhart reports that at the opening of a home for dying women opened in 1912, the Bishop of Birmingham said 'that his experience of the Friedenheim in London had taught him how such a home "filled the void which could be filled no other way"' (Lockhart 2008:25).

[99] This series also included a report on the philanthropic work of women in Ireland which specifically mentions the work of the Sisters of Charity and their hospice for the dying at Harold's Cross (Burdett-Coutts 1893:246-247).

[100] Butler/UoL/St.C/F/RR/undated, c.1903:15. At the start of the nineteenth century, missionary societies engaged physicians only to treat their own representatives abroad. By the time the Friedenheim opened, however, their attitude towards the work of medical missionaries had changed due to the professionalization of medicine, a change in the perception of the strategic advantages of medicine to the missionary cause, heightened philanthropic concerns and an increased readiness to use lay help in church work (Williams 1982:283). The greater numbers of physicians subsequently employed among the body of missionaries working abroad, may have increased the demand for professional nursing staff to accompany them.

Sprott felt that some of their experiences could be used to further insight into either the disease process or the dying trajectory,[101] but only Sprott wrote in the medical press offering suggestions and recommendations. He shows no evidence, here or later however, of the adjustment in thinking which might presage the emergence of a new, distinct medical discipline separating palliative from curative medicine.

Details of the medical presence and attitudes at the Friedenheim/St. Columba's reveal many differences with the other homes for the dying and therefore amplify our knowledge of institutional death in London in the Victorian and Edwardian eras. In particular, they call into question the general finding that 'spiritual care was… considered the most important form of care the dying could receive' (Humphreys 1999:208) or that 'pain and suffering were accepted within the homes for the dying' (Humphreys 1999:207). The Medical Officers at the Friedenheim, worked within a secular, though avowedly Christian, organisation, and indeed wielded considerable power within it. They sat, *ex officio*, on the Executive Council, which was also chaired by a medical man, and did not have the direct supervision of an authoritative religious presence which might have challenged them. Apart from several visiting Chaplains of different denominations (see below), they were indeed the only men in authority at the home. Although hope and faith contributed an important part of care for the dying (Munk 1887:23-25), nevertheless the supremacy of the medical men at the Friedenheim suggests the importance, even primacy, of the physical symptom relief there which is so frequently described in their Annual Reports.[102] Much of the comfort the doctors and nurses brought their patients must also have been on a psychological level and derived from their evident

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[101] FSC/AR/MR/1931 and FSC/AR/MR/1943 No record of any attempt by Clark Wilson to promote insight into the treatment or care of the terminally ill has been discovered. Clark Wilson's son, also Dr John Clark Wilson, confirmed in a private communication to the author that he was unaware of any relevant publications by his father.

[102] St Luke's House was, of course, founded by a medical man, Dr Barrett, whose authority must have been even greater than that of the Friedenheim's Medical Officers. The literature implies that St. Luke's gradually lost its primarily spiritual perspective and became more medical in focus (Humphreys 1999:313).

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close interest in the patient and his/her care and, in particular, the reassurance brought by the daily, or twice daily, doctor's visits.

The parts played by spirituality, religion and faith in patient care, together with the way that the social needs of the patients were addressed are described in the following chapter.

CHAPTER 9 –SPIRITUALITY, FAITH AND THE MANAGEMENT OF SOCIAL ISSUES

Prochaska cautions that nowadays, the importance of religion and religious influence on the Victorians, as well as their attitudes towards the state may be difficult to appreciate, since in our more secular age 'rights take precedence over duties' and people look to government rather that charities for support (Prochaska 2008:2). He has explored the crucial importance of religion, and specifically Christianity, as the motivating force behind virtually all forms of philanthropic effort in Britain during the nineteenth and early twentieth century (Prochaska 1988, 2008:1-29). It was, he found, the duty of Christians to promote those feelings of individual responsibility which would lead to the creation of a stable and law-abiding society, the redemption of the individual, and, through these actions, give hope for the philanthropist's own salvation in the afterlife. Essential services and moral training should be provided by religious associations, as 'religion and the public good were inextricably linked' (Prochaska 2008:3) and the state was merely an 'artificial contrivance, useful in punishing sinners, but incapable of redemptive action' (Prochaska 2008:6).

These findings must, however, be considered in conjunction with the, perhaps, paradoxical growth of atheism during the same period. Andrew Wilson, for example, has pointed out that during the Victorian and Edwardian periods in

England, 'atheism had become the religion of the suburbs'[1] and 'unbelief was ripe among the masses' (Wilson 2006:80). Although, therefore, Christian beliefs and values retained a dominant influence, the Christian worldview was no longer necessarily normative (see also Gilbert 1980:36).

Wilson argues that the new scientific thinking, exemplified by the work of Charles Darwin contributed to this rise in atheism as, paradoxically, did the work of North German biblical scholarship which challenged the authority of the Bible as an infallible text. Contemporary theologians were concerned to adjust their thinking in order to find an ultimate meaning in the Bible which would accommodate apparently contradictory scientific and medical findings (Wilson 2006:80).

Recognition of this duality of faith and secularism in society at that time, enhances understanding both of the foundation of the proto-hospices and the motivation of those who worked there, in particular the physicians, since Victorian medical writers, including Benjamin Brody (1854), J. Matthews Duncan (1886) and Munk (1887) united in recognising that faith might play an important role in alleviating distress during the dying process. The various Homes' medical staff therefore practised within a potentially tense and evolving complex of personal faith, medical progress and, in some places, the religious aims of the institution.

Current writing emphasises the distinction which must be made between spirituality and organised religion. Spirituality, according to Speck, is 'a search for existential meaning within a life experience, with reference to a power other than the self, which may not necessarily be called "God"' (Speck 1998:22). One, but not the only, way of finding this existential meaning may be through organised religion, which is a 'particular system of faith and worship expressive of an underlying spirituality and interpretive of the named religion's

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[1] Chesterton, G K (1905) 'Heretics' Bodley Head, London, cited in Wilson (2006:80)

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understanding of God' (Speck 1998:22). Although, therefore, spirituality is a requirement of religion, it can also be sought and experienced outside a formal religious environment. A search for existential meaning often assumes importance when a person is told, or becomes aware of his/her impending death,[2] and 'dying people often have a very heightened spiritual awareness. Some people have it when they have never experienced anything like it before in their lives…' (Neuberger 2004:81).

Although the Friedenheim had no formal ties to, or the support of, a specific religious organization, it was, nevertheless, an avowedly Christian institution. Evidence of concern for the spiritual and religious welfare of patients, including spiritual preparation for death, is to be found throughout much that was written about the hospital and by its officers. The importance of faith to the founders and those who ran the early homes for the dying, allowed and encouraged spiritual awareness, development and experience among their patients in a way, possibly inconceivable in today's more secular and physician-centred environment. A crucial difference can be seen, however, between the formal, religious backgrounds to care, particularly in the Hostel of God and St. Joseph's, and the necessarily more general spiritual reminders at the Friedenheim, and later St. Columba's. There, religious components of care were at the lowest basic level which could accommodate the different denominational persuasions of staff and patients.[3]

Humphreys suggests that much of the reasoning behind the religious fervour of the Victorian homes for the dying lay in their desire to counteract the growing secularity of the age (Humphreys 1999:36). She took the importance of religion

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[2] Cf. Savory '… the time of greatest mental distress is perhaps when the conviction first dawns on us that we are about to die' (Savory 1863:173).
[3] This was not necessarily a good thing. The comfort a devout Catholic might have felt at St. Joseph's, for example, would probably have been greater there, surrounded by the emblems of Roman Catholic faith and nursed by Nuns, than that same person would have felt in the Friedenheim, where religious observance was more diffused.

in the three homes she studied[4] as the focal point of her research and interpreted medical, spiritual and, to a lesser extent, social care through this lens. Winslow and Clark (2005, 2006) concur in the importance of religion and the spiritual approach to care of the patients at St. Joseph's Hospice, particularly in the early days, while Goldin (1981), although mainly writing about St. Luke's House at the beginning of the twentieth century, also describes the religious underpinnings of patients' care both in hospitals and what would later be called hospices. Given the importance of religion in philanthropic work, medicine and particularly at the end of life, the differences between the four proto-hospices[5] in this respect enhance evaluations of their work. The findings at the Friedenheim, discussed below, challenge, however, the importance of organised, institutional religious participation which was found in the other proto-hospices and therefore extend the work of Humphreys (1999, 2001), Goldin (1981) and Winslow and Clark (2005, 2006) by showing another type of spiritual involvement, originating in the personal devotion of the founder and expressed through the different faiths and philosophies of the people providing care.

Munk's thinking provides a further rationale, if one were needed, to the importance of faith in the early homes for the dying. Before embarking on any clinical recommendations, he stresses the importance of faith, irrespective of denomination, in the promotion of a calm and easy death (Munk 1887:22-23). Linked with hope in the hereafter, provision of spiritual consolation is, he suggests, and essential and imperative part of caring for those close to death. It is an integral part of care at least equal to, if not superior to the administration of medication for symptom relief and the provision of skilled nursing care.

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[4] See Chapter 2. The Hostel of God was run by two Anglican sisterhoods, St. Luke's House was a Methodist-led organisation and St. Joseph's Hospice was a Roman Catholic institution (Humphreys 2001:149).
[5] That is, the three homes researched by Humphreys and the Friedenheim, studied here. A fifth home, the Anglican Home of the Compassion of Jesus remains an early institution for the dying which has yet to be researched.

This chapter will therefore explore spiritual care in the Friedenheim and then extend consideration of non-physical care to reflect on support given to patients' families. As evidence of the Home's atmosphere, particular attention will be paid to the festivities around Christmas, which were celebrated not only as a religious festival but also made an occasion for parties and merry-making. The chapter concludes with an attempt to understand the atmosphere which prevailed on the Friedenheim's wards, which, though intangible, contributed to the overall well-being of those who died there.

9.1 Spirituality, pain relief and staffing

As with many Victorian philanthropic works (see, for example, Checkland 1980:80-90, Harris 2004:61-62 ff., Orr Macdonald 2000:41-167, Prochaska 1980:95-222), religion and faith[6] were integral to the creation, support and administration of the early homes for the dying, permeating the care of patients before death. Subordinate institutions to religious headquarters elsewhere,[7] the literature indicates that the primary rationale behind the founding of the other proto-hospices was devotional, since they were 'set up with the primary objective of caring for patients' souls' (Humphreys 1999:i). As part of their different Churches' response to the 'declining significance of spiritual issues,' they sought to extend the control of the church to the moment of death itself (Humphreys 1999:36-37). Personnel were 'motivated primarily by spiritual concerns and looked upon medical care, not as a less significant and separate sphere, but as a vehicle for achieving the former' (Humphreys 1999:205). They 'looked upon their spiritual obligations to the patients as their primary task' (Humphreys 1999:80).

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[6] For an extended exploration of the distinction between religion and spirituality and their importance at the death bed see, for example, Neuberger 2004 and Speck 1998, 2003, 2004.
[7] The link between St. Luke's House was firm, but slightly more tenuous than those between the Hostel of God and St. Joseph's Hospice and their mother organizations.

Exploration of denominational influence, its interpretation and evolution allowed comparisons and contrasts to be drawn between different themes within this care, such as pain relief, religious conversion, the place religion played in patient admission criteria and the interpretation and evolution of the concept of a 'good death' (Humphreys 1999:118-123).

Superficially, there appear to be many similarities between the Friedenheim and the homes described by Goldin, Humphreys, Winslow and Clark. There were morning and evening prayers, the walls were decorated with Biblical texts and, most strikingly, the vocabulary of those writing about the Home in the Annual Reports from the early years was replete with religious references.[8] A closer look at the details of actions, ethos and patient surroundings in the Friedenheim reveals a far less consistent picture of religiosity, however, when compared with the other early homes than these similarities imply.

The Friedenheim was not a religious foundation in the way that the Hostel of God and St. Joseph's were, nor did it have the direct link or support of a religious movement as did St. Luke's.[9] The High Anglican Hostel of God, although the idea originated with Mrs William Hoare, wife of the banker Colonel William Hoare, was managed first by the Sisters of St. James' Servants of the Poor and then by the Sisters of St. Margaret of East Grinstead (Humphreys 1999:62). St. Luke's House was, until formal ties were severed in 1911, a branch of the West London Mission, itself part of the London Wesleyan Methodist Mission. The West London Mission drew heavily on the services of the Sisters of the People, 'the most important of all Nonconformist church sisterhoods'[10] and the Sisters visited St. Luke's, and continued to do so even after 1911

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[8] Davidson's published writings in the Annual Reports bear many similarities to the Mildmay Mission publications, which may have formed her model.

[9] Goldin 1981:403, Humphreys 1991:272-3. The closest analogy might be the Friedenheim's connection to the Mildmay Mission, yet the documentary evidence shows that, although personally associated with Mildmay, both Davidson and the Mildmay rejected any direct administrative, managerial or financial involvement between the two (see Chapter 4:86). Even the medical support provided by the presence of a Mildmay nurse seems to have ceased in 1892.

[10] Charles Booth, *Life and labour* 3rd series, p354, cited in Humphreys 1999:58

(Humphreys 1999:58-60). Barrett, the founder, was to say that, '...those who, as instruments of the Holy Spirit, may be the means of curing the soul... are the real physicians of the home' (Barrett 1899, cited in Humphreys 1999:241). St. Joseph's Hospice was the third hospice for the dying founded by the Irish Roman Catholic Sisters of Charity,[11] and was an offshoot of the first Irish Sisters of Charity foundation (Humphreys 1999:51). Management remained with the Sisters who had 'virtually a free hand in running the Hospice' (Humphreys 1999:56).

In contrast, the Friedenheim and its spiritual ethos reflected the ideas of one person, Davidson herself, which nevertheless also affected patient treatment, staffing and attitudes towards the religious beliefs of patients. Her assertive management of the hospital, examined in Chapter 6, reveals her direct, personal involvement and control over the way in which the hospital cared for the dying. Two strands are clear in Davidson's own remarks, as well as those who knew her. Firstly, her emphasis is on the provision of a welcoming, comfortable, clean place for the dying where they could be cared for to the end. Spatial and structural vocabulary abounds:

> We welcome cases at the last stage of illness, when the hospitals can no longer care for them, and when no lodging house would take them in; and we give them the nursing, food, and comforts which their friends, however willing, and their crowded homes would never be able to supply them.'[12]

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[11] The first was Our Lady's Hospice for the Dying, founded outside Dublin in 1879, and the second was the Sacred Heart Hospice in Sydney, Australia in 1890 (Humphreys 1999:52-53).
[12] UoL St.C/F RR Butler (c. 1903)16, 18-19 This is, of course, at odds with previous remarks about the friendless or homeless state of her patients and perhaps, after approximately eight years caring for the dying, represents an enhanced appreciation of some of the needs of the dying.

'MMD'[13] described the 'purpose and intention' of the Friedenheim as caring 'for lonely ones who have *no home* to go to' (italics as original).[14] In 1891, Schofield reported that hospitals were daily turning away the moribund to die 'as best they could and where they could' until Davidson opened her 'tiny port of refuge' (Schofield 1891:423-424). Indeed, the Home was founded because 'there was not be to found any refuge, home or hospital but the workhouse for the man [sic]' who was dying (Schofield 1891:423). Burdett's editorial about the Friedenheim talks of the 'longing for release from uncongenial surroundings' among those nearing death and the way in which this was accommodated in the Friedenheim (Burdett 1893:lxx).

Only when such surroundings have been provided, does the second strand become evident. In the Friedenheim, all would be done:

> ...to reduce pain, to comfort and soothe sorrow and anxiety, and most of all [provide] quiet, and opportunities of spiritual help to enable them to look forward without dread to what lies before them.[15]

Here, Davidson suggests that the relief from physical concerns would create a space within which the future could be contemplated and perhaps religious feelings (re-)awakened. This was an integral element of care and emphasised in both names of the institution, the Friedenheim and Home of Peace for the Dying.

Pain relief

Pain relief played an ambiguous and unclear role among physicians and the religious at the end of the nineteenth century (Humphreys 1999:206-208,

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[13] 'MMD' is possibly Davidson's sister Mary Margaret Davidson who was actively involved with the Friedenheim, was a Trustee, and wrote some of the promotional literature.
[14] UoL St.C/F RR MMD *Friedenheim* 9
[15] FSCAR/SR/1901:8

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Jalland 1996:88-91). Pain itself was seen both as a medical symptom and a punishment imposed by God for mankind's original sin. In the homes run by some religious orders, pain and suffering were therefore 'an integral part of God's will' and were 'felt to play a crucial role in patients' spiritual development'. They were even a 'token of love' (Humphreys 1999:88-89). Efforts were made to relieve pain, but it was recognised as part of God's design and 'ultimately accepted because it had a role to play in the patients' spiritual life' (Humphreys 1999:259).

This ethos marks an important area of conceptual diversion from the work of the Friedenheim. There, pain was deemed an enemy which precluded spiritual peace, and Davidson wrote that symptom relief was '…the avenue through which moral and spiritual help comes, in addition to the physical which comes first.'[16] Lush further suggested that 'suffering, [should] as far as possible, [be] alleviated'[17] and to achieve this, he administered as much pain relief as was necessary,[18] prescribed opiates, carried out minor surgical procedures, gave oxygen and even 'electricity' when it might do some good.[19] This difference in practice and ethos regarding symptom relief at the Friedenheim/St. Columba's may have arisen from the administrative and institutionally powerful position of the Medical Officers, who had no internal religious authority to affirm the contrary. Their thinking appears, in addition, to accord with medical authorities of the day, such as Holland and Munk (see Jalland 1996:86-89).

Staffing

The spiritual differences between the homes also had a major influence on the staffing of the homes, which in turn, affected patients' care and experiences before death including the spiritual support they received.

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[16] FSC/AR/1917:12
[17] FSC/AR/SR/1907
[18] FSC/AR/MR/1913
[19] FSC/AR/MR/1914, FSC/AR/SR/1909, Sprott 1949:187ff

Most nursing care in the early years of the Hostel of God and St. Joseph's was provided by religious Sisters (Humphreys 1999:xiv) who, in addition played an important spiritual part in preparing their patients for death and were a link to the work of the chaplain (Humphreys 1999:247). St. Luke's broke formal ties with the West London Mission in c.1914, but Visiting (religious) Sisters continued to come several times a week to befriend the patients and '"with the utmost gentleness and delicacy to lead them to speak of their deeper thoughts, their spiritual difficulties, their hope and fears; to offer prayer with them and for them…"' (Barrett 1904, cited in Humphreys 1999:241). In the homes where spiritual matters were paramount, these nuns and religious nursing sisters provided an important, visible and constant link between patient, clergy and through them, the hereafter.

The situation regarding any faith requirements for the nurses at the Friedenheim/St. Columba's is confused. There is no mention in Minutes or Annual Reports of any formal religious requirements for the nursing staff, yet it is possible, even likely, that in fact, only those with a Christian faith were employed. A belief in an afterlife was felt to help support and reconcile staff to the difficulties of nursing terminally ill patients. Davidson wrote, for example:

> [M]any, nay most of them [who died], have owned with gratitude that… they have been led into the light and found the peace of God, which passeth understanding. Were it not for this, our hearts would sometimes fail us, when surrounded by suffering such as it is impossible to remove…[20]

An article published in 1921 intended to encourage recruitment, makes no stipulations about the faith of nursing staff however, merely stating that 'The Home is entirely unsectarian. A clergyman of the Church of England acts as

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[20] FSC/AR/SR/1911 (This paragraph is quoted more extensively below, see Footnote 108 p 253)

chaplain when required. The clergy of all other denominations are welcomed to visit their own patients.'[21] The implication of this article must be that, at least in the 1920s, no formal faith or denominational conditions were placed on nurses' employment.

Doris Baker, however, who worked as ward maid at Swiss Cottage and briefly at Hampstead Heath, stated that the then Matron, Olive Howlett would only employ Christian members of staff.[22] At this distance in time, it is impossible to establish the accuracy of Baker's perception of regulatory insistence on Christianity among the staff, whatever the personal convictions or, indeed, actions of those appointing them.

The situation regarding Chaplains at the Friedenheim is also slightly unclear, this very lack of clarity carrying implications about the role of formal religion in the home, or the lack of it. In 1902, the Friedenheim Council, which over the years included various clergymen, agreed it would be inadvisable to obtain the paid ministrations of a chaplain of any one persuasion.[23] A slip of paper exists, however, among other papers dating to c. 1910, which outlines the possible responsibilities of a chaplain.[24] This might refer to a visiting clergyman's duties as it is clear that only approximately five hours' presence per week was expected.[25]

In contrast, the chaplains at the Hostel of God and St. Luke's were named individuals, whose published reports importantly figured in each home's Annual Report (Goldin 1981:404, Humphreys 1999:244-247). Religious influences at St. Luke's were less 'ubiquitous', however, than at the other homes. Whereas full-

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[21] The Nursing Mirror and Midwives' Journal, 3rd December, 1921:171-173
[22] Both Baker and Howlett were devout Christians, though of different denominations.
[23] SMHA/CM/I:17
[24] The 'job description' is simply a loose leaf of paper in a mass of unrelated documents and it is not clear whether anyone was employed on this basis or whether it was simply an *aide memoire* outlining the theoretical tasks of a visiting cleric, were one to be employed.
[25] Unfortunately there is no way of knowing the extent to which this was a realistic estimate of tasks, if, indeed, it were ever used.

time chaplains were employed at St. Joseph's and the Hostel of God (Humphreys 1999:283, see also Goldin 1981:408), 'Spiritual staff …only visited [St. Luke's]… on a part-time basis'.[26] St. Joseph's did not publish Annual Reports, but maintained a close relationship with the local Roman Catholic clergy as well as a full-time Catholic chaplain (Humphreys 1999:248).

The Friedenheim/St. Columba's never had a chapel or prayer room in either its original or the Swiss Cottage locations, and therefore no physical place existed which might have acted as a focus for prayer or religious services. None of the visiting chaplains wrote in the institution's Annual Reports nor are their names mentioned there or in the Council minutes, with the exception of the Jewish chaplain involved in the incident described below.

Religious conversions

Described as 'the "real" work of St. Joseph's Hospice', staff there and at the Hostel of God went to great lengths to convert or reclaim the souls of their patients (Humphreys 1999:80ff). Without clerics or religious sisters, however, conversion was of less importance at the Friedenheim/St. Columba's. Davidson, in particular, appears to have lacked much of the active proselytising fervour of other institutions with a more missionary zeal (Humphreys 1999: 274-282,

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[26]The stipend paid the chaplain and chaplaincy at the Hostel of God was £93 in 1905, rising to £150 in 1916 and£256 in 1938. The Anglican chaplain at St. Luke's was paid £129 in 1894 and £200 in 1925 (Humphreys 1999:249 and 245). Humphreys also found a certain tendency towards what she terms 'ministerial exclusivity' at the Hostel of God, in that while chaplains of other persuasions might visit patients, they were not permitted to administer the Sacraments (Humphreys 1999:272). The incumbent's annual reports included the numbers of patients who had been baptised and confirmed as well as the number of Communicants (Humphreys 1999:117, 157).

2001:159, 162, Prochaska 1980:122)[27] and there were no pre-requisite religious barriers to admission as a patient, such as baptism or conversion (See Humphreys 1999:285 for the practice at St. Luke's). She claims to have left the encouragement of religious acceptance to the multiple, mainly Biblical, texts on the walls.[28] She wrote, for example c.1910:

> I leave them [the texts] now to do most of my talking… [for] one learns to be cautious about what one says oneself, so as not to encourage talking for talking's sake. But the texts speak, and I have both the assurance and the evidence that God's word does not return unto Him void.[29]

Or again:

> The spiritual work among the inmates, though quiet, is, I think, real and true, and it is very encouraging to find how one and another shows evidence of new life and love, and with what calm and often joy they pass away.[30]

Lush, then Medical Officer, emphasised the ecumenical and passive nature played by religion in the home: 'Men and women (and children) representing all

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[27]Humphreys described several incidents where the Sisters of Charity assertively brought vulnerable patients to an awareness of their sins and the need to confess them in order to obtain absolution and experience a good death (Humphreys 1999:274-278). She continued by describing 'the expectations placed on those coming into the homes' which included undergoing spiritual preparation for death, according to the ideals of each particular home (Humphreys 1999:275). The religious Sisters had a further motivation for securing the salvation of their patients in that 'works of mercy were as beneficial to the dispenser as they were to the recipient' and the 'rules of the Sisters of Charity also postulated that …they should attend to the salvation of their own souls'

[28] Humphreys describes the visual supports to faith which abounded in the Hostel of God and St. Joseph's including Bibles, statues, holy water and crucifixes (Humphreys 1999:282). Pictures in St. Luke's, however, were not confined to biblical or holy subjects (Humphreys 1999:283)

[29] Butler/UoL/SC/F/RR:9

[30] FSC/AR/SR/1910

kinds of religious views are received and made happy, as far as we can make them, and there is no attempt to proselytize.'[31] He confirmed this a year later:

> While no attempt is made to change the creed of the Jew or Roman Catholic, or adherent of any other faith, it is a cause for thankfulness that many in whom the Christian Faith was only nominal have been so influenced by the uplifting tone of the Hospital that their death has meant the awakening in the Light Eternal.[32]

This acceptance of others' faiths extended beyond Davidson's day. A visitor, later employee, who knew the hospital between 1924 and 1945, wrote about finding at St. Columba's: '…a practical Christianity that transcended all form and denominationalism'.[33]

The attempted conversion described below tested these sentiments and is remarkable for being the only recorded effort actively and aggressively to convert a patient to the Christian faith at the Friedenheim or St. Columba's. The incident concerned the 'conversion' of a young Jewish[34] patient alone with Macneill at the time of his death. She wrote in the 1924 Annual Report of a '…young Jew, in great distress of mind' as he lay dying:

> 'Shall we pray to God, asked one who was watching by his bed [i.e. herself], and word by word the following short prayer was repeated by the dying man: "Father, into Thy hands I commend my Spirit, forgive me my sins, for Jesus' sake, Amen." And then John iii.16[35] and these were

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[31] FSC/AR/MR/1915
[32] FSC/AR/MR/1916
[33] Long [no date] UoL/SC/F/RR/Item 1:1
[34] The Jewish community had grown rapidly in England between the years 1881-1905 (Neuberger 2004:101). In Hampstead, a new synagogue was built to cater for its growing congregation in the same year as the Friedenheim moved there. See: http://www.hampsteadshul.org.uk/about-us/how-it-began.php (accessed 13.05.2009)
[35] 'For God so loved the world that he gave his only begotten son, that whosoever believeth in Him shall not perish but have eternal life.'

the young man's last words. Can we doubt the prayer was heard and answered by Him who said, "Ask and you shall receive?"[36]

Complaints were made to the Editor of the *Jewish Chronicle*, a Mr. Greenberg, who in turn consulted the minister appointed to the Hampstead Jewish community, the Reverend Aaron Green.[37] Green spoke directly to Macneill and then wrote to the Editor, sending a copy of this letter to the hospital Council.[38] He first thanked Greenberg for his measured response in not immediately publishing the anonymous letter, 'which would have had the ultimate effect of alienating the Jewish support of and sympathy with the Hospital that it has always been my pleasure to enlist,' continuing:

> I have been a visitor to this Hospital for some years. It is one of the best of its kind and in the 40 years of my experience in the ministry, I have never found more consideration for Jewish Patients than has been consistently shown here… Although on no previous occasion of which I am aware has anything happened of this kind…I would like to say that it is frankly a "Christian" institution and one of its fundamental principles is to afford not only a Home of rest for the dying but an atmosphere of Christian preparation for the end of life. Miss Macneill, the Honorary Matron, has been a good friend to all our Patients and our relations have been perfect, and I was greatly surprised when she informed me of what had taken place.[39]

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[36] FSC/AR 1924:9
[37] The Rev, Aaron Asher Green (1860-1933) was the first minister appointed to the new Hampstead Synagogue opened in 1892. http://www.hampsteadshul.org.uk/about-us/past-ministers.php Accessed 29.03.09
[38] The full text from which the following extracts are taken can be found at SMHA/MB/III:280
[39] Ibid.

Green described the incident, which took place at night, when, '…Miss Macneill did not think she was justified in calling me up.'[40] After discussing with Macneill the practical and spiritual implications of her actions, Green went on:

> I told her I considered [the account in the Annual Report] a grave error of judgement because it magnified into a 'conversion' something which could only be testified to by one who was dead, it was an inferential animadversion on my work as the visiting Jewish Minister, it was bound to give pain to the man's friends and family and it was an implicit challenge to the Jewish Community. More than this it was open to the construction on our part of the magnification into a conversion as a subject of satisfied religious record of the repetition of certain words by a dying man whose psychology it would have been, at the very best, most difficult to estimate.[41]

He concluded by setting clear guidelines for the treatment of future Jewish patients, and remarked that if they could not be adhered to, he might be obliged to, '…inform friends of Jewish patients…[and] the Jewish Community that I did not think St. Columba's was a Hospital to which Jewish patients should be sent.'[42]

The Council discussed the issue with Macneill and, '…after careful consideration and full discussion'[43] replied to the Rev. Green, agreeing to his guidelines and stating that, '…the council quite understand your attitude with regard to this particular incident and expresses their sincere regret that the report should have been the cause of pain and annoyance to members of the Jewish Community.'[44]

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[40] Ibid.
[41] Ibid.
[42] Ibid.
[43] SMHA/MB/III:161 23 May 1924
[44] SMHA/MB/III:161 23 May 1924

The implications of this incident are of interest in two particular areas. Firstly, it testifies to the past goodwill between the two communities which had thus far been cordial and without incident. This implies, that up to now genuinely tolerant, ecumenical care had been offered at the Friedenheim/St. Columba's in spite of their 'frankly Christian' nature.

On the other hand, it should be noted that however carefully the Council considered and discussed the incident, they did not actually apologise for the events themselves, but rather for the '…pain and annoyance' that might have been caused. Further, they closed the letter '…and assuring you of our particular care with regard to future reports'. The Hospital nevertheless complied with all Green's requests and no further incidents of this type were documented.

Many pages were written in the Minutes about this one alleged 'conversion' together with transcriptions or copies of all the letters. The incident evidently caused considerable disquiet among the members of the management council which tends to suggest that such events were rare, unexpected, and with the Jewish community at least, unwished for.

Faith of the patient body

The independence of the Friedenheim from any one persuasion and the confessional differences among the staff[45] may be one of the contributory factors leading to the inclusion of a wide range of not necessarily Christian faiths and denominations among the patient body. These were certainly wider than those reported at St. Joseph's or the Hostel of God (Humphreys 1999:154-157) which were, in the early days, primarily intended for their co-religionists,

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[45] Lush, who worked with Davidson (an Episcopalian), was Baptist, as was Macneill, Davidson's successor as Superintendent. Clark Wilson, who succeeded Lush, was Presbyterian. Anthony was an Anglican whereas Howlett was a Baptist.

particularly if passive or lapsed. In this respect, St. Luke's Hospital more closely resembled the Friedenheim/St. Columba's and also admitted patients with a variety of religious beliefs (Humphreys, 1999:155).

The Friedenheim/St. Columba's Annual Reports occasionally document the faith of a patient, showing the spread of different confessions and practices received: Jewish (1908, 1915, 1921, 1924), Roman Catholic (1917, 1924), Unitarian (1918, 1928), Christian Scientist (1920),[46] Anglo-Catholic (1933) and from the Salvation Army (1933, 1935).[47] These connections with other denominations and faiths must have been more consistent than these occasional mentions might imply as donations are recorded from Father Hogan,[48] a Roman Catholic priest, on one of his visits in 1925 and from the West Hampstead Synagogue over a period of several years.[49] Annual Reports of the Friedenheim and St. Columba's do not list baptisms or conversions as was done in the Reports of the Hostel of God and St. Luke's.

The Friedenheim can therefore be distinguished from the other proto-hospices by the type and extent of spiritual impact on patient care. There is a contrast between the institutional religious and spiritual care which prevailed at St. Joseph's, the Hostel of God and, during its early years, St. Luke's, and the diverse, individual interpretations of spirituality among the staff at the Friedenheim/St. Columba's. This, therefore, furnishes another example and interpretation of the church/medical dichotomy described previously. Both strands evolved, apparently harmoniously, within the Friedenheim but, for the reasons outlined above and in the previous chapter, arguably the balance there

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[46] Clark Wilson was less than empathetic with this patient, suffering from cancer, 'who tried to the end to believe she had no pain, but found it impossible after a time, and had at last to commit the treason (as she considered it) of taking sedatives to relieve it' (FSC/AR/MR/ 1920) - evidence that there were, on occasions, exceptions to the general tolerance of others' faiths at the hospital.

[47] It could be suspected that the different faiths were mentioned as a marketing tool to encourage donors from various denominations, but this argues for a degree of cynicism in Davidson which is not borne out in her writings.

[48] Father Hogan was named in his capacity as a donor, rather than a visiting chaplain.

[49] Donations from the Hampstead Synagogue extend, at least, over the period 1922 to 1937.

lay with the medical staff over the religious, giving the physicians an importance and freedom they might not have found in the other proto-hospices.

Patients at the Friedenheim/St. Columba's represented a wide range of religions, and adherence to a particular church, or none, was not a precondition of admission. Davidson's personal belief that faith eased the approach to death and the passing of life encouraged her, nevertheless, to create an environment in which patients' personal spirituality could be expressed or allowed to mature. Her methods to encourage a (re-)awakening of faith tended to be indirect, even passive, and the one recorded attempt at more active proselyting demonstrates that this attitude survived her.

Davidson's strong personal faith and sense of religious duty imbued her writings and actions. As an integral part of care, her beliefs led her to create an environment in which spirituality could thrive and, she felt, ease the suffering of those approaching death. This was supported by current medical thinking which included hope and faith as desirable elements within the management of the dying patient. Unlike the other proto-hospices, however, the institution was not designed to serve the religious interests of a particular denomination, nor was it used as a vehicle for religious renewal.

9.2 Social issues: families, friends and Christmas

Families and friends

A certain nascent notion of what would now be called social work supplemented medical and spiritual comfort in the proto-hospices. There is, however, relatively little direct evidence of this in the literature and the following section, therefore, partially remedies this omission in the case of the

Friedenheim/St. Columba's. Christmas celebrations are discussed in particular, as an example of the hospital's policy towards patients' relatives and friends.

The Sisters of Charity who founded St. Joseph's visited the poor in Hackney and Hoxton and they, and the local priest, were responsible for many of the referrals to St. Joseph's (Humphreys 1999:140-141, Winslow and Clark 2005:8). It therefore can perhaps be assumed that contacts were maintained and support offered to the families of their patients. At St. Luke's House, a designated religious 'Visitor' concerned herself with what would now be termed social issues.[50] Although the main mission of these Sisters was to bring spiritual comfort to the patients, a Sister Lily, in particular, seems also to have been associated with helping patients' families cope with practical, financial issues. She visited the House once or twice a week and established a fund for the relief of 'some very hard-pressed and deserving people' (Goldin 1981:409).

Annual Reports and council minutes provide a fuller picture of concern and care for family members at the Friedenheim/St. Columba's. In view of the relative paucity of information on the other homes, it is therefore valuable to interrogate this material and explore the ways in which the hospital reached out to its patients' friends and relations. Without details from the other homes, however, it is impossible to know to what extent practice at the Friedenheim is generalizable across the other nineteenth- and early twentieth-century proto-hospices.

To modern eyes, the visiting hours at the early hospices were brief: twice a week for two hours (Goldin 1981:410, Winslow and Clark 2005:11, FSC/AR/1901:4). Goldin even suggests that at the homes run by sisterhoods, the nuns actually disliked any visitors as the home was also their convent and visitors 'intrud[ed] on their discipline' (Goldin 1981:400). At the Friedenheim, as at St.

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[50] Goldin implies that there were at least four visiting religious Sisters, Lily, Gertrude, Agatha and Constance, probably seconded from the West London Mission (Goldin 1981:408).

Luke's (Humphreys (1999:256), it is clear that these rules on visiting were interpreted very loosely, particularly as the patient's situation deteriorated. In 1896, the Friedenheim's policy on visits was described:

> There are special visiting days, of course, for the patient's friends, and as the time approaches for the last goodbye, near relatives are invited to stay with their dear ones to the end, and are just as carefully considered as the departing.[51]

One mother, for example, lived in the hospital for two weeks, while her daughter was dying.[52] A devoted husband was, '…never long absent from [his wife's] room'.[53] Another wrote of his or her indebtedness, '…to you for the many facilities we have had for remaining with her [the patient] during her last moments.'[54]

Families were encouraged to visit on festivals and holidays, and Annual Reports[55] mention the 'usual' family gatherings on these occasions.[56] The 1906 Annual Report elaborated further:

> The festivals of the year were as usual made seasons of special family gatherings round the beds of our suffering inmates. On each of the Bank Holidays, at Easter, Whitsuntide, and Christmas, the Patients invite their own guests, and our tea parties generally number about sixty or seventy. The children specially enjoy these occasions, and when fine, have games in the garden, and it is touching to see the pleasure of the dying Father

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[51] FSC/AR/1896:15
[52] SFTK 1887:11
[53] Butler UoL/StC/F/RR undated c.1903:12
[54] FSC/AR/1905
[55] Specifically those for 1903, 1905, 1906 and 1907
[56] One of the 'little family parties around the beds' merited a special mention, as the 'little' party included all five of the patient's children (FSC/AR/SR/1907)

or Mother watching, it may be for the last time, their little ones at their play.[57]

Care for the families went beyond tea parties however. During World War I, Lush was able to arrange for a soldier's leave to be extended:

> The husband of another patient came back from the fighting line for a few days' leave at the end of December, and I was able to get his leave extended sufficiently for him to see his wife pass away.[58]

Compassion for the families included overseas patients and those of all faiths:

> A West Indian soldier who served in Egypt and there contracted consumption, and through a mistake in embarkation was shipped to England instead of Demerara. His great longing was to go home, and at one time this was contemplated; but he was too weak to undertake the journey. After that his great hope was that his Mother might come to see him, but he grew rapidly worse, and died the day before she was to have started. We sent her the rosary and crucifix which he wore round his neck, and a lock of his hair....[59]

Another serious concern for some of the patients was their children who were going to be left orphaned. The nuns working at St. Joseph's were able to arrange for the care of any orphaned children either in another home run by the Sisters of Charity or a similar institution (Humphreys 1999:257). Dr Barrett at St. Luke's House, who presumably was running a practice in addition to his work with the London Mission and the home, left any, what might be termed 'social work', to the visiting Sisters (Goldin 1981:409). Davidson, however, as Superintendent, was able, like the nuns at St. Joseph's, to intervene directly.

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[57] FSC/AR/1906/SR
[58] FSC/AR/MR/1915
[59] FSC/AR/SR/1917

Lush reported in 1913, for example, on a woman who: '…passed away happy because Miss Davidson had been able to arrange for the care of her two little [soon to be orphaned] children'.[60]

This policy of aid to patients' families at St. Columba's continued long after Davidson's death. A more recent example was that of Doris Baker, left in a particularly vulnerable position when her mother died at St. Columba's in 1948. Before dying, Mrs Baker had begged the Matron, Olive Howlett, to look after her daughter. Howlett initially discouraged the fifteen-year-old from her wish to live and work in the hospital, fearing that it might be emotionally too difficult, but later acquiesced when the lack of suitable alternatives became apparent. Baker worked and trained at St. Columba's from 1948 to 1959, regarding it and its staff both as home and family and calling her time there the 'happiest days of her life.'[61]

Baker was an extreme, though not isolated case. Marjorie Long,[62] writing around the end of WWII, describes how, following the death of her mother there in 1925, she too joined the staff of St. Columba's in an administrative capacity and stayed until 1940.[63] The hospital policy of caring for patients' families continued at least through the 1940s and 1950s when Howlett was Matron.

> More and more we appreciate the privilege it is to ease the burdens of
> the friends and families of our patients who are going through the sad
> experience of parting with those they love.[64]

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[60] FSC/AR/MR 1913
[61] Conversation with Doris Baker 06.11.2007
[62] Long [no date] 'One personal contact with St. Columba's Hospital' UoL/StC/F/RR Item 1.1
[63] UoL/StC/F/RR Item 15 Long wrote a brief, but moving account of St. Columba's during WWII. As standard practice in war time, the hospital was not evacuated as, Long was told, 'it is those who are going to recover we must save'. In spite of bombs, incendiaries and 'Molotov breadbaskets' (firebombs dropped in a container) falling all around the hospital, only the Porter's Lodge was damaged.
[64] FSC/AR/1939

> Our chief thought is one of thanksgiving for those patients who have found love, peace and comfort; also for their relatives and friends who, because their loved ones were in our care, were enabled to carry on in their homes and at their work with ease of mind.[65]

The remedial properties of rest, good food, cleanliness and medical care allowed some patients to achieve some sort of remission of their condition and return home. Although mentioned only briefly, St. Luke's appears to have been ahead of all the other homes in the provision of some sort of aftercare for their patients following a respite (Humphreys 1999:258), and Sister Lily, one of St. Luke's Visiting Sisters, would also take patients out for a drive or for tea, another practice which is not mentioned elsewhere.

Special celebrations and Christmas

Examination of the Friedenheim records adds valuable insight into the daily lives of the patients, their visitors and non-medical care in such a Victorian institution. Christmas is of particular interest as an example of Davidson's approach to one of the major Christian festivals and its place in the hospital year. An exception to the lack of comparable information in the other early homes, Goldin mentions Christmas at St. Luke's in 1897 when Barrett wrote that the patients 'feasted royally (and some were royally "indisposed" the next day)'.[66]

Central to the theme of Christmas is the idea of family and the celebration of the birth of a child. Miller convincingly argues that Christmas, as a celebration of the birth of Christ which was virtually ignored in the earliest Gospel, was

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[65] FSC/AR/1944

[66] Saunders' transcript (n. 13), p. 16(1897) cited in Goldin 1981:403. Goldin also described an impromptu visit by HRH Queen Alexandra to St. Luke's in 1908 (Goldin1981:411-415). Humphreys wrote 'Efforts to involve nursing staff in putting on plays for the patients and participation in celebrations and festivities, especially Christmas, were probably intended to boost staff, as much as patient, morale' (Humphreys 1001:236).

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invented sometime in the fourth century. It replaced earlier festivals during 'a major shift in the norms and practices of family life, which led to the foundation of the idealization of the nuclear family that has continued in Western Europe ever since' (Miller 1993:14). He suggests that Christmas is the time when 'the actual importance of the family is valorized and given its due' (Miller 1993:15). Christmas celebrations, he reasons, spread out from the nuclear family to reach others through such things as the creation of 'minimal units of sociality' such as the exchange of Christmas cards, which are the tokens of potential for intimacy if circumstances should allow. Social death is 'placated' by such gestures, and, through such ties radiating out of the nuclear family, Christmas is 'felt to establish a relationship between the celebrant and the world at large' (Miller 1993:31).

Viewed in this light, Davidson's celebrations of Christmas must have held an important place in the lives of her patients, embracing and supporting them within a new 'family', yet subtly reassuring them that they were still members of a larger society, which, like them, was celebrating Christmas in a similar way.

Prior to 1840, Christmas had been celebrated locally in diverse fashions but nationally, it was essentially an insignificant festival. After this date, however, and as a result of various factors,[67] Pimlott records that the 'new Christmas was carried forward by an irresistible momentum' (Pimlott 1978:89) and a pattern, still recognisable today, rapidly evolved of festivities which included decorations, Christmas trees, and exchanges of gifts and Christmas cards. Pimlott dwells on the fact that these new customs brought a certain opposition from all established churches, particularly non-conformist denominations who

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[67] See Pimlott 1978:85-95 in particular for an exploration of the reasons for this general uptake of Christmas celebrations. He credits, in particular, the religious revival at that time and the influence variously of Dickens and Prince Albert during an age of social awareness, calling the new Christmas 'essentially a Christian Socialist institution' (p 88). It 'stressed the duties without which the material things could not be fully enjoyed and the special obligation which lay upon everybody to make sure the children had a happy Christmas' (p 88). Once launched, 'it was carried forward by an irresistible momentum' (p 89) since it appealed to many and fulfilled the need for a mid-Winter holiday.

saw unacceptable Marian influences in the emphasis on cribs and the Virgin birth. This opposition was particularly entrenched in Scotland, where New Year's Eve remained the focus of winter celebrations and Christmas Day only became a public holiday in the 1950s (Pimlott 1978:149).

Davidson, however, evidently enjoyed the Christmas festivities in spite of her Scottish background, and described them in detail in her annual Superintendent's Report,[68] revealing a very secular way of observing the season. Her unselfconscious pleasure in paper chains, gifts, decorations and Christmas trees perhaps indicates and underlines a potential gulf between her home and the religious foundations as at some point, both Catholic and Protestant churches objected to the de-sacralisation of Christmas (Kuper 1993:158, Lévi-Strauss 1993:38). The Friedenheim festivities were also in sharp contrast to those at the workhouses[69] although a modern eye may discern elements of patronage and condescension as well as compassion in some of the anecdotes.

At Christmas, Davidson wrote, 'rules are relaxed, diet sheets discarded, and indulgences permitted in a way that would never do at other times.'[70] Perhaps motivated by memories of the large family gatherings of her childhood, she instituted a tradition of celebrating Christmas which continued at least until the 1950s.

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[68] The Annual Reports were published at the beginning of the year, normally in January. It may have been that the Christmas festivities were, at that time, fresh in her mind and provided a useful source of anecdotes.

[69] See, for example, the dramatic monologue written by George R Sims in 1903, available online at http://www.victorianweb.org/history/poorlaw/poem.html, accessed 23.02.11

[70] FSC/AR/SR/1908 It is not clear what 'diet sheets' were discarded as Butler reported a nurse saying, 'They [the patients] have pretty much what they like if we have it to give. The doctor says, "Let them have just what they fancy," and he gives no regular diet list' (Butler/UoL/St.C/F/RR/undated, c.1903:125). This is very much in line with contemporary advice on nutrition for the dying. Munk, for example, says that 'the wishes of the patient himself … may generally be taken as a correct indication in all that relates to the administration of food' (Munk 1887:67).

At Christmas, the amusements are, of course, indoors, and "Father Christmas" proceeds from Ward to Ward with little gifts for the younger visitors. The day is always a bright one at Friedenheim, and the verdict of the Inmates generally is, that it is the happiest they have ever spent. One woman this Christmas went so far as to say, when she had finished her dinner of roast turkey and plum pudding, that she was "afraid she would be in Heaven before next Christmas!"

…the entire day was one of peace and gladness, and its brightness was not marred by the call of the "Prince of Peace" for one little weary child, who began his Christmas on Earth and finished it in Heaven.[71]

Happy anticipation of Christmas was even thought to have kept some patients alive till the day. Lush wrote that one boy of seventeen 'made up his mind to live through Christmas and have his little brothers and sisters to tea with him on that day'.[72]

Wards were decorated with Christmas trees, paper chains and paper flowers, the latter made by the patients themselves,[73] a tradition that continued throughout the years of WWI and after Davidson's death at least until 1934:

[1914] We felt that the decision to celebrate the season with the time-honoured festivities of decorated wards and all the usual paraphernalia – a decision not arrived at without considerable hesitation in a time of national crisis like the present [1914] – was fully justified, when it gave such pleasure…to our patients. The company that gathered for the short closing service late in the afternoon was one of the largest we have ever had; and the presence of two khaki-clad soldiers home from the battlefield, as well as a wounded and permanently disabled Belgian

[71] FSCAR/1906/SR
[72] FSC/AR/MR/1915
[73] FSC/AR/SR/1907 and FSC/AR/SR/1910

patient, reminded us – if such reminder were needed – of "man at war with man"...[74]

[1930] Christmas was a wonderful time at St. Columba's; the beautiful paper flowers, so realistic, were made by the patients, who took the keenest interest in all the preparations, and the wards looked like Fairyland.[75]

[1931] Christmas was a gloriously happy time spent in a quiet way, just as a united family. Dr Clark Wilson carved the turkey in Lush Ward, and Mr. Winstanley carved in Albert Victor, and the presents off the Christmas Trees were distributed in the afternoon.[76]

It is clear from the above dates that this tradition of decorations and celebrations continued well beyond Davidson's days. Baker remembered Christmas Day with great affection and described Christmas morning when all ward doors were opened and the night staff greeted patients and colleagues with carols in the central stairwell. All patients received gifts: 'beautifully made' bed jackets, socks or perfume for the women, bed socks, cardigans, tobacco or shaving soap for the men. She describes a day of jokes, parties and fancy dress[77] when the senior staff waited on the more junior at table and the turkeys were carved either by the doctor or the chaplain, whose families also came to join in the celebrations.[78]

However by Baker's time at St. Columba's, a different custom had also become the norm which appears counter to the 'indulgences' of earlier years. In spite of the fact that Christmas was and is a family celebration, visitors were no longer

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[74] FSC/AR/MR/1915
[75] FSC/AR/1931
[76] FSC/AR/1932
[77] These memories are confirmed by many photographs in Olive Howlett's personal photograph album.
[78] Conversation with Doris Baker 06.11.2007. The presence of the doctors' families is of particular interest as it demonstrates unusual freedom in the doctor/patient relationship.

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permitted on Christmas Day. Baker gave two reasons behind this, at first sight arbitrary and autocratic decree. Firstly, very little public transport ran on 25th December. The exclusion of visitors therefore placed all patients on an equal basis. More important, however, was the second reason; the effect that this lack of public transport would have on the patients' immediate family. Many would have wanted and/or felt obliged to make a special effort to come on Christmas Day and could literally have spent several hours crossing London, only to repeat the journey at the end of the day. Their own Christmas and that of any children would have been stressful and disrupted. By forbidding visitors, the family was allowed to spend a guilt-free Christmas at home.[79]

Boxing Day, however, was a day of parties when, public transport running again, all were invited. At tea time, the children were taken down to the kitchen for a children's party with Father Christmas, small gifts, games and a large cake. This not only kept them occupied, but permitted parents some time alone together on their last Christmas.[80]

These accounts of Christmas celebrations at the Friedenheim give a vivid idea, not only of how the festival was observed, but of the atmosphere in the home at this time and provide insight into the staff/patient relationship. As always, however, it must be remembered that the available accounts are one-sided and emanate not from those cared for, but only from their carers.

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[79] This is similar to Saunders' thoughts expressed in her first formulation of plans for St. Christopher's and hospice care: 'We might keep one day free each week so that relatives need have no conscience at having a "day off"'. (Saunders,' The Need' UoL Saunders' Papers Box 7 1/2/3 early 1960:4)
[80] Christmas and Boxing Day details from the 1950s were drawn from a conversation with Doris Baker 06.11.2007

9.3 Mental distress, individuality and atmosphere

The religiosity of the other proto-hospices led them to lay great importance on faith as the way of assuaging mental distress and, '[t]he homes' religious underpinnings meant that many of their physicians ultimately saw patients' mental health as linked to their spiritual well-being'(Humphreys 1999:230). It is not clear, however, whether these physicians nevertheless assumed responsibility for their patients' mental health or considered it a separate and distinct element of the patient's condition which would be 'treated' by the homes' spiritual advisors.

This attitude, of mental health being linked to spiritual well-being, possibly also prevailed among the Friedenheim's physicians and Munk had made the importance of faith and its role in assuaging the distress prior to death clear (Munk 1887:22-23). It is evident that, in the Friedenheim, spiritual consolation and the opportunities for reflection, no doubt supported by the Biblical texts which featured on the walls and above the beds, formed an important part of the care given to patients. Mental distress, as opposed to physical however, is not specifically mentioned in the Annual Reports until the Medical Report of 1933:[81]

> We acknowledge with gratitude the help given to patients by means of the many concerts and other entertainments got up by friends of the Hospital and of the patients from time to time. I mention them here because they are a very real help to the medical treatment through the mind – a means of treatment not always recognised and made use of as it ought to be....[82]

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[81] N.B. this is some 12 years after Glaister's paper on *Phantasies of the Dying*.
[82] FSC/AR/1933

Sprott elaborated this theme in his paper in *The Medical Press*, where he wrote: 'Of equal importance with the physical treatment of these patients is their psychological management' (Sprott, 1949:190).

Prior to this, however, any conditions which alleviated patients' mental distress at the Friedenheim/St. Columba's must be inferred from the details given of their treatment. The comfort in which the patients lived, for example, shown in photographs of wards, bedding, day rooms, smoking rooms, balconies and gardens shows the extent to which the material surroundings of the patients were calculated to provide welcome, comfort and well-being during their final days.[83] Although more crowded, the photographs of St. Luke's House[84] show similarly comfortable physical surroundings. Undoubtedly, the motivation behind the provision of such comfort had its birth in the complex influences behind any philanthropic enterprise, but the result was that many were able to die in conditions of cleanliness and repose, even, according to remarks reported in the Annual Reports, contentment, which circumstances might otherwise have denied them.

As in the other homes, staff at the Friedenheim/St. Columba's provided a presence at the final moments to assuage the essential loneliness of those facing death.[85] 'For many years she [Davidson] personally attended the

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[83] Photographs of patients in the day rooms, conservatory and gardens testify to the contrast between the situation at the Friedenheim/St. Columba's and the other homes. Rooms at St. Luke's around 1900 were extremely crowded, but decorated with wallpaper, pictures and fresh flowers. The beds had linen sheets and white, monogrammed counterpanes (Golding 1981:402). Goldin cites the matron of another institution (unnamed) who claimed that conditions there had been more Spartan and patients were confined to bed, without dressing gowns or slippers or were given dressing gowns only when they went to the day room. They had no 'outdoor' clothes (Goldin 1981:399-400).

[84] Goldin 1981: between 396 and 397

[85] Elias describes this loneliness: 'This 'alone' refers to a whole complex of inter-related meanings. It can refer to the expectation that one can share the process of dying with no one. It can express the feeling that with our death the little world of our own person… will vanish forever. It can refer to the feeling that in dying we are left alone by all people to whom we feel attached…. If a person must feel while dying that, though still alive, he or she has scarcely any significance for other people, that person is truly alone' (Elias, 1987:59 and 64)

deathbed of nearly every patient who passed away in the Home',[86] a tradition continued by Olive Howlett through to the 1950s.[87]

The patient as an individual

In the institutional surroundings of a home for those at the end of life, the personalised nature of treatment and care are of great importance, and the Friedenheim was no different from the other homes in claiming to treat each patient as an individual. Culled from her study of the Annual Reports, in her references to the early days at St. Luke's Hospital, Saunders at least twice refers to the founder, Howard Barrett's, respect for his patients as individuals. They were not '"The Poor" but "this person in need" (Saunders 1987:59) and his interest was in 'each individual person and his or her desolate family left at home with no welfare state support' (Saunders 1988:20).

In the Annual Report of 1912, Lush described the Friedenheim patients as individuals with unique requirements, and acknowledged the essential vulnerability of that individual facing death – in spite of any belief in an afterlife. Rarely for medical writing, he also admitted that same vulnerability in the staff, recognising his own mortality in his empathy with the patients:

> …it is never forgotten in Friedenheim that our patients are not "cases" simply, but men and women, with the same strong clinging to life, and the same shrinking from death, which we all feel, and shall feel more vividly when *our* sands of time are sinking.[88] (Italics as original)

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[86] FSC/AR/1921 This can be compared with Humphreys (1999:249) who says that a nun was always present at a death bed.
[87] Conversation with Mrs Freda Rudall 24.05.2007
[88] FSC/AR/MR 1912

Although there is no direct testimony from the patients themselves, it is nevertheless of interest to look at some of the minutiae of care aimed at catering for each person's needs:

> Dear Miss Davidson, a few lines to tell you I do not like this place [a new nursing home], so strange after the happy home I have left. I would come back tomorrow if I could. Will you let me come after I have been here a time? Please do. I can't get my porridge in the morning nice, nothing like I had with you. I shall pine away if I stop here. God bless you. Yours faithfully, W.N.[89]

> One dear old Grannie was rather worried the day she came in: she had left her little home and she could not bear the thought of not going back to it. "I can't make up my mind to stay," she confided, with her face wrinkled and puckered with the worry of it all. When it was suggested that she should settle down for the night and we would talk it over in the morning, she looked up with a beaming smile and consented with, "All right duckie, kiss me good night," and from that time her nightly "Good night duckie, God bless you!" was the richest reward one could ever wish to have.[90]

Not being able to comfort or care for a patient was also cause for concern: 'Lydia is quite blind and has lost the sense of taste and smell; so we cannot even refresh her with little delicacies or sweet flowers'.[91]

To compound the lack of independent patient testimony, which applies to all the homes, Davidson was also in principle reluctant to quote the patients directly in the Annual Reports. Already in 1899 she wrote, 'I feel this year more

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[89] FSC/AR/SR 1907
[90] FSC/AR/1931
[91] FSC/AR/SR/1905

than ever that the closing scenes of life are often too sacred to be printed'[92] and again in 1907, 'It is not easy to give particulars about the patients themselves, for one shrinks from printing the sayings of those who have passed away'[93] so, as is frequently the case with the dying, the patient's voice remains unheard. Testimonies to the individual, personal care given in the hospital from surviving relatives are, however, numerous[94] and continue well into the twentieth century.

> One [patient] told a friend, 'she was so happy and comfortable, and all were so kind to her at Friedenheim, that she feared sometimes that it might only prove a beautiful dream, and that she would wake up and find herself back in the Parish Infirmary.'[95]

A friend writing after a patient's death wrote: 'The personal element in the Hospital touched me greatly, and I feel that it is just this that comforts and heals and helps.'[96]

In 1924, a daughter expressed her gratitude about the care given her mother:

> …It seemed to me, and I know it did to her, so much more than mere Official duty on the part of the staff, the kindness and general attitude were so full of personal interest, which did everything to make the sufferings of a sick woman as easy as they could reasonably be made.[97]

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[92] FSC/AR/1899:11 This is further evidence of Davidson's personal religious ethic.

[93] FSC/AR/1907

[94] These are drawn from the Annual Reports and the selective nature of material published there should not be forgotten. The authors of the reports nevertheless felt such details of individuals in their care to be worthy of note.

[95] FSC/AR/1909 It would be of interest to know how many other patients came to the Friedenheim/St. Columba's from the workhouse infirmaries, but unfortunately, apart from isolated mentions, this information has not survived.

[96] FSC/AR/SR/1915

[97] FSC/AR/1925

On one occasion, however, a patient's mental distress was directly reported in the Annual Report. The unnamed woman's condition had robbed her of speech and she therefore wrote to the Matron, extracts of the letter being extensively reproduced in the Annual Report.[98] Her worry related to possible behavioural changes occurring as a result of treatment:

> I feel greatly troubled now that I must commence the morphia regularly because of the moral degeneration it brings with it, the selfishness and indifference and slacking of dainty habits, and I am particularly distressed at the thought of thus bringing discredit to my Lord and Master … I am venturing to ask if you will help me all you can to keep my self-control and avoid screaming etc.[99]

This worry was apparently appreciated by the staff, who were able to help her so that, 'through all the weary days and nights she never murmured or complained, and was kept very calm and peaceful to the end.'[100]

Throughout the Annual Reports, there are numerous examples – some not without humour – of the staff's intimate knowledge of the patients' psychological and physical needs as individuals. One patient, for example, engaged in useful and no doubt appreciated occupational therapy: 'Mrs. J died. Her great delight was to curl our feather boas, and she did them beautifully, as it had been her trade.'[101] The discomfort and thirst of hot weather might be assuaged by dietary treats: 'Another lady, who wishes to remain anonymous, gave £1 for fruit, which was used on warm days for melons etc., so cool and refreshing in the heat.'[102]

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[98] Davidson's reluctance to quote the dying does not appear to have included the written word.
[99] FSC/AR/SR/1910
[100] FSC/AR/SR/1910
[101] FSC/AR/1912
[102] FSC/AR/1911

Children frequently have a special mention in the early days of the institution whether as examples of virtuous or reformed behaviour:

> Freddy is a very good little boy, and it was most touching how he withstood his [alcoholic] Mother's pleading to give her his pennies, as he knew that she would only spend them in drink, and he saved them all up till he had tenpence, and then bought her a packet of tea for Christmas.[103]

> We have a policeman on the ward… Little A sat next to him at table one day and called out to Sister, 'See where I am!' He is only eleven, and has, I think, not been in the habit of associating with Policemen in a friendly way.[104]

Atmosphere

The atmosphere in the other proto-hospices was permeated by religion and it is difficult at this distance in time to evaluate either the sense of peace and alleviation of dread this might bring or, alternatively, the stress and defiance which might be incurred when a patient resisted attempts to bring him or her into the devotional fold. With the usual caveats about internally generated promotional literature, Dr Barrett, writing at the turn of the century declared, 'we are usually cheerful, and have many pleasantries and jokes among ourselves, and are often touched with mild festivity', going on to say that he finds the atmosphere of St. Luke's 'delightful and invigorating' (Goldin 1981:399). The patients, he later claims, when staying temporarily at another home, missed St. Luke's. 'Because you are dying everybody [in the 'new' home] is solemn, and talks seriously. *We never get no fun*.'[105] It is difficult to reconcile

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[103] FSC/AR/1912
[104] FSC/AR/1914
[105] Saunders transcript p 49, 1901, cited in Goldin 1981:399

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Barrett's use of the words, 'pleasantries', 'jokes', 'delightful and invigorating' and 'fun' with the story of the patient, also mentioned in the St. Luke's Annual Reports, who left there c. 1899 because he was 'bored, intensely bored and tired of his unchanging and rather dull surroundings… and asked to be allowed to go out somewhere, he didn't much mind where'.[106]

Commentators frequently report on the prevailing sense of peace at the Friedenheim/St. Columba's but it is impossible to ascribe it to any specific cause. In a way not dissimilar to the religious foundations however, Davidson and Lush attributed the atmosphere to the personal faith of those working there and, on the patients' side, an acceptance of death[107] engendered by a growing awareness of God.[108]

Lush was sometimes asked:

> …if the work at Friedenheim is not very depressing. One is tempted to reply by suggesting a visit to the wards, the usual aspect of which is as bright, I think, as in other hospitals. Some of the patients may be seen playing quiet games in the Day room, or sitting round the fire. Some of the men are in the large conservatory enjoying a quiet pipe, while those who are in bed do not, as a whole, appear to be in any distress.[109]

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[106] Saunders transcript p28, 1899, cited in Goldin 1981:398

[107] cf. Kübler-Ross, 2003:123-146

[108] FSC/AR/MR/1909 Davidson attributed the staff's relative cheerfulness to a belief in the afterlife. On the twenty-fifth anniversary of the home's founding, she wrote: 'During these years over two thousand four hundred Patients have passed through the Wards, of whom nearly one thousand seven hundred have died…. Of the spiritual influence on those inmates one hesitates to speak, but for the glory of God we may say that many, nay most of them, have owned with gratitude that the dark cloud of sorrow and dread has been lifted, and that they have been led into the light and found the peace of God, which passeth understanding. Were it not for this, our hearts would sometimes fail us, when surrounded by suffering such as it is impossible to remove, but the stars of hope shine out brightest in darkness, and we have the assurance "that at evening time it shall be light." We therefore at the close of the old and beginning of a New Year "thank God and take courage." 'FSC/AR/SR/1911

[109] FSC/AR/MR/1906 This is, of course, the institution's own assessment of the patients' feelings.

One of the ways, it was felt, that would encourage tranquillity and ease fear among the patients was the re-creation of home-like surroundings. The Christmas celebrations are a prime example of this, but it is clear that this was intentional:

> While St. Columba's is a Hospital, the aim has always been to make it as much of a Home for our patients as possible; and if strict rules are sometimes relaxed, it is with a view to preserve a home-like atmosphere for those who are sent to us to take care of.[110]

This objective continued well into the twentieth century:

> The great aim of those in charge has always been to avoid anything like an institution feeling, to give each the fullest comfort and help possible, both for their bodies and their souls, and to make it a real home. This was Miss Davidson's aim ever since the foundation of the Hospital over fifty years ago.[111]

Sprott's paper of 1949, discussed elsewhere, recommended for the dying, 'a homely rather than institutional atmosphere' in institutions of no more than fifty beds, since, 'more than that and the homely atmosphere tends to be lost.'[112]

Their success in this mission to create homely surroundings can to some extent be gauged by the comments of family members and observers:

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[110] FSC/AR/MR/1915 Note the ambiguity here. Prosaically, the patients were 'sent' by referring hospitals, but might also be perceived as having been 'sent' by God.
[111] FSC/AR/SR/1937
[112] Sprott 1949:191. Saunders was to reiterate much the same principle in her proposed solution to 'The Need' elaborated in the 1960s (Undated paper: Early 1960; The Need: UoL Saunders' Papers Box 7 1/2/3)

The brother of a patient who was with us fifteen months, writes, "St. Columba's will always remain amongst my happiest memories because of the lovely spirit pervading it. The homeliness and lack of formality are among its most attractive features."[113]

Even during the troubled times before World War II, a visitor remarked, 'Oh, here we find a haven of rest, where there is no strain or fear; it is so different from outside.'[114] Howlett put this down to the efficiency with which everything was organised, '…how smoothly everything has gone forward even in the difficult times.[115] It is due to this that it is possible to maintain the happy spirit of sympathy and love in the Hospital',[116] whereas Sprott gave credit to the staff themselves:

The happy atmosphere that seems to hang about St. Columba's fortunately continues. Generally speaking the courage and cheerfulness with which our patients face their misfortunes is marvellous, and much is done for their spiritual as well as their bodily comfort by members of the regular staff and by voluntary workers.[117]

Although not as frankly hearty as Barrett cited above, the staff at the Friedenheim were nevertheless apparently cheerful and there is no mention in the Council minutes of problems with staff turnover or exhaustion in the face of the undoubtedly difficult work.[118]

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[113] FSC/AR/SR/1935
[114] FSC/AR/SR/1939
[115] Cf. Christopher Saunders, 'Efficiency is comforting' cited in du Boulay, 1984:172
[116] FSC/AR/SR/1942
[117] FSC/AR/MR/1946
[118] Nurses at the Friedenheim/St. Columba's did not benefit from a seaside rest home, as did the nuns at St. Joseph's (Humphreys 1999:250) but they enjoyed the benefits of their own sitting room, garden, tennis court and proximity to Swiss Cottage underground station. Although there is no evidence in the material on hours of work, it is also probable that they did not work the extremely long shifts expected of the nuns.

This atmosphere, calculated to ease the patients' dying trajectory, was even commented on by the official Visitor from the COS in 1936, N. Hugh Smith, who remarked, 'There is an unusual atmosphere about the place of combined cheerfulness and compassion and I cannot imagine a greater Godsend than such a hospital.'[119]

Conclusion

Although care must be taken in interpreting the words and sentiments expressed by the various authors in the Annual Reports, this examination of the non-medical aspects of care at the Friedenheim/St. Columba's, particularly the spiritual side, has revealed the need to amplify previous descriptions of early institutional care for the dying to include a home which was not a religious foundation, nor yet had connections to such a foundation.[120] In spite of her personal faith, Davidson's primary desire to provide a place where people could die led to a difference in the way that religious and spiritual issues were involved in patient management. The home practised a policy of tolerance and religious inclusion both among patients and staff, and care, while encouraging spiritual peace, did not have a defined confessional or denominational purpose. Its independence enabled, and in turn thrived on the confessional differences among the staff who found a welcome there. In consequence it also stands out among the other homes for its lack of proselytising zeal.

The wealth of contemporary descriptions of the Christmas celebrations at the Friedenheim and later St. Columba's reveal an enthusiasm for a, perhaps surprisingly, secular way of celebrating the festival. As well as providing a glimpse of life on the wards at that time of year, the accounts also provide examples of, what might be termed, social concern for patients and families

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[119] LMA/A/FWA/C/D160/2 1898-1943 17.03.1911
[120] References to Mildmay cease around the time of the move to Swiss Cottage (1892) and, even before then, had been limited to the presence of a nursing sister and Davidson's personal involvement with the Mission as an Associate (see p 86).

which is unavailable for the other homes. Consideration of these examples of non-medical care further complements and extends the literature on care of the dying in the early proto-hospices and our understanding of the nature of care offered there.

The Friedenheim then, was not simply an adjunct of a religious mission, but rather an original, and then unique, institution in London, intended solely as a place for individuals approaching the end of their life. Spirituality was nevertheless an important, even essential part of care. Although the moment of death itself was generally expected to be peaceful, faith and religion played, according to medical theory, an important part in assuaging the distress generally experienced following the diagnosis of 'dying' (Munk 1887:21-23, Savory 1863:173). This persuasion continued into the twentieth century, and was recognised by Sprott (1949:190). Spiritually, the institution is also of interest, not as further evidence of clerical compassion and an extension of church control, but rather as an example of the size and longevity of a project conceived and achieved through one woman's personal faith.

CHAPTER 10 – ST. COLUMBA'S, CICELY SAUNDERS AND THE MODERN HOSPICE MOVEMENT

Following the hospital's incorporation into the National Health Service (NHS), the evolution of the Friedenheim/St. Columba's becomes impossible to trace consistently due to the paucity of records. It seems, however, that initially little changed in either location or day-to-day management of the hospital until the mid-1950s when the controlling authority, the North West Metropolitan Regional Hospital Board, became more actively involved with the direction the hospital was to take. This chapter first considers the surviving material and then reviews Cicely Saunders' connection with the home while she was elaborating her own plans for the care of the dying.

10.1 St. Columba's and the NHS, c.1947-1981

Reports and letters of recommendation written by the COS before and during WWII are unequivocally favourable.[1] The King's Fund shared this opinion and, as late as 1946, wrote about, '…a serious lack of hospital facilities for patients in the last stage of illness and enquiring whether the Council were in a position to consider increasing the number of beds at St. Columba's'.[2]

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[1] A/FWA/C/D160/2 1898-1943
[2] SMHA/CMB/VI/157

Before enlarging facilities, however, the future relationship of the hospital with the NHS had to be clarified. Unfortunately, the entire sequence of communications with the NHS can no longer be reassembled, but surviving letters suggest confusion and even perceived helplessness as the Council waited for the Ministry's decision on their management. Called a hospital, it was nevertheless not clear whether caring for those dying formed part of the remit of the new service. In May, 1946, Midwinter attended a meeting convened by the Special Hospitals Association to discuss the situation, which was not unique to St. Columba's,[3] and afterwards lobbied various MPs, pleading that the 'special nature and exceptional position of St. Columba's Hospital' should allow it to retain control of both funds and patient management.[4] He wrote:

> This hospital has for 60 years given invaluable service to patients without distinction of creed or class and also to their relatives…[5] [Control of the hospital and its endowments, under general governmental guidance,] should be left to those who know by experience what our patients need – bodily, mentally and spiritually. All this involves not only comfort of body and relief from pain, but that personal kindness, sympathy and understanding which can surely best be afforded by those who, with a sense of vocation, have the cause of the hospital and all it stands for at heart and give it their enthusiastic service.[6]

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[3] SMHA/MB/V:152 It is not clear who else attended this meeting.

[4] SMHA/MB/V:152 The minutes go on to record that, 'a copy had also been sent to Mr. Abel-Smith who asked to see it as he was interested in the Hostel of God, a similar hospital to St. Columba's.'

[5] Ironically, the ecumenical nature of care given to the patients removed one justification for continued independence since the hospital could claim no Church-related links to justify maintenance of its Christian character and independent status. The National Health Service Act of 1946, Clause 61 states, 'Where the character and association of any voluntary hospital transferred to the Minister by virtue of this act are such as to link it with a particular religious denomination, regard shall be had in the general administration of the hospital and in the making of appointments to the Hospital Management Committee to the preservation of the character and association of the hospital.' Cited in Sims 1996:xii

[6] SMHA/MB/V/155

The confusion intensified following Midwinter's death early in 1947, but his successor, Lord Amulree,[7] continued to seek clarification, writing to the Minister of Health in April, 1947 to inquire whether, '…the Hospital's function as home for the dying means it will come within the framework of the NHS or not'.[8] Minutes suggest that the Management Council feared that by losing financial independence and control over its particular approach to care, the character of the hospital would inevitably change for the worse.[9]

Later that year, however, St. Columba's came under the control of the NHS under the North West Metropolitan Regional Hospital Board, Paddington Group (21) Hospital Management Committee[10] with clinical direction through St. Mary's Hospital, Paddington. Amulree sent letters attempting to negotiate the right of the hospital to appoint staff[11] and suggesting the creation of a special House Committee to manage its affairs,[12] apparently without success. A final meeting of the Council was held on 9th July, 1948 when it was recorded that all the assets of the hospital had been handed over to the Ministry of Health.[13]

It would seem that, initially, little changed[14] and it can be supposed that the Paddington Group initially concentrated on larger institutions offering curative medicine.[15] An extraordinary extension of the lease was negotiated and St.

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[7] Little is recorded about the appointment of Lord Amulree, the geriatrician, who was later to be briefly involved with Saunders at the inception of St. Christopher's.

[8] Amulree's use of the word 'home' may already have raised questions about the comparative funding responsibilities of health or social services where cure was impossible. See Clark 1999a *passim* and Harris 2004:296-297.

[9] SMHA/MB/V:152, 164, 165, 167, 170, 173

[10] In 1974, it then became subsumed within the North West Thames Regional Health Authority, North West (Teaching) District Health Authority.

[11] SMHA/MB/V/170

[12] SMHA/MB/V/173

[13] SMHA/MB/V Loose, unnumbered pages in back of Minute Book.

[14] With one exception, discussed later, all further information about St. Columba's Hospital has been derived from external sources which include the King's Fund, the Saunders' archive and national and local press.

[15] HL/H362:42 The Group was responsible, for example, for the 600-bed Paddington General, whereas at that time, St. Columba's offered 40-50 beds and, of course, could offer no 'cure' to its patients.

Columba's continued to occupy the Avenue Road premises until 1956.[16] Six years after takeover by the NHS, a King's Fund Report[17] dated June/July 1952 found:

> The Hospital for the dying, founded in 1880 [sic], seems still to retain its individual atmosphere. Its work remains unchanged and is carried on in an atmosphere of quiet cheerfulness which is as remarkable as it is difficult to convey on paper. The matron has a missionary outlook and is an inspiration to her staff. The strong religious atmosphere, which is reflected in the texts on the walls, remains unaltered by the NHS. It apparently did not lack for any money as a voluntary hospital and does not now seem to have any serious need. We thought perhaps that there was too much linoleum and too little carpet in the Nurses' Home, but the staff, both nursing and domestic, who seem to stay for a long time, seemed quite happy. Some of the assistant nurses and domestic staff have been there for 25 years. The building is in an adapted house which is held on the tail end of a long lease. Its future is uncertain but as the Hampstead Borough Council want[s] the site in order to build a new Town Hall it will have to move one day.[18]

Five key points in this report deserve emphasis. Six years after takeover by the NHS, St. Columba's continued as a hospital for the dying; the atmosphere was one of 'quiet cheerfulness which is as remarkable as it is difficult to convey on paper'; the 'strong religious atmosphere' remained; the staff were long-serving and happy and finally the institution did not lack for money. Little would appear to have changed since the pre-NHS days under Midwinter.

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[16] SMH/MBVI/1947:165. The Avenue Road building was eventually demolished in July, 1958 (HL/HHE/11.07.1958)
[17] Authored by Dr G. F. Abercrombie and Dame Katherine Watt
[18] A/KE/735/41/1:61:5

The hospital had to move in 1956, however, when Camden Council took over the site. This seems to have been the catalyst for major changes in the direction of the hospital, exacerbated by the retirement or resignation of three key players on the staff: the Medical Director, Norman Sprott, who resigned in 1954;[19] Matron Olive Howlett; and Assistant Matron Eva Burchett; both of whom retired, '…just before the transfer of the hospital to its new premises' in 1956.[20] Howlett's state of mind is hinted at in a letter from Saunders to her brother Christopher in 1960:

> I have watched…St. Columba's starting off with the right spirit and the right people and then gradually changing in character… I won't bother you with the whole story of how the Matron and Assistant Matron have retired after having no consideration at all given to their feelings about the choice of the new building etc, nor the fact that the £70,000 given by other people for rebuilding were really swallowed up by the machinations of the Hospital Management Committee (Saunders 1960, cited in Clark 2002a:35).

Saunders at that time knew Howlett (see below) and could well have been privy to her feelings about the new premises chosen for the hospital.

In light of the apprehensions expressed by St. Columba's Executive Committee,[21] it is tempting to speculate whether this defection from the hospital was due to a certain disaffection with the newly imposed management and principles. In the absence of any evidence, it must, however, remain just speculation.

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[19] HL/H362:23
[20] HL/H362:23
[21] SMHA/MB/V:152, 164, 165, 167, 170, 173

Nothing about St. Columba's exists in the NHS Paddington Group's own records,[22] but letters from them requesting financial help for the purchase of the new hospital buildings are in the King's Fund archives.[23] C.R. Jolly, of the Paddington Group, wrote on 23 July 1954, to the King's Fund, reminding them that the current site was scheduled for demolition, adding:

> You will probably remember that this hospital is for advanced cancer patients[24] whose prognosis of life on admission is a few months only. I believe you have visited the hospital so there is no need to describe the splendid work that is done there and the spirit in which it is undertaken.[25]

The Paddington Group was considering re-housing St. Columba's in 'The Elms', a large estate on Hampstead Heath.[26] The building, they thought, would accommodate 45 patients and 17 staff. Jolly outlined their plan which involved selling four to five acres of the 12.8 acre site to the LCC to defray outlay. The asking price was £60,000, the Treasury was willing to advance £15,000 and:

> …my Committee is willing to provide £25,000 from Free money earmarked for St. Columba's Hospital.[27] Adaptations would cost about £10,000 and additional equipment about £5,000. The total net cost is therefore approximately £60,000 but some land would be offered to the LCC for which we might get £2,000 or £3,000. My Committee has in consequence to find about £17/18,000.[28]

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[22] Personal communication from Kevin Brown, Archivist of St. Mary's Hospital, October, 2007
[23] LMA/A/KE/735/41/1
[24] This seems to imply that St. Columba's now no longer admitted those presenting with other conditions.
[25] LMA/A/KE/735/41/1
[26] See Figure 5.5 p 114
[27] The White Paper of March 1946 outlined the administrative arrangements envisioned under the NHS. 'The endowments of the hospitals for which the regional boards were to be responsible were to be removed from the individual hospitals and handed over to a central Hospital Endowment Fund to be controlled by the Minister [of Health]' Abel Smith 1964:478
[28] LMA/A/KE/735/41/1:107

Privately, the King's Fund Distribution Committee, meeting in July 1954, resolved to donate £5,000 for equipment[29] though they mentioned no specific sum in their reply to Jolly on 03 August, 1954. In this letter,[30] they made clear that they would not contribute to the purchase of the estate, but offered a grant of an unspecified amount towards, '…the necessary equipment should the scheme in fact take place'.[31]

Responding perhaps to the implicit doubt expressed by the King's Fund, Jolly reported substantial progress early the following year as the Minister had approved the purchase of 'The Elms'. He took this opportunity to press for financial assistance, reiterating that the Paddington Group itself was contributing £25,000 from, 'non-exchequer funds'[32] and adding that:

> Consideration is now being given by the North West Metropolitan Regional Hospital Board to the provision of capital monies in relation to the adaptation of the premises and money now has to be found for additional equipment.[33]

Could they help?

The King's Fund Visitor's Report from 1952 (three years earlier), cited above, is inserted in the Fund's files at this point, perhaps suggesting that Fund officers wanted a copy of this to hand while considering their reply to Jolly. In October 1955, Jolly sent the Fund a list of requested 'additional equipment' and notified them of their intention to open the new premises in June 1956. The 'additional equipment' included beds, bedpans and curtains for the wards, equipment for the nurses' bedrooms and dining room, the kitchen, the domestics' dining

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[29] LMA/A/KE/735/41/1:108
[30] Written by a Mr. Pears
[31] LMA/A/KE/735/41/1:109
[32] LMA/A/KE/735/41/1:111
[33] LMA/A/KE/735/41/1:111

room, chapel, garden and domestics' bedrooms which would cost an estimated grand total of £5,964.2.0d.[34]

These requests were refused outright at a Distribution Committee meeting on 29 November, 1955 which felt that these items were in fact basic equipment which it was the responsibility of the Regional Board to supply. The feeling of the meeting was that once the Regional Board had supplied the necessities, they might assist towards, for example, the purchase of a piano.[35]

The reason behind the change in feeling within the King's Fund evidenced by the proposed drop in financial support from £5,000 to 'assistance' towards the purchase of a piano remains unexplained. Nothing more appears in the Fund's files until a report by their Visitors, Dr G.F. Abercrombie and Sir Desmond Morton, in March, 1957. This reinforces the reluctance and certain lack of confidence hinted at in the earlier documents as well as the unwillingness of the Fund to support the hospital in any substantial way. The report stated:

> St. Columba's Hospital (29 beds)
> This hospital has been moved from Swiss Cottage to a large house on Hampstead Heath, once owned by a Woolworth. The property cost £40,000 and houses 29 patients in magnificent but inconvenient rooms. Our feeling is that this house with superb views from the windows and its fine lawn, grounds and outbuildings are quite inappropriate for the use now being made of them. Surely they should be for the benefit of those who will recover and go out rather than for those who have no hope of going out in the future.

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[34] LMA/A/KE/735/41/1:116 The inclusion of equipment for a chapel in the list of 'requirements' is, of course, of interest since the hospital had never previously had a chapel. Unfortunately, it is not known whether or not this became one of the new facilities.

[35] LMA/A/KE/735/41/1:119 It should be noted that the King's Fund had originally offered to contribute to 'necessary equipment', but somewhere this became re-interpreted as 'additional equipment'.

It might be used as a small recovery home, which would, however, be wasteful of space. The proper use of it would seemingly be to build on to it a hospital with operating theatre and other adjuncts, using the existing house for offices, board rooms, nurses' dining rooms and quarters for the resident hospital officers. Otherwise it is hard to see what value it can have to the Health Service. In fact, unless some such long range scheme is in mind, the purchase would seem to be a waste of public money.[36]

This is the final entry under St. Columba's Hospital in the King's Fund archives.

The conclusions of this damning report are indirectly supported by the Triennial Report of the Paddington Group No. 21 Hospital Management Committee itself, which covers the years 1954 to 1957.[37] The publication covered all hospitals under its care and included a photograph and half page report on the new site of St. Columba's Hospital. The picture[38] shows a large, multi-storeyed and gabled building in extensive and elaborate grounds. The accompanying text, however, pointed out that:

It had been hoped that accommodation would be provided for 40-50[39] patients but the decision not to instal [sic] a bed lift meant that all the patients had to be accommodated on the ground floor and hence the bed complement was reduced to 35.[40]

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[36] LMA/A/KE/735/41/1:122:6

[37] This document followed a decision by the Paddington Group to issue Triennial Reports, but only a single copy survives in the Holborn Public Library, and there are none in St. Mary's Hospital archives, confirmed by Kevin Brown, see above.

[38] Reproduced on p 114

[39] There are, of course, discrepancies between the number of beds proposed in Paddington's initial estimates made to the King's Fund (45), the number they claimed to be expecting here (40-50), the reported actual number (35) and the number found by the King's Fund Visitors (29) (see above). The report discussed below found in St. Christopher's Hospice reported 28 beds.

[40] HL/H362:23

This change in location and clinical management appears also to have led to a change in atmosphere. Doris Baker, who continued to work at St. Columba's after the move, reported that the appointment of a new Matron after Howlett's retirement, as well as the relocation itself, led to major changes in mood among staff and patients. Unthinkable under the old regime for example, she was reprimanded for giving a glass of water to a patient, not on medical grounds, but because it was not her place, as ward maid, to do so. Domestic staff were refused permission to enter the nurses' rooms even if invited. Miss Baker was therefore denied the possibility of attending the weekly prayer and Bible study meeting held by one of the Sisters which she had attended for several years. These are, of course, her personal reflections and she was extremely bitter about the transformation of her 'home'[41] to a hierarchically structured institution.

With the exception of the King's Fund and Paddington Group reports noted above, no hospital records survive after the move to Hampstead Heath. The hospital nevertheless existed for a further twenty-some years and financial data which might have explained the discrepancy between Howlett's understanding of St. Columba's financial reserves (£70,000) and those 'earmarked' by the Paddington Management Committee (£25,000) would have been particularly interesting.

By the late 1970s, however, rumours about the hospital's closure started to circulate in the local press.[42] The building's unsuitability as a hospital had apparently never been remedied, and little appears to have been spent on maintaining the fabric of the building.

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[41] It should not be forgotten, that without any other family, St. Columba's was perhaps more of a 'home' to Miss Baker than to some of the other staff.

[42] HL/HHE 24.08.1979. For a detailed analysis of the complex strategic issues facing London hospitals and the rationalisation of NHS services at a time of national economic difficulty, see Geoffrey Rivett, at http://www.nhshistory.net/strategy_&_stringency.htm (accessed 07.2007 and 05.2011).

The cost of making it viable and fit for purpose would by then have been, depending on the source, between £350,000[43] and £1 million.[44] There is some discrepancy, therefore, with the report held at St. Christopher's whose author described a 'large new airy dayroom' which had just been built (see p 115).

An article in the local newspaper, the *Hampstead and Highgate Express* (HHE) in August, 1979, reported a campaign to save St. Columba's under the headline 'Forces muster to save St. Columba's'. For the next eighteen months, this and other local papers recorded rescue plans, setbacks, hope and disappointment as schemes to save the hospital, some led by their local Member of Parliament, Geoffrey Finsberg, ultimately failed.[45]

The local press suggested that a proposed 'temporary closure' in 1979 was deliberate dishonesty on behalf of the Ministry aimed at avoiding the statutory consultation procedures necessary for permanent closure.[46] Further, they indicated that the authority had already 'begun to run down the unit' which now contained only 17 patients and reported that the visiting G.P.[47] had been encouraged to take early retirement.[48]

Growing public awareness of Saunders' hospice movement and the needs of the dying may have encouraged the various rescue campaigns. Only fourteen years after the opening of St. Christopher's Hospice, a letter to the Editor of the HHE pointed out the folly of closing the hospital at a time when a working group on terminal care had recommended that, '…every Regional Health Authority should plan for terminal care'[49] and St. Columba's was even called a 'hospice'.[50] In

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[43] HHE 31.10.1980
[44] *Morning Star* 28 Oct, 1980
[45] HL/HHE see, for example, 22.1.1980, 31.10.1980, 07.11.1980, 02.01.1981
[46] HHE 22.08.1980
[47] Dr John Etheridge
[48] HL/HHE 22.08.1980
[49] HL/HHE 29.08.1980
[50] HL/HHE 24.07.1981

August 1980, however, the Minister of Health, Dr Gerard Vaughn, decided to close the hospital.

Opposition nevertheless continued and the closure did not proceed without incident. When the services of the locum consultant, Dr Philip Hopkins, were dispensed with in October, 1980, the HHE linked this with a television interview he had given:

> Dr Hopkins had been employed there since last September on a weekly basis. Last Friday he spoke out against the closure of St. Columba's on television. On Monday he received a letter from St. Mary's telling him his services were no longer required as there were so few patients left there.[51]

Other members of staff belonged to the National Union of Public Employees (NUPE) which rallied in their defence. When it became clear that dying patients were to be transferred to another location in order to vacate the premises, the hospital gates were picketed, and NUPE ambulance drivers refused to cross their lines. The gates were then soldered open by the district works department to enable access by private ambulances, supplied by a company called Medicare, which had been hired by the Kensington, Chelsea and Westminster Health Authority to move the patients. The closure became the subject of headlines again when a Union official was hit by one of the private ambulances and needed hospital treatment.[52] Medicare's ambulance drivers then refused to re-enter the premises and the sole remaining patient remained in St. Columba's, allowed to die in peace. The building and lands were then put up for sale[53] and eventually sold for development. The funds gathered by Midwinter to assure the future of St. Columba's had apparently been spent on a building which was

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[51] HL/HHE 24.10.1980
[52] HL/HHE 21.11.1980, HL/SPC 21.11.1980
[53] A copy of the real estate agent's sales brochure can be found in St. Mary's Hospital Archives (SMHA/CF/18).

costly to run, had not been maintained and was demonstrably not suitable for the purpose for which it was bought. St. Columba's had changed from being a 'Godsend' to a 'waste of public money'.

These unedifying struggles over the last patients characterised the final months of London's first proto-hospice. The Department of Health neither transferred St. Columba's to new premises nor merged it with another institution, but finally closed its doors in 1981.

10.2 St. Columba's and Cicely Saunders

Saunders always acknowledged her debt to the early homes for the dying (Clark 1998, Saunders 1988, 1992a, 1996b, 2001a, 2005b) but her more detailed remarks were reserved for the two homes she knew best, St. Luke's and St. Joseph's (Saunders 1962, 1988, 1996a, 2001a, 2005b.) Saunders volunteered as a nurse at St. Luke's Hospital for the dying in addition to her work as an almoner (medical social worker) elsewhere, observing and obtaining first-hand experience of the care of those terminally ill. After gaining her medical qualifications, Saunders obtained a research scholarship specialising in pain in the terminally ill (du Boulay 1984:69), drawing on her work at St. Joseph's Hospice for many of her case studies. Containing statistically relevant conclusions on a large number of patients, this research formed the basis for much of her early published work, generating generalised interest in, and acceptance of, palliative care in the medical profession for the first time.

Saunders' references to the Friedenheim/St. Columba's by name are few and in passing (Saunders 1958, 2005b), from which it could be assumed that she had either no, or little contact with the home. Given her demanding and all-encompassing search for available information on the dying process at that time (the late 1950s) (Clark 1998, du Boulay 1984), it was inevitable, however, that

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she knew about St. Columba's and the people who worked there. Surviving documents were therefore examined to establish the extent of any contact that might have existed. They revealed a slightly closer connection than might at first have been expected. The various sources are considered separately below, followed by some tentative conclusions and speculations.

Publications

In early published works, Saunders' frequently used case studies to demonstrate the points she was making, drawing theoretical or general points together in the conclusion (see for example Saunders 2006: 1, 13, 17, 41). The only mention of St. Columba's in a specifically medical publication by Saunders occurred in her first paper, 'Dying of Cancer', which appeared in the *St. Thomas's Hospital Gazette* in 1958. The first case she described in this paper was that of 'Mr. S.' who died while at St. Columba's. Along with a description of his condition, its evolution and his family circumstances, Saunders wrote of his drug regimen at St. Columba's, which left him, 'alert and fairly comfortable when visited there' (Saunders 1958: 37). 'Mr. S.' had originally been a patient at St. Thomas's, as were the remaining three examples cited in that paper. Later in the same paper, Saunders extensively (some nineteen lines) cited the opinions of Dr Sprott,[54] who had then been St. Columba's Medical Director, including his 1949 paper, also called 'Dying of Cancer', in the bibliography (Saunders 1958:41ff). She appeared to value Sprott's observations and respected his opinions which were based on his experience of caring for the 200 patients who died yearly. Saunders emphasises the inclusiveness of St. Columba's, although it is not clear whether or not it was the implied exception ('nearly all') when she wrote, 'It is significant that nearly all the Homes [for the dying] are run on a religious basis… [Although] Mr. S., the atheist publisher, was happy at St. Columba's, an atheist to the end (Saunders 1958:42).'

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[54] Sprott had retired to Jersey in the Channel Islands c. 1954.

Saunders had also referred to Sprott's paper in her unpublished thesis[55] and cited his work in the bibliographies of later publications at least five times.[56] In *The Management of Patients in the Terminal Stages*, Saunders also thanked St. Joseph's and St. Luke's by name and 'the other terminal care hospitals in London for their inspiration and help' (Saunders 1960a:416).

It is evident from the above citations that Saunders not only knew of the work carried out by Sprott and St. Columba's, but that she had also visited the hospital when following up on 'Mr. S.'. Saunders' personal diaries were therefore examined in order to ascertain whether this had been a regular occurrence.

Diaries

Some of Saunders' personal appointment diaries for the period under discussion, i.e. before the opening of St. Christopher's Hospice, survive and were placed by her in the King's College Hospital archives. Those for 1949, 1950 and 1951 are missing but that for 1948 is there, as are those for 1952-1967 and beyond.

A key event in the inception of the hospice movement was the death of Saunders' patient and friend, David Tasma (du Boulay 1984:54-59ff, Clark 1998, Saunders e.g.1996b). Saunders' diaries reveal that even before Tasma's death on 25th February, 1948, she had visited both the Hostel of God (on 23rd January) and St. Columba's (on 14th February) that year. These homes were, therefore, known to her before she offered her services to St. Luke's, '…within days of David's death' (du Boulay 1984:60).

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[55] UoL IOELC Saunders' papers Box 1 1/1/8
[56] Saunders 1959a, 1960a, 1960b, 1961, 1967

It is particularly unfortunate that the diaries for the years 1949 to 1951 are missing, as later volumes record a minimum of eleven further visits to St. Columba's between 1952 and 1956. Saunders visited St. Columba's once in 1952, twice in 1953, four times in 1954, once in 1955 and three times in 1956. Some entries referring to appointments at St. Columba's have been crossed out or partially erased. The diaries contain personal reminders and it is possible that visits to replace those crossed out may have taken place without the new date or time specifically having being written down. This compares with two documented visits to the Hostel of God, one, as mentioned, in 1948 and another in October, 1960 over the same period. The last firmly documented visit took place in 1956, the year St. Columba's moved to its new premises and two years before Saunders' first published work on treatment of the terminally ill. Evidence cited below demonstrates that her connection, at least with some staff, continued beyond this date.

The 'Memoranda' section at the back of the 1954 diary contains an extensive list of the drugs and prescribing practice at St. Columba's, suggesting contemporaneous notes taken on one of her visits that year.[57] This list may have informed the table Saunders was to draw up for comparison purposes, undated but perhaps sometime in the 1960s, of the drugs used at four homes for the dying.[58] Medication used at St. Columba's is listed there in some detail and includes treatments not documented in the 1954 list, indicating yet further investigation of treatment options there.

After 1957, Saunders took to abbreviating the names of some of the locations she was to visit. There are, for example, some references to 'S.C.H.' (or possibly S.L.H., the writing is not clear) in 1959 and 1961. Although frequently referring to St. Christopher's as 'S.Ch.H', the likelihood is that frequent later entries (1961 – 1969) of 'S.C.H.' refer to St. Christopher's, not St. Columba's.

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[57] There are no similar entries for other homes.
[58] UoL, IOELC Box 1 1/1/1

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The diaries all contain a list of telephone numbers at the front or back. No reference to St. Columba's, Sprott or Howlett was found, suggesting that whatever the connection with St. Columba's and its staff, that connection was not sufficiently frequent to warrant repeated telephone contact. It should be noted, however, that telephone numbers for St. Luke's and St. Joseph's appear for the first time only in the 1959 diary, although her close connection with the two institutions had existed for over ten years.

One final point of possible interest is the visit scheduled for Monday, 30th August, 1954 which has the name 'Tom' written against it. It is possible that 'Tom' refers to the resident chaplain, Tom Law, known to all[59] as 'Uncle Tom'. This visit occurred around the time when Saunders had begun to explore the nature of spiritual, Christian care of the terminally ill (du Boulay 1984:94), and suggests that Saunders might have consulted him about the spiritual welfare of the patients.[60]

Both Mrs Rudall and Miss Baker independently remembered Saunders visiting St. Columba's and 'spending the day there'.[61]

Letters

Saunders kept much of her extensive correspondence. There are however, clearly lacunae in the existing collections at the Universities of Lancaster and King's College, London where surviving documents refer to letters, now missing, between Saunders and two senior members of staff at St. Columba's: Olive Howlett, the Matron and Norman Sprott. Surviving letters support the diary

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[59] Conversation with Freda Rudall. 'Uncle Tom' was apparently an elderly Anglican clergyman who lodged in the small upstairs apartment once reserved for the Superintendent.
[60] The name Tom is not, of course, unusual and it is known that Saunders had close friends of that name. In this diary entry, however, the names' St. Columba's' and 'Tom' are closely juxtaposed as though linked.
[61] Conversations with Freda Rudall and Doris Baker.

evidence of a connection between St. Columba's and Saunders, and show that this connection was closer than merely that between informed professionals.

The correspondence with the late David Rudall, part-time voluntary chaplain and family friend of Olive Howlett, relates primarily to the preservation of the early documents concerning the Friedenheim.

Olive Howlett

Only one of the letters between Saunders and Howlett has been discovered (see below), but reference to previous communications between the two was made in a letter Saunders' wrote to her brother Christopher in 1960 (Clark 2002a:35). Saunders had been undecided for some time about the basis for her projected home for the dying, particularly the extent to which it should be a religious or a medical foundation (Clark 1998:46, du Boulay 1984:94-101). This letter, part of which was cited above (p 263), is of particular interest therefore, as it is indicative of the way she was gradually rejecting the idea of a religious foundation for a medical one. It should be remembered that although St. Columba's was not a religious foundation in the same way as St. Joseph's, the Hostel of God or even St. Luke's, Howlett was extremely devout and the King's Fund Visitors had found a 'strong religious atmosphere'.[62] This letter also incidentally hints, perhaps, at one of Saunders' underlying reasons for establishing St. Christopher's as an independent institution outside the NHS:

> I am still not completely happy about the religious foundation… what makes me particularly anxious about this all the way through is that I have watched both St. Luke's and St. Columba's starting off [in the NHS] with the right spirit and the right people and then gradually changing in character (Letter to Christopher Saunders written 1960, cited in Clark 2002a:35).

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[62] A/KE/735/41/1:61:5

Some four years later, in a letter to Rudall, Saunders calls Howlett and Burchett her, 'friends… late of St. Columba's Hospital' (Clark, 2002a:65), suggesting that they were still in communication with each other. In spite of the title 'friend', Saunders' diaries do not mention appointments or meetings, although references to a 'Miss H.' abound. After leaving St. Columba's, Howlett and Burchett set up a Home for retired Christian workers called Troutstream Hall in Rickmansworth, now a home for the elderly. One diary entry was found for Troutstream Hall which Saunders had planned to visit on the afternoon of Saturday, 27 April, 1957. Although this entry was crossed out, Christine Kearney (see below) volunteered that Saunders did, in fact, sometimes visit Troutstream Hall for spiritual refreshment.

The letter to Howlett in the IOELC implies a closer relationship between the women than could be surmised from the previous communication and diaries. Dated 8th March, 1960, Saunders wrote:

Dear Miss Howlett,

Thank you so much for your circular letter… I would very much like you and Miss Burchett to have [copies of her series of articles in the 'Nursing Times'] with my compliments and my thanks for what I have learnt from you and St. Columba's in the past. I know that you scarcely ever have time to write letters; perhaps I shall have a chance to come and see you and hearing [sic] your comments and criticisms. I am also enclosing a scheme which I have been planning and praying for for some months now. I do believe the Lord is leading me to found a new Home, and is gradually introducing me to people who can help in its foundation. The question of the religious basis, and the way in which we are going to work together as a community after it is founded, are problems which need a great deal of thought quite apart from the immense work of drawing up the terms of the trust, attracting enough eminent people and raising the very large sum of money involved. Again, I think I shall

need to come and see you to discuss some of these problems. Perhaps I could telephone you one day?[63]

If Howlett replied to the letter, it has not been found.

Norman Sprott

Saunders last cited Sprott's paper in the late 1960s and she had continued writing to him after his retirement in 1954. Two letters from Sprott have survived as well as a copy of one from Saunders.[64] All indicate that others, now lost, existed.

In her letter dated July, 1963, Saunders referred to the fact that she had heard from Miss Howlett (i.e. three years after the letter cited above) that he, Sprott, was keeping well and she wrote, 'I still have your reprint and refer to it and try to remember what I learnt from St. Columba's – now rather a long time ago';[65] further evidence of her appreciation of the opportunities afforded by her visits to St. Columba's to observe and learn about the care of the dying. Sprott's letters contain mainly family news but a warm admiration and respect appears to have been mutual.

David Rudall

A different sort of connection existed between Saunders and Rudall. Clark, in his collection of Saunders' letters, reprints two letters, one to Rudall and the other to Professor Dr F.J.J. Buytendijk, the philosophical anthropologist Saunders had met in Holland who was interested in the terminal phase of life (Clark 2002a:65-66). As described elsewhere (Chapter 2:38), on her departure from St. Columba's, Howlett passed many early Friedenheim papers to Rudall for

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[63] UoL OELS Saunders' papers Box 27 1/4/8
[64] UoL IOELC Saunders Papers Box 27 1/4/10
[65] UoL IOELC, Saunders papers Box 27 1/4/10

safekeeping, knowing that he possibly intended to write a short history of the hospital. Saunders wrote to Rudall on 7th January, 1964, asking him to forward, 'anything in print or any notes' (Clark 2002a:65). He had evidently not replied by 16th January when she wrote to Buytendijk:

> There is another Home founded by an evangelical Christian lady at about the same time. The Home itself has no records of its founding now as it has been taken over by the Health Service. The late Matron has put me in touch with someone who was going to try and write a history but I have not had any reply to my letter to him so it looks as if I am not going to be fortunate there (Clark 2002a:66).

Rudall did, in fact, reply the following day when he explained:

> I collected a whole heap of scribbled notes, mostly of a personal nature, together with the early reports of the work.[66] The hospital itself became very dear to me while I was working in the area, and its work seemed so remarkable that I determined that some record should be made. My object was to show the hospital as a direct work of God on behalf of patients in the final stages of T.B. and cancer, for whom no other satisfactory arrangements were available.[67]

They communicated sporadically throughout 1964. Having gone through his material, Rudall sent sixty pages of his draft of the history of the Friedenheim to Saunders in April (now lost), together with a copy of Streetly-Smith's *The Story of Friedenheim, 1885-1915*.[68] Saunders did not return them until September that year and although Rudall's style had obviously not found favour, she

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[66] According both to Mrs Rudall and other members of the family, these notes no longer exist.
[67] UoL IOELC Saunders papers Box 15 1/2/98
[68] UoL Saunders papers Box 15 28.04.1964

commented on the fact that the Friedenheim made, 'a good story!'[69] Rudall's proposed history of the Friedenheim/St. Columba's was never completed.[70]

Forty years later, Saunders played a crucial role in the preservation of information about the Friedenheim/St. Columba's. Terminally ill with cancer, Rudall begged Saunders to take care of the records entrusted to him by Howlett. In a letter dated 19th May, 2002, he wrote:

> What I ask now is that you will, out of the goodness of your heart, use your influence to have the St. Columba's records stored with those of your other work, so that they will not be lost to posterity. The physical amount is not large – one big parcel.[71]

Saunders, by now frail herself, wrote back, suggesting that the parcel be sent directly to Professor David Clark, who was already undertaking his History of Hospice project at the University of Lancaster. It arrived there in 2002 after Rudall's death, and its contents constitute the main source of information about the early days of the Friedenheim.

Christine Kearney

In addition to the textual evidence described above, Christine Kearney, PA to Saunders between the 1970s and 2005 provided the following recollection of Saunders' involvement with St. Columba's. Prompted with the name Olive Howlett, Kearney volunteered that Saunders had been 'in the habit' of visiting Troutstream Hall and Howlett for a 'recharging of batteries' although she later preferred to go to St. Julian's for spiritual retreats.[72] Kearney could not

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[69] UoL Saunders Papers Box 15 17.09.1964
[70] Conversation with Freda Rudall, 25th May, 2007
[71] Copy of letter provided by Mrs Freda Rudall
[72] Conversation with Christine Kearney, 22 April, 2008

remember the number of times Saunders had visited Troutstream, but suggested it was, 'occasionally,' rather than frequently.

Kearney further stated that Saunders had hoped to emulate Olive Howlett when she opened St. Christopher's. She 'admired Howlett very much' and particularly appreciated the way Howlett, 'had a grip on everything that happened at St. Columba's'.[73] The name of Norman Sprott failed to evoke any memories.

Conclusions

Saunders' connections with the work at St. Columba's took place in the formative years surrounding Tasma's death in 1948 and before the opening of St. Christopher's in 1967. During this time she was elaborating the approach she was to take towards the care of the terminally ill within what was to become known as the modern hospice movement.

Saunders never worked at St. Columba's as she did at St. Luke's and St. Joseph's but nevertheless she did visit the hospital and maintained contact over a period of at least sixteen years with those primarily responsible for patient care: the Medical Officer and Matron.

Kearney's evidence suggests that Saunders particularly respected the work of the Matron, Olive Howlett and the one surviving letter from Saunders to Howlett supports this interpretation. Howlett was an older woman than Saunders and was at that time much more experienced than her in both the care of the dying and the management and administration of a home for the terminally ill. Saunders twice reiterated in her letter that she would like to hear Howlett's opinion on both her, Saunders', work and plans for what was to become St. Christopher's Hospice, suggesting they either meet or telephone.

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[73] Conversation with Christine Kearney 22 April, 2008

Sprott's 1949 paper, 'Dying of Cancer', which has some relevance even today (see Chapter 8:197), was known to Saunders and cited in her early publications. In it, he covered pain and symptom management, treatment of the mind and the individuality of each patient. He touched on the social needs of the residents and the importance of their surroundings, describing the ideal environment, in his opinion, for care of the terminally ill. He also proposed the establishment of scattered homes for the dying which should not be 'buried in the country' (Sprott 1949:191) but conveniently situated where means of communication are good. The drug regimen at St. Columba's bore comparison with those at St. Luke's and other homes in London;[74] opiates were given as needed and patients did not have to 'earn' their relief (Sprott 1949). The tenor of their surviving letters suggests that the two had met and conferred on patient management and care.

The above points indicate that, whether positively or negatively, Saunders cannot fail to have been influenced to some degree by the experience of St. Columba's. That she never explicitly acknowledged this in print may be an indication that this influence was only minor or simply that it was very much less than that of St. Luke's and St. Joseph's. Saunders' 1960 letter to her brother, cited earlier (p 263), might even be taken to imply that she held no high opinion of St. Columba's under NHS management. By the time Saunders was writing in the 1960s, of course, the nature of St. Columba's had apparently changed (see p 114 and 197) and it had become 'simply' another home for the elderly dying and had possibly lost its unique purpose and ethos. Saunders was planning for the future and St. Columba's was already part of the past. Although she therefore perhaps had a personal debt to the people involved, the hospital as such could no longer be considered an exemplar of the type of institution she would create. A certain deliberate distancing from the early homes was also a calculated part of Saunders' policy in order to enhance the general applicability of her ideas. In a paper authored in 2003, she explained: 'The aim of moving

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[74] UoL, IOELC Box 1 1/1/1

away from the few early charities and the National Health Service was to demonstrate practices that could be applied both in those systems and more widely,' an indication of her desire that the ideas and practice associated with hospice care could and should gain recognition nationally and even internationally.

CHAPTER 11 – RESULTS, DISCUSSION and CONCLUSION

This research undertook to describe the work of the Friedenheim/St. Columba's Hospital, Home of Peace for the Dying, to locate it temporally and geographically and, through examination of contemporary reports and comments, test the hypothesis that it was the first institution offering dedicated and compassionate care for the dying in London. The origins of the home and the approach to care offered there were sought in the background, motivation and philosophy of Frances Mary Davidson, its founder. The constraints and actions of those responsible for the management of the home were then considered, as well as the administrative difficulties they faced. Two issues proved to be of particular interest, the financial management and planning at the home, and the successes and problems of charismatic leadership. In addition, the hospital's relocation, by the NHS, to expensive and inappropriate premises in 1958, suggested an important element in the institution's ultimate failure to survive.

An examination of available information about the patients showed not only the numbers who had been treated and died there before 1947, but also some of their ages, occupations, nationalities, religions and underlying medical conditions. The surroundings and evolution of care practice towards those dying at the Friedenheim/St. Columba's was then explored, particularly as it related to clinical and spiritual care. Finally, links with Cicely Saunders and the 'modern' hospice movement were described and considered.

Research results support the thesis that the Friedenheim/St. Columba's was the first institution in London to provide care dedicated to dying individuals. As such, it typified voluntary organizations in general, which tend to be at the forefront of social change (Braithwaite 1938, Kendall and Knapp 1997, Macadam 1943). In spite of the founder's recognition of the unmet needs of many dying individuals however, the managers and medical staff evinced only a modest desire to expand their activity[1] or disseminate practice. The history, and particularly the financial management of the Friedenheim, nevertheless exemplify Victorian philanthropic endeavour, exhibiting many characteristics of the genre and contributing to the picture of charitable enterprise at that time. Further, the findings of this study fill an important gap in the historiography of Victorian medical institutions and the history of care for those who are terminally ill.

This chapter examines the research results and concludes by considering unanswered questions and themes which might form the basis of future research.

11.1 Results

A group of idiosyncratic Victorian and Edwardian homes for the dying were founded before 1906, of which the Friedenheim/St. Columba's was thought to be the first. A hiatus followed in the provision of institutional care for the dying,[2] until the opening of the first of the so-called 'modern' hospices in 1967 and the start of the hospice movement. Two of the early homes, St. Luke's and

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[1] Different types of voluntary organization define themselves by function (Kendall and Knapp 1997:254) and crucially, the Friedenheim/St. Columba's held only a 'service-providing' function, never, unlike St. Christopher's, holding a 'pressure-group' function.

[2] It must be recognised, however, that the Marie Curie Memorial report of 1952, although mainly concerned with nursing cancer patients at home, identified the need for residential and convalescent care for some of their patients (Marie Curie Memorial 1952:41).

St. Joseph's, contributed in a meaningful way to the new movement through the person of Cicely Saunders who gained invaluable experience working there.

This thesis sought to test the unproven assertions in the literature (Hospice History Programme,[1] Goldin 1981, Humphreys 1999, 2001, Lydon 1998, Murphy 1986, 1990, Saunders 1988, 2005b), that the Friedenheim/St. Columba's was the first institution specifically and uniquely founded to care for the dying in England. If valid, the hospital could be placed unequivocally at the genesis of specialised, compassionate in-patient care for the dying in this country, and therefore would also merit closer investigation both as an institution, and for its potential place in the evolution of care for the terminally ill.

The historical primacy of a specific endeavour is necessarily difficult to establish. Although some hospitals did not discharge the dying[3] and others might establish special wards for their own dying patients,[4] extensive searches of nineteenth-century medical reference works failed to reveal any other home in England specifically and solely intended for the dying. The Friedenheim remained unique in this respect until the opening of the Hostel of God in 1891,[5] six years later.

Contemporary evidence for the Friedenheim being the first home in England dedicated to those dying is compelling. Davidson's own words (Butler c.1903:17)[6] show that she, herself, believed this to be the case. Both the Mildmay Mission newsletter and an article in *The Queen* in 1887 describe the Home as 'experimental'.[7] The evidence of third parties such as Schofield, Burdett or Helen E. Don, Honorary Secretary of St. Luke's is convincing.

Schofield, for example, a medical man with wide interests in his profession, wrote unequivocally that:

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[3] The Hospital of St. John and St. Elizabeth was noted in this respect.
[4] For example the Royal Marsden Hospital
[5] Then known as the Free Home for the Dying
[6] UoL St.C/F RR
[7] SFTK 1887:9-10 and Anon 1887:65

...there is not to be found any refuge, home or hospital, but the workhouse, for the man [sic] who is neither curable nor incurable, but simply dying, save one tiny home, of ten beds, founded and worked by the exertions of one gallant woman [i.e. the Friedenheim] (Schofield 1891:423).

The editors of Burdett's *Yearbook* were in an even more advantageous position to judge the innovative nature of the home than Schofield, with their privileged overview of England's (and even the English-speaking world's) medical facilities. Their assertion therefore that the Friedenheim filled an otherwise unmet need is supported by their wealth of specialised knowledge of medical facilities available to the public (Burdett 1894:lxx).[8]

As one of the few other practitioners in the field, Helen Don, Honorary Secretary of St. Luke's, also acknowledged the innovative nature of Davidson's work and called her the 'honoured pioneer in this section of hospital work.'[9]

The literature review revealed the conflicting information currently in print about basic information about the Friedenheim/St. Columba's, including size, dates and addresses. Based on cross-referencing contemporary documents, these have now been established and clarified throughout the body of this thesis. Founded in 1885 at 133 Mildmay Road in Islington, the home expanded to include 131 Mildmay Road around 1891. In 1892, the Friedenheim leased premises originally called Sunnyside, in Upper Avenue Road (later re-named Avenue Road) Hampstead, where it stayed until 1956. The final years of St. Columba's Hospital were spent at The Elms, Spaniard's Road, Hampstead Heath until its closure in 1981.

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[8] Entries from the Free Home for the Dying (Hostel of God) appear for the first time in Burdett's 1898 Annual, although the Home was founded in 1891.
[9] SMH/MB/III:21

Lack of surviving documents has meant that information about the youth and upbringing of the hospital's founder, Frances Mary Davidson is general and essentially speculative. It can only be hoped that diaries or letters may emerge in the future which will inform her schooling and training, particularly during the years 1869 to 1885. By the time Davidson was in her late thirties or early forties, third party sources reveal an established relationship with the Mildmay Mission and its philanthropic work in London. Further, an undated family letter indicates a particular occasion, the death of a young girl from tuberculosis whom Davidson took into her own home to nurse, as the emotional trigger event behind the founding of the Friedenheim in 1885.

Knowing that Davidson was present at the deathbed of her father,[10] it is tempting to speculate that the contrast between his death in physically comfortable surroundings and that of her protégée, discharged from hospital to die in a crowded slum dwelling, added weight to her determination to found a home for the dying.[11] Evidence in *The Queen* shows that following the first year of operation in Mildmay Road, Davidson was already convinced that the need existed for a home such as hers, and hoped to encourage other, similarly placed women to follow her example in their own neighbourhoods (Anon 1887:65). Davidson foresaw each home as the individual responsibility of its founder and had none of the grander plans of a Nightingale (or indeed a Saunders), intent on policy changes and wide-reaching reforms under her leadership. Rather these were to be the 'private' endeavours of individual women.

The large number of applications received at Mildmay Road encouraged her to extend the home, but a certain modesty and reluctance can be sensed before undertaking the removal to Upper Avenue Road. Indeed, it was only when

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[10] F/SC.AR1921:16

[11] Davidson was, possibly surprisingly given the internationalism of Protestant philanthropic endeavour (Summers 2001), ignorant of the work of Mary Aikenhead in Ireland and Jeanne Garnier in France.

convinced that this was the path to which God was guiding her,[12] that she took the steps which led to wider public and posthumous knowledge of the Home.

Davidson was a Scot who came from Aberdeen, and an unresolved question arises in relation to her ability to generate interest in, and even royal patronage of, her project. Any evidence of social connections in London before the opening of the Hampstead premises in 1892 is missing, and yet on that occasion, over three hundred people were invited to three separate Open Days at the new location.

Due to the fortuitous preservation of some early reports and in spite of the general destruction of hospital archives following acquisition by the NHS, enough material survives to generate a picture of management, administration and the essential elements of care provided between 1892 and 1947.

The problems associated with leadership, finance and strategic planning were discussed in Chapter 6. In spite of an apparent dearth of management skills or structure, and with neither financial nor strategic planning, the hospital survived and was able to provide, indeed provide well, for its patients until the 1920s when financial circumstances nearly brought the home's closure. The chairmanship of Midwinter in the early 1930s introduced stringent management controls and methods which, although temporarily compromising the core values of the home,[13] nevertheless ushered the institution into an era of prosperity and it seemed set to survive indefinitely, known and appreciated by the medical community which supplied its patients. After only nine years under Midwinter's management, St. Columba's Hospital entered the Second World War in a position of strength, financially viable and with clear plans for the future. Even during the war, the hospital was spared enemy bombing and no lives were lost to enemy action in spite of its London location.

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[12] *Daily News* 04.11.1892 Issue 14537
[13] Although the home was intended for the dying poor, patients, during this financially challenging period, were admitted who were chronically ill and paid for their care.

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Midwinter however, like Davidson, failed adequately to provide for a successor and a combination of events, including his and other deaths, the aftermath of war and the inception of the NHS all affected the fortunes of St. Columba's. The resignation of key figures, lack of a champion within the nascent Health Service and, crucially, the major miscalculation involved in purchasing The Elms, signalled the slow demise of the institution which finally closed in 1981 in spite of local support.

Examination of patient numbers, presenting diagnoses and personal circumstances delineated the patient body along broad lines. Between 1885 and 1947, some 7,500 patients were treated at the hospital, of whom 5,545 died and 1,966 were discharged. Although the breadth of occupations is extremely wide, the majority of occupations suggest a large number of what would have been the poorer classes. Davidson, in particular reached out to those in a 'friendless condition'[14] and the 'lonely ones'.[15] A lack of direct testimony, however, means that information about patient perceptions of their care is missing, and the few surviving records of relatives' remarks are necessarily subjective.

Between 1885 and 1947, the majority of patients presented with either some form of tuberculosis in the early years, or cancer in the later, a trend which reflected changes in disease patterns in the population as a whole. The hospital clearly understood and differentiated between the clinical needs of these types of patient, both of which could be particularly difficult to nurse at home. It was, however, able to adapt to the evolving needs of the community it served until, by the 1940s, there were essentially no tubercular patients and the majority

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[14] F/SC AR 1901:5
[15] UoL St.C/F RR MMD *Friedenheim* 9

suffered from cancer.[16] Admittance was therefore based on the condition of 'dying', rather than an individual disease.[17]

The influence of the medical staff on the care of patients was both crucially important and yet difficult to analyse in detail without, for example, patient records. The weight of evidence suggests dedication in the medical staff, the daily attendance of doctors and the presence of someone, Davidson or a nurse, with the patient at the moment of death itself. Staff turnover, whether of physicians, nurses or even domestic staff was low, implying dedication among the staff or good working conditions.

Reference is made throughout the hospital's publications to the necessity of, where possible, controlling pain and relieving symptoms.[18] Pain relief did not have to be 'earned' and analgesics were offered when needed. Minor operations for symptom relief, such as tracheotomies and gastrostomies were carried out at the hospital and oxygen was provided for those it helped. Diet, whether to stimulate appetite, relieve or simply comfort patients was also a feature of care.

It was only with the publication in 1949 of 'Dying of Cancer', by the hospital's medical officer, Norman Sprott however, that full details of the comprehensive symptom relief offered to patients are available. This must have represented the exception rather than the rule for patients dying in an institution at that time, and indeed for some years later (Glyn Hughes 1960, Grant 1957, Marie Curie Memorial 1952).

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[16] Source documents do not provide the exact number or percentage of patients who suffered neither from tuberculosis nor cancer over the life of the hospital. Figure 7.5 (p 175) suggests that between 1900 and 1930 the percentage varied between 5% and 13% of admissions, rising to as much as 23% in 1935 following the admission of some patients with chronic conditions. Sprott records that non-cancer patients accounted for between 5% and 15% of admissions in the 1940s.
[17] As has been noted elsewhere (p133), chronically ill, paying patients were also admitted for a few years to generate income during the hospital's financial crisis in the early 1930s.
[18] See, for example, the Medical Reports of 1922 and 1938

In non-medical matters, a real desire to accommodate and supply the needs of the individual is evident in the details of care, whether expressed through cooking porridge in a preferred way, appreciating the contribution and the skill of a patient in curling a feather boa or refreshing patients with ripe melons in hot weather. Charles describes a vignette perhaps typical of the sensitivity shown for the needs of the individual. A young, recently married woman had been given, 'a quiet nook to herself screened off, where her husband could be with her alone whenever he came' (Rundle Charles 1893:182). Throughout the published material, the individual nature of each patient is emphasised and the consequent necessity of tailoring appropriate treatment to suit his/her particular and personal needs.

The cherished independence of the organisation until 1948 meant that the Friedenheim/St. Columba's could display widespread flexibility towards the rules, and although official visiting hours were theoretically brief and occasional, relatives were allowed to be with patients towards the end, sometimes even sleeping at the hospital. Diets were based on patients' wants and even though the regulations indicated that 'stimulants' (i.e. alcohol) would not be given, this rule, too, could be relaxed if felt necessary.

The warm, simple kindness of Davidson's approach to patients and families is evident. This spirit of kindness appears to have continued beyond Davidson's day, as similar words are used by Midwinter in 1946, when he wrote that dying patients needed not only physical, mental and spiritual care, but also 'kindness, sympathy and understanding'.[19] Sprott, too, perhaps unusually in a medical text, uses the word 'kindness', suggesting that it may be a formal requirement of care:

> From the patients' point of view, kindness, encouragement and bodily comfort are much more important than frequent medical examinations,

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[19] SMHA/MB/V/155

scientific investigations and useless attempts or pretences to cure (Sprott: 1949:187).

References are made throughout the Annual Reports in particular, to the care and thought accorded to those soon to be bereaved. The most extreme examples of this are where the hospital undertook to provide for the accommodation of the soon to be orphaned or vulnerable children of their dying patients. Solicitude was also shown for the treatment and viewing of the dead, accommodated in the ponderous Victorian pomp of their own mortuary. Although ripe with Victorian sentimentality, actions such as the covering of a dead child's extreme facial disfigurement with flowers[20] demonstrate a real compassion and concern for grieving relatives.

Founded by an Evangelical Christian and with a strong religious element permeating administration, occasions and even wall decorations, the spiritual care of the patients, expressed through this religiosity, can never have been in doubt. The atmosphere of peace in the hospital, which was commented on by many, can perhaps be attributed to the religious motivation of many of the staff and may have played a significant part in assuaging the fears of some patients, effectively also becoming an element of care. Evidence presented in Chapter 9 demonstrates the breadth of denominations welcomed in the institution. This is supported by references in the Annual Reports to donations made by ministers of different religious denominations. Of particular interest is the good relationship that existed between the local Jewish community and the hospital. The impression given by the Annual Reports, although remembering the caveats concerning the purpose for which they were written, is one of acceptance of others' choice in their preferred way to worship. Any conversion was effected by presence and example rather than aggressive proselytism.

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[20] FSC/AR/SR/1904

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Limited material inhibited extended examination of St. Columba's after 1948. The 1950s were, however, of particular interest from another point of view. Although generally unacknowledged in her published writings, Saunders' personal diary entries, confirmed by witnesses, show her presence at the hospital during its final years in Avenue Road while she was developing her plans for St. Christopher's and the hospice movement. Letters between Saunders and the senior staff at St. Columba's reveal that they enjoyed a cordial relationship over several years. Saunders demonstrated detailed knowledge of the regime for symptom relief at St. Columba's as well as the ethos and care in the hospital. St. Columba's must, therefore, have contributed in some way to her thinking about St. Christopher's and the future hospice movement, whether on an administrative, spiritual or medical level.

In spite of the private nature of Davidson's original creation, there is modest evidence of a desire, by her and her supporters, to promote the concept of the Friedenheim beyond this one institution. Burdett refers to the need to provide accommodation for the dying, 'in every poor district of London at any rate' (Burdett 1984:lxx). Schofield, closely associated with the expansion of the Friedenheim in 1891, pointed out that the need of the dying poor was so great, that, '…no one institution will meet the case' (Schofield 1891:427).

No evidence was found, however, of any attempt to translate these thoughts into action except an early article in *The Queen* which encouraged women similarly placed to Davidson to open their own homes. Other institutions for the dying did however open, according to Charles, in emulation of the Friedenheim: 'Two similar homes have been lately begun, suggested by it; one in Holland and another in London' (Rundle Charles 1893:180). Davidson also reported that similar homes were 'springing up' in other places.[21] Murphy's unattributed reference to the opening of 'Friedenheims' in London, Manchester and Glasgow cancer hospitals is supported by the wording on Davidson's tombstone in

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[21] FSC/AR/1901:8

Banchory, which reads: '…Foundress in 1885 of the *first* home of peace for the dying, now named St. Columba's Hospital, London' (emphasis added). No evidence has, however, been found for the creation of any other home directly inspired by the Friedenheim.

11.2 Discussion and future research

The Friedenheim/St. Columba's and other proto-hospices

These research results are of particular interest when added to those of Humphreys (1999, 2001), who, together with Goldin (1981) and Winslow and Clark (2005, 2006), are the only authors who have examined in detail the other early homes for the dying. The idiosyncratic nature of the Friedenheim suggests, however, that it cannot simply be subsumed within the group of other proto-hospices active at the time which were characterised by their foundation and management through a religious authority. These homes served the interests of particular denominations which used them as vehicles for religious renewal, conversion and control of their co-religionists (Humphreys 1999:261 et seq.). The standard view of the early proto-hospices is, therefore, one where care of the dying is ancillary to, and an extension of, the overwhelming mission of the founding organisation. This was variously to care for the deserving poor, convert lapsed members, and help others to find the peace in dying that only professed belief would provide. By providing evidence of another type of home, the findings of this research challenge the general nature of these views and add to the body of evidence concerning early institutional care for the dying in England.

The origin of most differences lies in the home's independent foundation, having no other mission than the care of the dying and with no ties to an organised religious group. With 'soul cures' as their fundamental aim, the other early homes for the dying were extensions of their missions to the poor, and were '…primarily intended as a means of controlling them through moral and spiritual reformation' and managing them '…right up to the end of life' (Humphreys 1999:3, 315). Although religion and spiritual comfort played an important and visible role in the Friedenheim/St. Columba's, its managers and administrators never attempted to minister to any but the dying and bereaved, concentrating their efforts on those close to death.

In contrast to the other homes (Humphreys 1999:315), there were no spiritual criteria for patients' admission to the Friedenheim, and although a 'frankly Christian' organisation, it did not have the same religious agenda as those institutions operating under the aegis of a specific denomination. Although frequently mentioned in tandem, there is no indication that spiritual care received precedence over physical (cf. Humphreys 1999:317), or that the dying patients were 'singled out as special objects of [religious] conversion' (Humphreys 1999:318). There was no chapel, no full-time, paid clergyman in attendance, and nor were the nurses religious sisters.

In particular, the doctors' work was neither circumscribed nor controlled by a clerical hierarchy. As regards pain relief, for example, in some proto-hospices, staff regulated the use of morphine and alcohol because of their 'Christian belief that pain should ultimately be accepted because it had a role to play in the patient's spiritual life' (Humphreys 1999:229). In the Friedenheim, however, every effort was made to achieve pain relief, Davidson believing and stating that symptom relief was '…the avenue through which moral and spiritual help comes, in addition to the physical *which comes first*' (emphasis added).[22]

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[22] FSC/AR/1917:12

Physical conditions were also at variance with the other homes. Early photographs of the Friedenheim show fully dressed patients in the Day Room or relaxing on chaises longues in the garden, as well as frailer residents in bed. In some of the other homes, patients were not allowed day clothes, and in one, not even a dressing gown or slippers (Goldin 1981:399-400). As compelling evidence of respect for the individual's needs and dignity at the Friedenheim, this fact deserves special mention.

Writers, particularly in the Friedenheim's early Annual Reports, present the picture of a home where belief in the fundamental role of God in this life and the next was central. While some of the exuberant religious vocabulary, italics, capitals and underlining can be attributed to contemporary style, nevertheless the personal religious convictions and piety of Davidson and her colleagues is evident. It seems likely that the personal devotion of the staff played some part in the creation of the, frequently testified, peaceful and welcoming atmosphere of the institution. This will in turn have contributed to the well-being of the patients and formed in itself an element of care, perhaps difficult to replicate in the more secular institutions of today.

Another feature differentiating St. Columba's from other proto-hospices was that of its economic fortunes. By the 1930s, patient numbers and funds in other homes declined, a fact attributed to the adverse financial climate, the disappearance of 'paupers' (see also Rose 1988:56-72), less interest in charitable enterprise and the inadequacy of traditional religion. Humphreys further suggests that homes for the dying might have appeared 'largely irrelevant' after World War I (Humphreys 1999:327-328).[23] These findings are at variance with those presented here concerning St. Columba's Hospital.[24] Although experiencing financial difficulties in the 1920s and early 1930s, later that decade it was not only operating at a profit, but also, with the exceptions

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[23]See, for example, Ariès 1975:76 ff., Gorer 1965:6 or Vovelle 2000:674-678 for the reasons behind this feeling of irrelevance.
[24] See Chapter 7

of 1938 and 1939, when wards were closed in case of an influx of war wounded, maintained admission numbers. The hospital's highest ever number of admissions was in 1947, immediately preceding absorption into the NHS.

The Friedenheim/St. Columba's is also of interest as an example of a voluntary institution which confirms the theory of philanthropic effort described by Braithwaite, Macadam and Salamon. The pioneering work, not only of Davidson, but also the founders of the other proto-hospices, failed to gain the widespread public or governmental recognition which might have encouraged either the creation of further homes dedicated to the care of the dying, or state-supported legitimacy for their work. These theories go some way to explaining the hiatus in institutional care for the terminally ill which existed between the creation of the proto-hospices and the advent of the modern hospice movement in the late 1960s.

Unlike the founders of the original institutions caring for the dying, Saunders held a larger view which encompassed far more than just one institution. Her ability to raise public, medical and governmental interest in the care of the dying has led to the current NHS involvement with specialised care of the terminally ill. The Liverpool Care Pathway,[25] or the Gold Standards Framework for Community Palliative Care,[26] for example, are directives intended to cover the specialised needs of the dying within both institutional and home-delivered care.

The institutions nevertheless demonstrated that such homes were necessary and viable. Their practice had evolved over decades and, in the Friedenheim and probably St. Luke's (Humphreys 1999:313), revealed the growing importance of medical care at the deathbed, possibly overshadowing the spiritual. In spite of the use of complex drug combinations and methods for

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[25] Described on http://www.endoflifecareforadults.nhs.uk/eolc/lcp.htm (accessed 21.01.2009)
[26] Described on http://www.goldstandardsframework.nhs.uk (accessed 03.07.2009)

symptom relief demonstrated in Sprott's 1949 paper, the conceptual leap to a separate and distinct discipline of palliative care for the dying which would combine and develop this practice was, however, missing in these homes. This potential went unrecognised in spite of the fact that they were loci where a concentration of dying patients permitted significant evaluation of methods for symptom relief.

Although generally subsumed in the literature with the other early homes for the dying, this research has nevertheless revealed the Friedenheim/St. Columba's to be a distinctive and original institution, dissimilar in many ways to its immediate followers in the nineteenth and early twentieth centuries. The picture of the proto-hospices is now necessarily more complex, suggesting a diverse group of institutions which demonstrate a spectrum of characteristics in their founding principles, administration and religiosity, arguably stretching from the first, the Friedenheim to perhaps St. Joseph's Hospice, the last. The history of the Friedenheim/St. Columba's reveals a distinct and unique element within this accumulation of practice which formed part of the broader picture of care in pre- and post-war London and preceded the foundation of the modern hospice movement.

Davidson and her colleagues acted under the imperative of their own social norms and expectations, including that of an omnipresent and accepted religiosity. Interpretative challenges arise from our different viewpoints as we consider their actions in a spirit of analysis and cognisant of the theoretical work underpinning today's practice. The material presented here has focussed on an exploration of patient care and the genesis, administration and impact of the home, therefore other issues of potential interest for further research, such as the place of Davidson (and her sisters) within studies of feminism, Victorian philanthropy, nursing, tuberculosis care or the institutionalisation of the sick, have not been examined.

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Two areas under discussion today are the importance of space and place for the dying and the sequestration of those near death. Mellor and Shilling (Mellor and Shilling 1993) used the term 'sequestration' of the dying to refer to the on-going 'privatisation of the organisation of death' (Mellor and Shilling 1993:414) and its consequent sequestration from public places as death came to be perceived as a threat to the individual rather than the group. They argued that the nineteenth-century Protestant fascination for individual deaths, followed by 'the decline of traditional religious belief, and the desacralisation of death' meant there was 'even less of an impulse to keep it in the public domain' (Mellor and Shilling 1993:416). Lawton (Lawton 1998) has developed this argument and more specifically suggests that nowadays, hospice patients are sequestered in order to hide 'the taboo processes of bodily deformation and decay' and set the 'disintegrating body' apart from mainstream society (Lawton 1998:121). Although active some eighty years before interest in the dying process became general,[27] it is therefore informative to consider whether the activity of the Friedenheim/St. Columba's presents any experiences which are relevant to these discussions.

Space and place for dying

Davidson set out literally to provide a 'home' for the dying. Bachelard has written of the importance of 'home' to the individual (Bachelard 1994:7-15) and Benjamin expounds on what he calls the Victorians' 'addiction to dwelling' (Benjamin 1993:216, see also Bryden and Floyd 1999:2 and Rose 1988:22). Perhaps recognising the importance of place of death, reports and articles written about the Friedenheim by Davidson and others are replete with spatial references: the place they provide for the dying, the 'welcoming home', the 'small refuge', the 'place wherein [the poor] may die'. The building in Mildmay Road and the later one in Hampstead were physical expressions of Davidson's

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[27] See Chapter 1

aim to give home-like surroundings to those dying without family, friends or accommodation. Indeed, as noted earlier, the house Davidson chose for her institution in 1892 architecturally resembled the country home of her childhood, Inchmarlo. Arguably, Davidson literally saw the Friedenheim, unlike some proto- and current hospices, as an extended private house rather than an institution. The article in *The Queen* referred to elsewhere reveals Davidson's feelings on this matter. Having lost her 'home' when her brother inherited the estate, she now suggests and encourages similarly placed women without husband or children to establish 'homes' of their own where the dying can be received. She lived at the hospital and therefore, by extension, invited the dying into her home, where staff supplemented family and a 'good' home death could be emulated. Taking patients into her own house may also explain some of the selective admission criteria and her preference for the more deserving (as she saw it) type of patient. What we see as an institution, she saw as her extended home. This attitude of its charismatic leader was likely to have outlasted her (Schein 1983) and may have gone some way to account for the hospital's difficulties in adapting to management under the NHS.

There appears also to have been a certain relaxed, unselfconscious atmosphere permeating the hospital, similar to that of a large family home. This is demonstrated, not only by the testimony of visitors but in the large family parties at Christmas and other occasions, the sometimes offhand attitude towards rules and regulations, the doctors' use of patients' first names and the activities and clothes worn by patients.

Current research (Lowton 2009, Tang 2003, Thomas et al. 2004, Thomas 2005, Tiernan et al. 2002) has shown the extent to which dying people desire to die at home,[28] and hospices continue to express a wish to emulate home-like surroundings for their patients (Douglas and Douglas 2004, Saunders 1964:4). Walter, however, has argued that in terms of patient autonomy, hospices

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[28] This may, however, evolve over the dying trajectory, see Sprangers and Schwartz 1999.

remain more like hospitals than homes (Walter 1994:133). This is also reflected in the physical surroundings of the patients where medical equipment such as beds, hoists, oxygen cylinders, room decorations including flooring material and the uniforms of nursing staff reflect the clinical nature of their surroundings. These clinical surroundings must also have existed at the Friedenheim, in spite of Davidson's desires, particularly once the expanded 'home' opened in Hampstead.

After 1918, hospital wards 'were no longer depicted as domestic but as long, empty, clean, spacious, symmetrical and functional'.[29] Only some of these characteristics applied to wards at the Friedenheim/St. Columba's ('clean', 'spacious', 'functional') as it had open fires, flowers and plants, reflecting perhaps a transitional phase in ward design. As an institution, it fell into the same dilemma as today's hospices however: constrained by the practicalities of nursing the 'unbounded bodies' described by Lawton (Lawton 1998, 2000) there was, and is, an inherent inability truly to reflect purpose in the physical surroundings.

The possible concern associated with being in a clinical institution must, of course, be balanced by the undoubted relief of some patients to be in an environment where the more unpleasant physical manifestations of their disease process can be accommodated and managed with minimal distress to non-professional carers, such as family or friends. Indeed, Sprangers and Schwartz (Sprangers and Schwartz 1999) explore the tensions and evolution of desired place of care over a disease or dying trajectory. The sometimes high rate of self discharges from the Friedenheim/St. Columba's, however, reflects the unwillingness of some patients to conform to the needs of the institution, and their preference for true home surroundings.

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[29] Humphreys 1999:299, citing Lawrence, Daniel and Fox, Christopher (1988*) Photographing Medicine: Images and power in Britain and America since 1840* Greenwood Press, California 1988:42, 181

Complete autonomy is not, in any case, necessarily possible within a family home, and the matriarchal figure of Davidson at the bedside may have afforded comfort to her young, tubercular patients.[30] Further, human beings are social animals and, as Elias argues, people, particularly in the past, were less accustomed to living and being alone (Elias 1987:74 and see also Saunders 1964:3, Sprott 1949:190); a factor which must have had its implications not only for those dying in a Friedenheim ward, but also for those alone in the single rooms for paying patients upstairs and at a distance from their fellow patients.

Sequestration of the dying

Lawton describes modern hospices as liminal 'no place[s]', situated between life and death, containing 'spaces within which the taboo processes of bodily deformation and decay are sequestered' (Lawton 1998:121) and also as 'enclaves, in which a particular type of bodily deterioration… is set apart from mainstream society' (Lawton 2000:124). Linked with social and even self-rejection, Lawton argues that hospices nowadays essentially receive only unbounded bodies, i.e. those where the person has lost 'control of the body's physical boundaries' (Lawton 2000:124), which are then sequestered within their walls. Although her conclusions were drawn from observation and analysis of only one hospice in the late twentieth century, Lawton's insights nevertheless provide valuable material for the consideration of the early homes for the dying.

Any sickroom is, by its nature and function, a physically separate place, which allows its resident psychic space and relief from many of the tensions and duties of everyday life. Although the patient may be unable or unwilling to assume his/her social responsibilities, this protective space is nevertheless sanctioned

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[30] Florence Nightingale wrote to her nurses, 'While you have a Ward, it must be your *home* and its inmates must be your children.' (British Library Nightingale Papers, ii, Ms included in Item 137, cited in Prochaska 1980:147). See Froggatt (1997:130-132) for an exploration of the familial structure of hospice care.

by society as a whole and is characterised by the rise of an alternative community within its confines (see also Bailin 1994).

These characteristics of sickrooms are apparent, even enhanced, within the Victorian and Edwardian homes for the dying. The physical separateness of the Friedenheim's patients, for example, particularly during the central and final years, was emphasised by the hospital's location within a gated and walled garden which placed residents in an enclosed and delimited space, insulated and cut off from the city's busy streets. The institution was the first place in England where the dying, as a discrete group, were physically sequestered; accompanying the possible loneliness as well as social and psychological isolation of those close to death (Elias 1985). Founded at a time before death became 'taboo' (Walter 1991:297), it was nevertheless a place where dying was carried out privately, isolating the patient and his/her family from society in general and keeping them away from public gaze (see also Froggatt 1997). Of this world, but where staff and patients were also preoccupied with the next, the home may have seemed to many a half-way house, or at least resting place on the threshold of an afterlife.

Numbers preclude the possibility of any generalised effect, but arguably, this physical separation was an early symptom of the so-called 'denial' of death in society (Ariès 1975, 1977, Walter 1991). The physical sequestration of those dying facilitated, enabled and was an indication of the more generalised 'forgetting' (Willmott 2000:654) about death which arose later within a more secular society as described by Giddens (1991), Lawton 1998, Mellor and Shilling (1993) or Willmott (2000).

Three factors may have countered this social sequestration at the Friedenheim/St. Columba's which could have contributed to patients' isolation facing death. Firstly, the hospital offered an active welcome to individuals, many of whom had been rejected by the hospitals and possibly even family; a situation particularly poignant for those of its patients aware of the

Friedenheim's purpose. Patients could enter there, knowing that in this seclusion they were safe from the vagaries, though not the limitations, of uncertain medical care, difficult living conditions and the threat of the workhouse infirmary.

In addition, no matter how 'unbounded' and disintegrating their bodies, details of, amongst other things, the quantity of dressings used, demonstrate that the care staff did not avoid their responsibilities towards the, to use Lawton's words, 'dirty processes' of dying (Lawton 1998:140). Withdrawal to an institution was the possibly welcome consequence of a pragmatic response to their ailing and possibly unbounded body, difficult to accommodate within a crowded, unsuitable domestic environment.

This seclusion, with its implications of separateness, possibly loneliness and isolation, nevertheless also brought those dying into a community of others in the same position and into contact with staff who were specialised in the terminal phases of illness, experienced in intensive 'listening' as part of care (Walter 1994), and acquainted with death.

11.3 Conclusion

In the Friedenheim Annual Report of 1897, Conrad Thies, Secretary of the Royal Free Hospital wrote that he was 'convinced… "Friedenheim" was really and truly one of the grandest works introduced into London for the relief of the sick poor.' No one then, or even fifty years later, imagined that the hospital would not last for ever, a monument to the work of its founder, Frances Davidson, who had sought to bring 'comfort of body, relief from pain and personal kindness'[31] to her patients. They were wrong, and diverse circumstances combined to bring

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[31] SMHA/MB/V/155

about the closure of this first home for the dying. Ironically, it happened at a time when the modern hospice movement was expanding, there was increasing interest in palliative care and growing recognition of a need for institutional accommodation for some of those dying.

If the Home left any direct legacy, it was only in the unrecognised, unacknowledged and modest contribution it made, through Cicely Saunders, to the new hospice movement. Details of the drug regimen at St. Columba's, for example, confirmed Saunders' findings at the other early homes for the dying, and her contacts with its Medical Officer and Matron must have informed her thinking about the possible administrative structure at St. Christopher's. St. Columba's very existence demonstrated that a home for the dying which was not run by a religious organisation was possible, and had even once been successful.

The real success of Davidson and her 'experiment', however, can now only be calculated in the guessed at, but ultimately unknowable, peace brought to the many thousands of individuals who passed through the doors. They were welcomed in a place which, through medical and nursing expertise, spiritual openness and simple kindness attempted to assuage the diverse pains of dying.

APPENDIX A

Facsimile reproduction of Friedenheim Application Form and

Medical Certificate c. 1917

Form of Application for Admission.

*Recommended by*_____

*Address*_____

A.—ANSWERS TO THESE QUESTIONS TO BE SUPPLIED BY THE APPLICANT.

1—Name in full, age, and sex.
Address.

2—Name, address, and occupation of
responsible relative or friend.

3—Present or past occupation.
Salary or wages received in health.
If insured under the National
Insurance Act.

4—Married or single,
Widow, Widower,
or Orphan.
By whom supported?

5—What Church or denomination
does applicant belong to,
and what Parish?

6—Give the names of Hospitals,
if any, of which the applicant
has been already an inmate
or out-patient.

7—Circumstances of Family,
and any special facts
regarding the case.

No.

Medical Certificate.

B.—TO BE FILLED UP BY THE APPLICANT'S MEDICAL ATTENDANT.

1—*Name*_____*Age*_____*Single or Married*_____*Occupation*_____

*Address*_____

PLEASE DESCRIBE AS EXACTLY AS POSSIBLE.

2—Nature of disease and when it first developed.

(If morphia or other narcotic has been found necessary, kindly state particulars).

3—When did you last see the applicant?

4—How long under Medical supervision?

5—General prognosis as to—

   (*a*) ultimate result.

   (*b*) probable duration.

6—Progress of disease in the last 3 months.

7—Present condition of applicant as to—

   (*a*) Pain.

   (*b*) Morning and Evening Temperatures.

   (*c*) Emaciation.

   (*d*) Bedsores.

   (*e*) Ability to walk, feed, or otherwise help h   self.

   (*f*) Any offensive discharge.

   (*g*) Any mental affection, or delirium.

8—Is the applicant fit to be moved?

9—Do you consider that the applicant is above the Infirmary Class?

(*Signed*)_____

(*Address*)_____

(*Date*)_____ 191

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APPENDIX B

Text of memorandum from F. M. Davidson to the Council of St. Columba's, dated 23 May, 1918. Typewritten carbon copy, with manuscript additions (SMHA/CM/II:235-236)

1. PROPOSED ALTERATIONS TO ALLOW OF ADMISSION OF MORE CASES

The number refused must always be painful, but however many more you accommodated you would still always have many to refuse, and, in my opinion, the gain of only four would be counterbalanced by the loss of space and privacy – and therefore comfort – to those now taken in.

As an alternative, it would, however, be possible to admit two more on the top floor, by putting two adult beds in the children's ward, and putting curtains to screen them from the rest of the room when wanted, (though I dislike curtains!). These beds could be kept for younger women and girls who would otherwise be in the women's wards, and so would release two beds in the women's wards for more serious cases. Six children could still be accommodated. With the new outside balcony from the children's ward, two lighter adult cases would be quite happy there, especially as the children, in fine weather, are so often not in the room.

2. PROPOSAL TO TRANSFER 'PRIVATE' WARDS TO ONE – (Children's Ward)

One of the foundation reasons for this Hospital was to provide a place where women of the upper-middle classes, (the class that needs it most),[32] should be able to die in quiet, privacy, and happy surroundings, and get the best of nursing, while only paying the small sum of one or two guineas, which is the utmost they could afford. This need has been met by the two private wards, and would be destroyed if four patients were crowded into one room, even though they were curtained off, and had their own furniture as proposed. In countless cases it has been an untold boon to the patient and to their friends to be so quietly private as at present. To have three other patients and their friends, could not be considered private, and certainly no such fees could be asked for, as by no imagination could they be called 'private' wards. For the sake of the private patients, for whom, as I said, - I specially chose those rooms and thought out every detail, I must strongly urge that the private wards are left as they are. Another objection to turning the children's ward into one for private patients – often cancer cases – is that it is next door to the Nurses' Kitchen, and so it

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[32] This statement clarifies the declared aim of the hospital to provide accommodation for the dying poor and the extent Davidson to which had been hoping to generate funds from the provision of rooms for paying patients.

would be very close to it and, possibly, disagreeable at times, as you, and those who are nursing, will understand.

<u>An advantage</u> in the present arrangement is that when necessary, one of the private rooms can be used for isolation or observation purposes.

<u>3. LARGE WARD OF 8 BEDS FOR CANCER CASES</u>
<u>Some practical difficulties and objections</u>

The grouping of the beds in the proposed plan is uncomfortable, as the irregular line against the inner wall is not good [hand drawn diagram of bed placement follows in the text] none could speak to each other comfortably, as they would each be a little behind each other – while those on the other side would have one side of the beds against the wall (awkward for nursing) and below the windows which are too high to look out at, and each patient would be "head and tail" with the other.

<u>Inconvenience</u> As one door is to be shut up, it would necessitate all the washing and lavatory arrangements being carried past most of the patients, which is undesirable, especially with cancer cases.

Another objection is that as only the one door is to be left, the patients going to the lavatory, and everything that had to be carried out, would face the main staircase.

As Dr. Lush knows, <u>I have always tried to keep down an undue proportion of Cancer cases</u>, as 'Friedenheim' was mainly intended for dying consumptives, for whom there is so little provision made in London, whereas there are Homes and Hospitals for dying cancer cases. I feel that there are now as many cancer cases at St. Columba's as should be for its accommodation and nursing staff.

I have, time and again, racked by [sic] brain to think of any way by which I could rightly increase the accommodation on the top floor, and have many times – in past years – measured, planned, and considered, it from all points of view, and each time I came to the conclusion that it could not be done without so altering the place as to destroy the aim I had in my mind, and in the minor (as well as major) ways, would add to the work of the nurses and impede the benefit and welfare of the patients there.

4. You know my great wish has always been that the whole place should be <u>a Home rather than a Hospital</u> (the word 'Hospital' did not come into the title until we were obliged to use it, and we retained 'Home' as its second title) and the ideal of being nursed at home is privacy, comfort, and space, and 'home-li-ness', and adequate attention from the nurses. We have, I think, fully maintained this reputation, and it is owing to the un-crowded and sufficiently staffed wards – especially the private ones – that we have been able to do so. Many who have come from other Hospitals and Institutions have testified to these characteristics at St. Columba's. At St. Luke's it is not so much the rules, as the crowded beds, the nearness to other patients, and the consequent air-less-ness (or worse!) that patients have spoken of when they experienced the change to St. Columba's.

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It would go to my heart to feel that in order to take in two more patients we had so adulterated the top-floor (or any ward) that these characteristics were lost.

As I hold all these opinions – just detailed – so strongly, and remember the ideal I had in my mind in founding St. Columba's and which I strove to carry out, I am sure the Council will understand that it will be directly contrary to my wishes if the suggested alterations on the top-floor are carried out.

We must also bear in mind that the 'Annie Zunz' Ward was named and largely fitted up by the 'Annie Zunz Trustees', and the private wards were individually named by the Princess Christian, so I hardly feel we would be justified in changing them without very exceptional reasons and only with their acquiescence, and I do not think these reasons are at present, convincing.

(sgd) FRANCES M. DAVIDSON

APPENDIX C

Facsimile reproduction of: SPROTT, Norman (1949) Dying of Cancer

The Medical Press February 16, 1949:187-191

7. Pelvic examination with the aid of anæsthesia may be of great assistance in diagnosis.

8. A history of a missed period or of more than one missed period is obtainable in about half of the cases; that it is not given more frequently is due to the vaginal hæmorrhage.
The presence of other signs of pregnancy is not very common.

9. A positive Zondek Aschheim or Friedman test may be of use in diagnosis.

10. Needling of the pouch of Douglas may assist in the diagnosis, but is not without danger if performed outside an operating theatre.

11. The diagnosis of the difficult case rests mainly upon a careful consideration of the history, combined with clinical examination.

Conclusions

1. The age of the patient, the side upon which the pathological process lies, the parity, the history of previous ectopic pregnancy, the past menstrual history, or history of previous pelvic inflammation, or of sterility, do not help in making a definite diagnosis.

2. The combination of abdominal pain, with vaginal hæmorrhage, during active sex life should always arouse suspicions of possible ectopic pregnancy.

3. Attacks of syncope are of considerable significance in association with pain and vaginal hæmorrhage. Syncope may be caused by severe intra-peritoneal hæmorrhage or may be due to tubal distension or intra-

mural hæmorrhage in the absence of severe intra-peritoneal hæmorrhage.

4. Abdominal tenderness is unlikely to help in the diagnosis of a difficult case.

5. The presence of a pelvic mass in association with pain and vaginal hæmorrhage is of the greatest significance.

6. Laparotomy may be a justifiable procedure in selected cases after adequate observation, even when some doubt remains as to the diagnosis.

My thanks are due to Professor F. J. Browne, Mr. Clifford White and Mr. Norman White for permission to use the notes on their cases and for their kindly help.

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DYING OF CANCER

By NORMAN A. SPROTT, D.M., M.Ch., F.R.C.S.

Medical Superintendent, St. Columba's Hospital, London

A Home for the Dying

FACING the Old Swiss Cottage at Hampstead, where prize-fighting and bull-baiting once took place and cocks fought and died to make an English holiday, is St. Columba's Hospital. It is rather a shabby building just now, like many others in the neighbourhood, but it has three large balconies facing south and overlooking a beautiful garden, which comes as a delight and a surprise so near to the centre of London. On the gate-post is fixed a bronze and enamel nameplate of pleasing design, depicting a dove with an olive branch, the emblem of St. Columba and of the peace that reigns within.

St. Columba's was founded by a pious Scots woman in Victorian times as a home for the dying, where their bodily pains could be eased and their souls prepared for the life to come. Its 32 beds are now almost entirely reserved for people dying of cancer. There is far too little accommodation of a comfortable kind for patients

of this class and our waiting-list is so long that many die before they can be admitted. As in this country one in every seven ultimately dies of cancer, it is a matter of almost personal interest to each of us that the needs of such patients shall be provided for.

At this stage cure of the disease is out of the question and what is needed is medical, nursing and spiritual care. From the patients' point of view, kindness, encouragement and bodily comfort are much more important than frequent medical examinations, scientific investigations and useless attempts or pretences to cure. A friendly, homely atmosphere, and to many a religious atmosphere, both of which prevail at St. Columba's, are all important. To one of scientific training and outlook it may seem a pity that the clinical material at St. Columba's is not being more fully utilised from a scientific point of view. Patients in the last stages of cancer present many queer signs and symptoms, and a

careful correlation of these with post-mortem findings and the results of X-ray and laboratory investigations would surely be of value and interest. But to carry this out would require staff and equipment which are not at present available, while the suggestion of post-mortems would be likely to arouse a good deal of opposition from patients and their friends. I am told that the same difficulty about post-mortems occurs also at much larger and better-equipped institutions. It follows that my experience and understanding of these cases is clinical and empirical rather than strictly scientific. But for all that there is this compensation—my problems at St. Columba's much more closely resemble those of general practice, except that whereas in an ordinary practice perhaps two or three patients in a year will die of cancer, nearly 200 cases a year now pass through my hands.

Although the official returns show that the incidence of cancer is about equal in the two sexes, at St. Columba's we get more than twice as many women as men. Why this is so is not easy to explain. It may be partly because a sick man can often be nursed by his women-folk at home, whereas when the woman of the house falls ill and her husband has to go to work there may be no one to look after her, and she must go into an institution.

The proportions of different forms of cancer may be of interest. During the seven years 1942 to 1948 we received 1,017 cases of carcinoma, 25 of sarcoma, 9 of glioma, 5 of lymphadenoma and 1 teratoma. Of the various forms of carcinoma, the breast accounted for 24 per cent., rectum 11 per cent., uterus 10 per cent., colon 9 per cent., stomach 8 per cent. and primary lung 7 per cent., these six together accounting for 69 per cent. Other forms were less frequent, but carcinoma of ovary, bladder, prostate and various parts of the face, mouth and throat accounted for a good many.

The duration of life after admission to St. Columba's varies greatly. Some patients are already moribund and die within 24 hours, while a few unexpectedly live for years; but the average expectation of life is about three months. Some improve for a time with rest, good food and good nursing and relief from pain, until the relentless progress of the disease once more gains the mastery.

No two cases are the same and each is a problem to itself, but at the same time cancer cases have much in common; and in a general way their treatment may be considered under two headings—treatment of the body and treatment of the mind.

Treatment of the Body

By the time they come to us surgery, radiology and possibly medicine have been tried and failed. The growth has got out of hand and metastases are often present, particularly in lungs, abdominal viscera, skin and skeleton. The primary growth may or may not be present. Often it has been surgically removed and not recurred locally. All the better, for death from metastases alone is usually less distressing than when a large ulcerated primary growth is also present. Frequently the primary growth could not be removed or has recurred locally and we have to deal with a fungating or ulcerated growth on the surface or in and around one of the viscera. Multiple nodules in and under the skin are common, and in breast cases we often see cancer en cuirasse, ulcerated masses in the axillæ and swollen painful arms. The size and depth of some of these growths is surprising. You would think they were incompatible with life. Bits of the sternum and ribs may be eaten away and the grey surface of the lung be visible in the base of the ulcer. Fistulæ are often present, particularly in growths of the uterus, vagina, rectum and bladder. Occasionally, but not very often, we get a fistula between the colon and stomach. Growths in the mouth will often throw the cavities of the mouth and nose into one. Many of our patients come in with colostomies, and a few with suprapubic cystostomies, gastrostomies or tracheostomies, and require the appropriate special nursing care. Others have had their ureters transplanted into the lower part of the bowel and in consequence suffer from perpetual " diarrhœa."

Of the various complications of cancer, apart from the general cachexia, emaciation, anæmia, uræmia, etc., perhaps the most frequent are those in the lungs. With or without metastases, but probably in most cases with, these patients suffer from bronchitis, pneumonia and pleurisy, and these very commonly hasten the end. One could often bring brief temporary relief by drawing off fluid from the pleural cavities, but this is a time-consuming procedure and can rarely do much good. At most, it prolongs for a little while an existence already hard to endure. On the other hand, tapping an abdomen distended with ascites requires less of the doctor's time and can often be done with advantage. The patients are often further from the end than those with large pleural effusions and are grateful for the relief that ensues. Two things which should always be borne in mind are a distended bladder and a loaded rectum. The former is compatible with apparently normal micturition or with incontinence, and a loaded rectum is compatible with diarrhœa. Purgatives may result in the bowels being " well open," while a mass of hard fæces remains undisturbed and unsuspected but causing considerable pain and discomfort. A catheter in the bladder and an exploratory finger in the rectum, followed by appropriate action, can often bring great relief.

Pathological fractures are not uncommon and sometimes multiple, the commonest situations being the limbs, ribs and spine. Elaborate treatment is hardly possible or worth while in these cases. Rest, sandbags, simple splints and mor-

phia are usually enough, and it is surprising how often these fractures become united. Occasionally the spine breaks with dramatic suddenness, giving rise to surgical shock, dyspnœa and paralysis and death within a very short time.

Not infrequently complications occur from tumours directly involving the brain or spinal cord. Sometimes the cancerous process spreads along the meninges causing widespread anômalous forms of paralysis. Whether from the direct effects of growths or from the general toxæmia of the disease or the drugs given to relieve it, the mind is usually affected sooner or later, often strikingly so a few days before death. Many patients drift into an apathetic state or one of varying confusion, knowing and caring little of what goes on around them and gradually sinking into coma. Many pass through a phase of delusions and may become suspicious, or complain that the other patients are talking about them, or that they are being unjustly blamed for something they have said or done. Some become euphoric or excited for a time. But these complications are easily dealt with.

Other common complications include hæmorrhages and cardiac failure, intestinal obstruction, jaundice and every kind of sepsis—suppurating sinuses, abscesses, fistulæ, bed-sores, gangrene, urinary infections, sore eyes, foul mouths, sialadenitis and lardaceous disease. Most of the patients at some time or other run an irregular fever. A severe hæmorrhage is an occasional, though not very frequent, cause of death.

When patients have reached the stage which may be described as " dying of cancer " further efforts to stay the course of the disease are out of place. In the words of Clough's " Latest Decalogue " :

Thou shalt not kill; but need'st not strive
Officiously to keep alive.

The time for œstrogens is over. Cardiac stimulants, tonics, hæmatinics and vitamin preparations seem equally futile, though we give them occasionally as a placebo. Now and then the relations, though never the patient, have begged us to use the much-advertised " H11," and to please them we have done so, but in no case has it seemed to us to have any influence on the progress of the disease and it has only meant more trouble for patient and staff. What is required is the relief of symptoms.

Anorexia, vomiting, constipation, diarrhœa, incontinence, retention, anxiety, sleeplessness and pain are perhaps the commonest symptoms which demand relief. Certain symptoms seem almost impossible to control, at any rate in some patients, and one of the most obstinate of these is vomiting, due either to the disease and its complications or to drugs given for the relief of pain. Washing out the stomach would no doubt be helpful in some cases, but with an already overworked staff reliance has to be placed on simpler measures, of which iced or effervescing drinks are often as good as anything. Careful dieting and various

drugs are of course tried. Constipation is more manageable though often extremely obstinate. When the patients are very weak and ill and near the end, and taking little solid food, it is often best to leave their bowels alone and not disturb them too much with purgatives and enemas. It is surprising what a long time these patients will sometimes go without an action and without apparently being any the worse for it. Diarrhœa seems sometimes to be quite uncontrollable. Anxiety and insomnia when not due to pain can be controlled by reassurance, phenobarbitone and various hypnotics, of which we use chiefly soluble barbitone, chloral hydrate and bromides.

Relief of Pain

But the symptom which demands the greatest attention is pain. Some cases of carcinoma run their course with little or no pain, but in most of them pain is a prominent feature and can only be relieved by analgesics in large doses. Drugs should be freely given, the amount and frequency depending on the patients' symptoms and often on their wishes rather than on any preconceived idea of what should be necessary. Only the patient knows the extent of her suffering. Large doses of narcotics will sometimes shorten a life —a result for which the patient might be profoundly thankful—but just as often, by bringing rest and sleep and comfort, they seem to prolong life, though even then the suffering is greatly lessened. If the pain is not very severe we usually start with tablets of aspirin 5 grs. and codeine phosphate ¼ gr. made by Duncan Flockhart and Co., which seem more effective than the official compound codeine tablets, and if they are not enough we give injections of morphia, using 1 oz. rubber-capped bottles containing 1 gr. of morphine tartrate in each c.c., giving as much as is found to be necessary, perhaps ¼ gr. to start with but in many cases as much as 1½ grs. or even more. A few patients who have been ill for many months with severe pain will require very large doses of morphia, which seem to have no more effect than a small dose in an average patient. When morphia causes too much vomiting we try the more expensive diamorphine, which seems to suit some patients better. This also is supplied in rubber-capped bottles. Very often we use injections of hyoscine compound, each tablet of which contains morphine hydrobromide ¼ gr., hyoscine hydrobromide 1/100 gr., and atropine sulphate 1/150 gr. Other drugs are used less frequently—allonal veramon and nepenthe. Pethidine has proved rather disappointing. Physeptone is often useful but very variable in its action, suiting some patients but not others. Apart from the necessity of giving large doses, very rarely has drug addiction ever been a serious problem. All doses of " dangerous drugs " are carefully checked and recorded.

Certain drugs have been used to produce euphoria, though we have not used them much

at St. Columba's for various reasons. They are very uncertain in their action and with our present staff it would be impracticable to use them on a large scale and delegate the responsibility of regulating the dosage to obtain the best effect. Alcohol, tobacco, cocaine and cannabis indica might have to be considered in this connection. I will only say a word about cocaine. This may be tried where the patient is unduly depressed, though of course on account of the danger of addiction only when he is certainly beyond hope of recovery. It can be given alone as cocaine hydrochloride, say ¼ gr. three times a day, or in the form of "Brompton Hospital Mixture," which was originally given to patients dying of tuberculosis. Its formula is:

Cocaine hydrochloride	⅙ gr.
Morphine hydrochloride	¼ gr.
Clarified honey	1 drachm
Gin	2 drachms
Water to	1 fl. oz.

To dying patients it can be given "as often as required."

I have had little experience of attempts to relieve pain by intrathecal injections of 90 per cent. alcohol and caudal block with proctocaine, and such experience as I have had has been unfortunate, though I cannot help thinking that these forms of treatment are worthy of further investigation and trial. But at present the injection may be very painful, risks are considerable and benefit uncertain, so that they are not procedures to be lightly undertaken. Much better in suitable cases is laminectomy with cutting of several posterior nerve roots. Pelvic sympathectomy has also been used for a similar purpose. But most of our patients are too ill and their expectation of life too short to make such operations justifiable.

In some cases pain can be relieved for a time by a short course of X-ray therapy.

Treatment of the Mind

Of equal importance with the physical treatment of these patients is their psychological management, and many pages could be written on this subject. I must however confine myself to a few points. Perhaps the most important one is this: There should be complete confidence between patient, doctor and nursing staff. The patient should be able to look upon the doctor as a friend in whom he can confide and who has time to listen to his complaints and answer his questions, and I am told that a *daily* visit by the doctor is much appreciated and has an important psychological effect. But confidence cannot be based on deceit and falsehood. Whatever may be the case in the early stages of the disease (and I cannot help thinking that the same general principles apply), my experience of the later stages leads me to state that the majority of patients are much happier when they know the true state of affairs and the hopelessness of the outlook so far as life is concerned. Generally speaking, those who come to us in ignorance of

the nature and seriousness of their trouble tend to be anxious, suspicious and dissatisfied, whereas when they realise the truth they are much relieved in mind and after a few days adjust themselves to the situation, ready to make the best of a bad business. Most of the patients want to know the truth, though frequently their friends are most unwilling that it should be revealed to them. Many patients on learning the truth express great resentment towards those who have previously deceived them, especially when they have been told they were going to a "convalescent home" or to a hospital where they would get "special treatment"—a form of kindness that can only lead to bitter disappointment. Learning the truth is often a gradual process which results from question and answer spread over a number of days. It is a good rule never to lie to the patient, though one may sometimes prevaricate if intuition suggests that the psychological moment for enlightenment has not arrived. One does not usually need to use the word cancer, at any rate at first, unless the patient deliberately asks for it.

Once their doubts have been put at rest and they know the worst, it is surprising how cheerful many of these patients can be before they reach that apathetic state when they take little interest in their surroundings. There is no need to be deadly serious all the time in discussing their troubles, and many of them are quite ready to joke about their "lumps," their "silly old pains" and "rotten bones." They get used to the idea that the life that remains to them on earth is a short one, and they are helped by the spiritual comfort that a sympathetic chaplain of their own denomination, whatever that may be, worthily supported by a devoted nursing staff, can bring to them. They become familiar with the approach of death, which when it comes quietly to a suffering mortal behind the curtains in a neighbouring bed seems not so terrible as a few weeks previously they would have expected. They know that everything is being done for their relief and comfort. It is much easier to face misfortune and death when you are one of a community of people similarly afflicted. To be alone in a house during an air-raid was a worrying experience, but if one went along to the first-aid post and the company of a number of others, though the danger was as great, one's feelings towards it were quite different and fear was largely forgotten. It is the same with these cancer patients. We are gregarious animals and it is easier to endure misfortune in company. One patient, and she was not exceptional, informed her friends towards the end that the happiest time of her life was the time she had spent in St. Columba's.

Of course no two people are alike and every patient has to be individually handled. There is a minority, mostly of the duller kind, that does not seem to want to be enlightened. These patients ask few questions and seem quite con-

tent to take things as they come and slip quietly away without worrying about a diagnosis. They are easy. Much more difficult are some of the psychoneurotics.

There is quite a lot of social life in a ward of a " home for the dying." Something is always going on. Visiting hours are generously Jax. There are religious services and occasional entertainments and plenty of books and ear-phones. Most of the patients are too ill for much " occupational therapy," but for those who are so inclined such things as sewing and knitting are encouraged.

A Few Points of Administration

People dying of cancer who cannot be satisfactorily nursed at home want somewhere with a homely rather than an institutional atmosphere, and their needs would best be served by a num-

ber of scattered hospitals at convenient points with not more than fifty beds. More than that and the homely atmosphere tends to be lost. The ideal building would have all the wards on the ground floor, with balconies and ramps, so that the patients could be easily wheeled out into the garden in fine weather. Most of the patients should be in medium-sized wards though a few small wards of one, two or three beds would be useful for special cases. A pleasant outlook and garden are essential and the surroundings should be reasonably quiet, but such patients rather like to watch the traffic and hear the sounds of life going on. It is most important that such hospitals should not be buried in the country but situated where means of communication are good and the patients can be readily visited by their friends.

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CORRESPONDENCE

HIGH DOSAGE PENICILLIN AND INFLUENZA

To the Editor of THE MEDICAL PRESS

SIR,—Generally, penicillin is considered to be inactive against the influenza or any other type of virus. Certainly in the United States immense dosages have been injected in cases of anterior poliomyelitis without any apparent effect.

In view of the increased prevalence at the present time of influenza in this country and the indeterminate and relatively mild virus which is the cause, the following is of interest.

L.N. A man, aged 38, woke up at 6 a.m. on January 8, 1949, shivering, with aching bones and the sore-skin sensation that is characteristic of influenza. In addition there was very mild bronchitis. The patient took a tablet of aspirin, got up and went to work. But the recollection of the morning was vague and he was forced to return home at midday. He had great difficulty in driving the car and getting into the house.

When seen at 12.30 p.m. the temperature was 102.5° F., pulse full and bounding at 100 (normal for this patient 60/min.). He looked as ill as he said he felt.

This patient was an extremely busy man, so as a trial 500,000 units of penicillin were given in an attempt to cut short the attack. At 4 p.m. he was feeling almost normal again. Aches and pain had gone; suffused conjunctivæ and flushed skin had subsided. Therapy at this dosage was continued for two days and recovery was rapid and uneventful.

Since that time six typically influenzal cases have been treated. Three have been given the usual dosage of penicillin, i.e., 50,000 to 100,000 units four-hourly. Three have been given either 500,000 or 750,000 units at the same time intervals. No effect was noticed on the cases having the small dose, while those given the larger lost their feeling of extreme lassitude, pains, headache and nausea, and the pyrexia fell almost to normal within a few hours.

In the circumstances it is impossible to attribute the rapid recovery to anything but these almost heroic doses of penicillin. Improvement is noticed about 1½ hours after the injection and though no blood-penicillin

levels have been estimated so far, it is reasonable to assume that 5 units per ml. or even more has been reached with 750,000 units.

Personal experience has confirmed these findings. dose of 750,000 units administered four-hourly recently aborted a typical and what promised to be a severe attack in the writer. But when the dose was reduced to 300,000 units little benefit was felt.

Quantities of penicillin in the region of 100,000 or 200,000 units six-hourly are often given in respiratory infections. But dosage approaching the mega unit is rare apart from bacterial endocarditis and specific disease.

The majority of cases of influenza are treated at home. Now that penicillin is available in unlimited quantities it would appear to warrant extensive clinical trial in these really massive doses in cases of influenza occurring at the present time.

Yours faithfully,
NEVIL LEYTON, M.R.C.S., L.R.C.P.
Supernumerary Medical Registrar,
St. Stephen's Hospital.

10, Harley Street,
London, W.1.

DIAGNOSIS AND TREATMENT OF LOW BACKACHE

To the Editor of THE MEDICAL PRESS

SIR,—Dr. Good has not preached to deaf ears or blind eyes. Long ago (Souttar, 1923) a British surgeon described a similar technique using quinine and urea hydrochloride. This work has been amplified since and various papers have appeared in the British medical periodicals.

A "nodule" is probably a local area of muscle spasm which may be due to many general as well as local causes. Each cause needs proper treatment. Local anæsthetic injections are not always preferable to digital pressure, intense local application of faradic currents or a large dose of Kromayer ultra-violet light. Sometimes one is efficacious, sometimes another. Sometimes all fail.

Dr. Good states that there is no definite evidence that myalgia results from sacro-iliac subluxation. May I ask him how this statement tallies with the disappearance of pain as a result of manipulation?

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