

**“Undying Spirits”: Religion,
Medicine and Institutional Care of
the Dying 1878-1938.**

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December 1999

SUMMARY

This thesis focuses upon the emergence of a new phenomenon in the late nineteenth century: institutional provision for the 'respectable poor' medically certified as 'dying'. For the first time this group was identified as having special medical, nursing and spiritual needs which could only be provided by trained staff through an institutional medium.

Through a comparative study of three institutions founded in London - St Joseph's Hospice, the Hostel of God and St Luke's House - this study aims firstly, to understand why homes for the dying were set up during this period; secondly, to explore their foundation and development up to 1938; and thirdly, to situate them within the broader context of late nineteenth and early twentieth-century Britain. It argues that the homes were essentially a response to three perceived deficiencies in care for the dying 'respectable' poor which became apparent to certain groups and individuals at this time: a paucity of medical provision, inadequacies in domiciliary care and a lack of spiritual ministrations. As religious and philanthropic institutions, the homes were very much influenced by wider developments in these areas, particularly moral attitudes towards the poor and the Churches' concern to counter what were seen as widespread working class religious indifference.

The different denominational basis of each home (Catholic, Anglo-Catholic and Methodist) was important in determining perceptions of death and dying and how patients' deathbed experiences were portrayed, while their varying management structures had profound implications for subsequent development. In particular the homes provide an insight into the tensions that can arise when modernising influences encounter strong prevailing traditions. An increasingly modernising and secularising medical and social climate posed considerable challenge to institutions set up with the primary objective of caring for patients' souls and the homes responded to it in different ways.

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Acknowledgements

This research was made possible through a scholarship provided by Sheffield University and Sheffield Hallam University.

I am extremely grateful to Professor David Clark and Dr David Cantor for excellent supervision and for their willingness to give so generously of their time and support. Thanks also to Dr Mick Worboys for reading the first draft of the thesis and for giving so many invaluable suggestions.

I am indebted to all the archivists who were so helpful and patient in assisting me with the location of primary sources, especially the Wellcome Institute, CARITAS, Lambeth Archives, London Metropolitan Archives and St Mary's Hospital. I would particularly like to thank the Sisters of Charity for all their help and for providing such wonderful hospitality.

Thank you to all my colleagues and friends at Trent Palliative Care Centre and the University of Sheffield for all their advice and support.

Last, but by no means least, thanks to my family and friends for all their encouragement and support, particularly my parents whose unwavering faith in their daughter has been a source of inspiration to me throughout.

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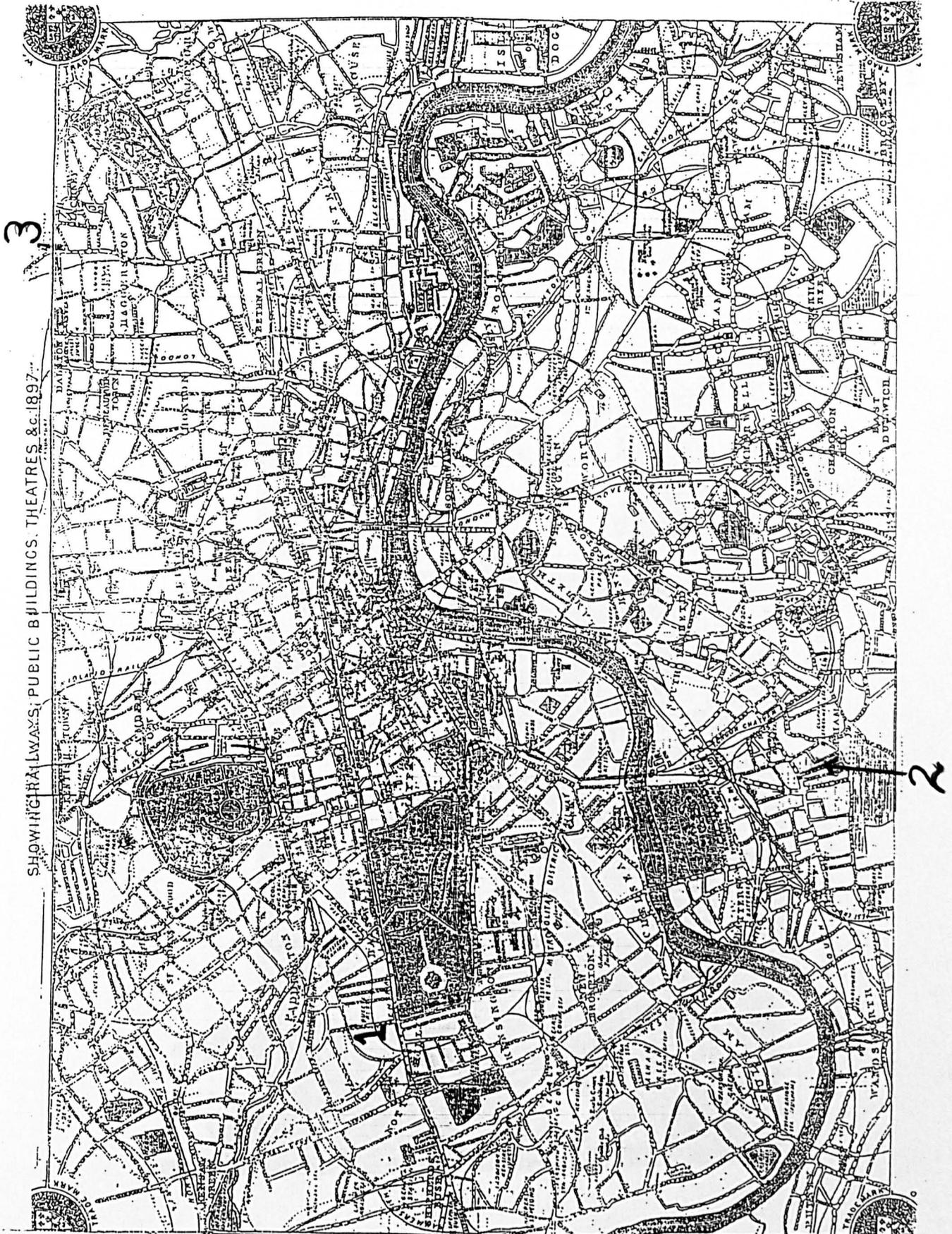
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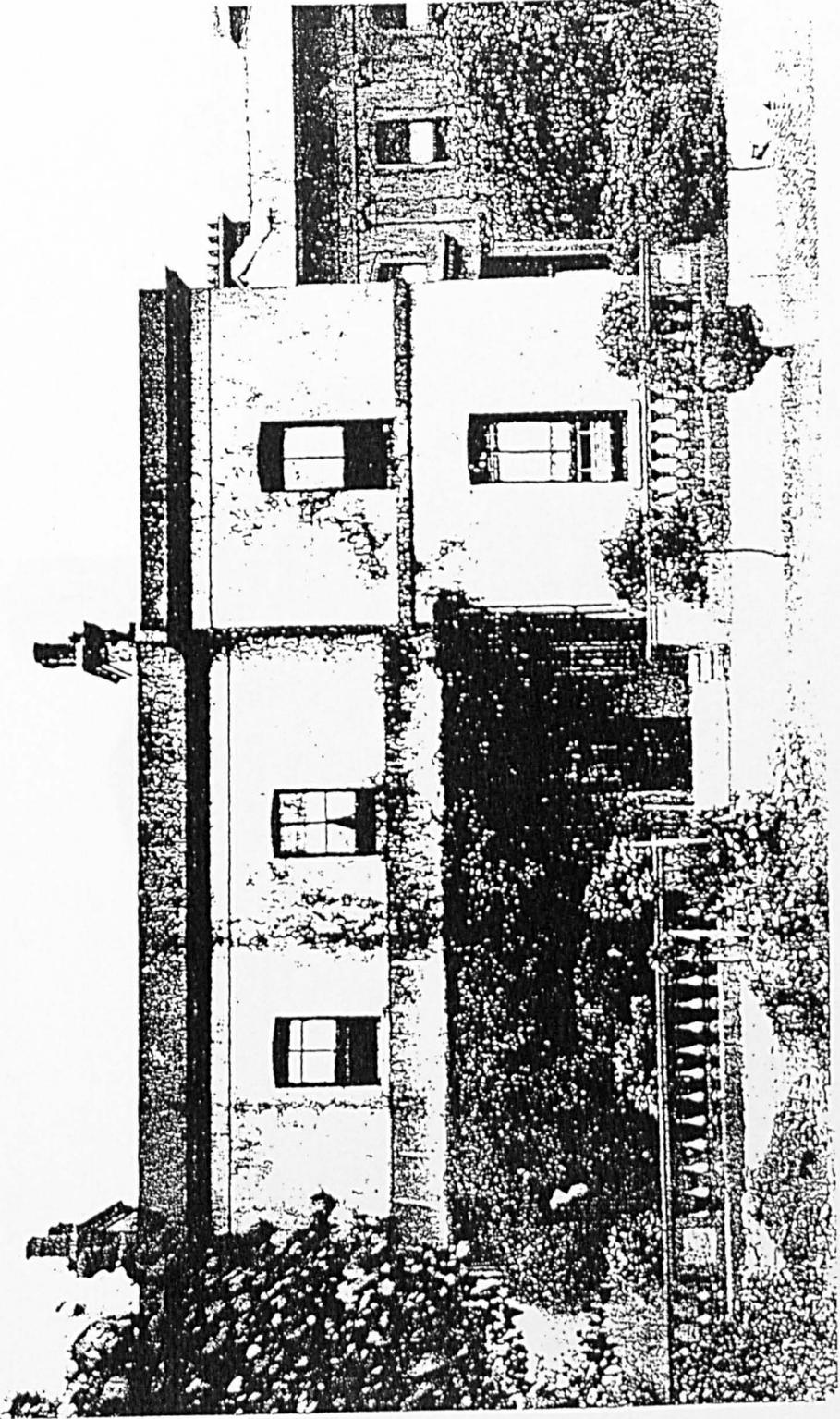
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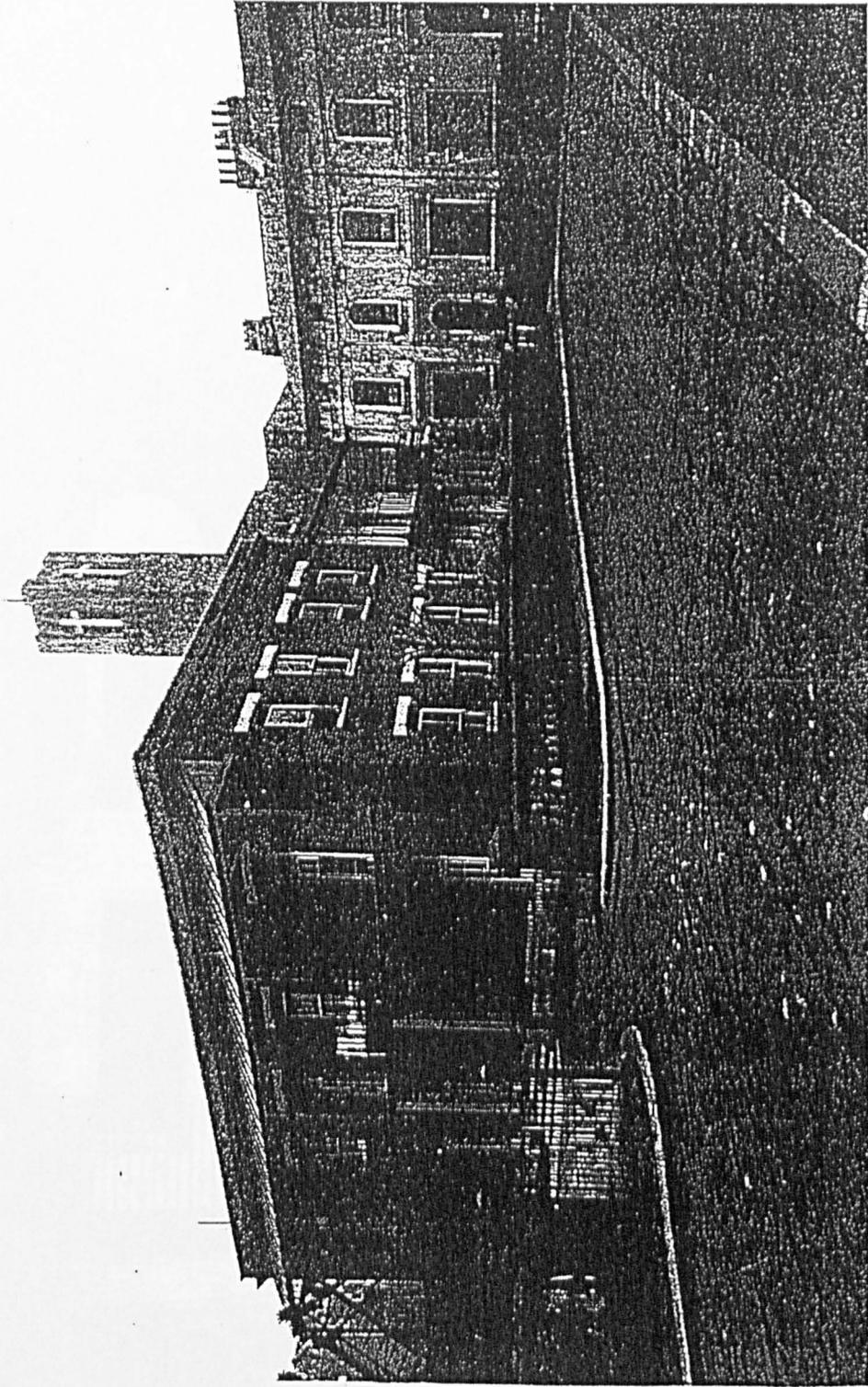
Map of London (1897) Showing the Location of St Luke's House, the Hostel of God and St Joseph's Hospice for the Dying



- 1 = St Luke's House 2 = Hostel of God
3 = St Joseph's Hospice for the Dying



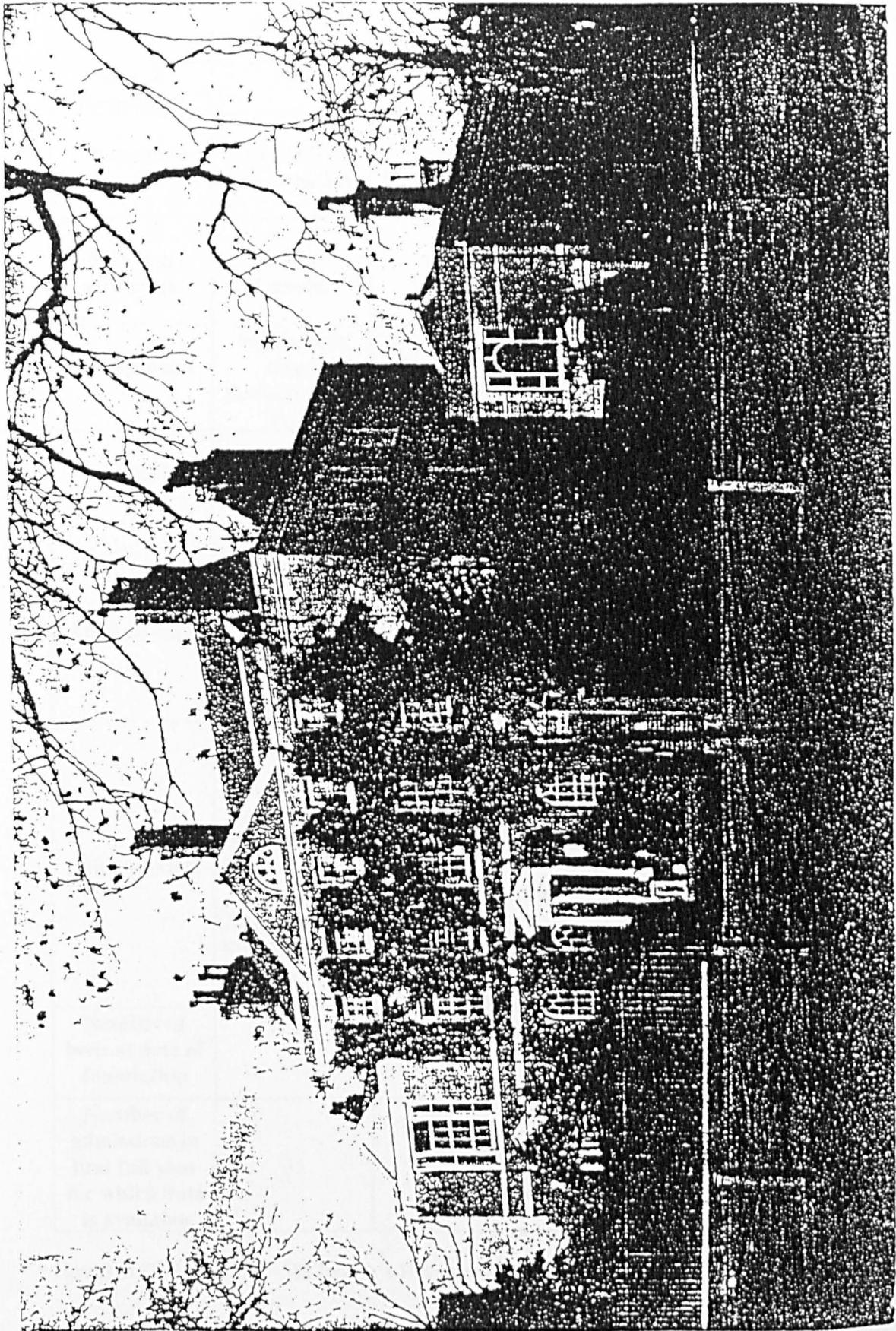
St Joseph's Hospice for the Dying, Mare Street, Hackney, 1905



St Joseph's Hospice for the Dying, Mare Street, Hackney, 1930

St Luke's House, Osnaborough Road, Regent's Park, 1893





The Hostel of God, Clapham Common, 1929

Brief Summary of the Three Homes

| | THE HOSTEL OF GOD | ST LUKE'S HOUSE | ST JOSEPH'S HOSPICE |
|--|--|---|---|
| Date of foundation | 1891 | 1893 | 1905 |
| Founder | Col. William Hoare, banker | Dr Howard Barrett, Medical Superintendent of West London Mission | Father Peter Gallwey, Jesuit priest |
| Religious affiliation | Anglo-Catholic | Methodist | Roman Catholic |
| Management | Sisters of St James Servants of the Poor | Dr Howard Barrett | Irish Sisters of Charity |
| Nursing staff | 4 Sisters 1 trained lay nurse | Matron 2 fully trained nurses 1 probationer nurse | Irish Sisters of Charity |
| Medical staff | Honorary Medical Officer Honorary Medical Adviser | Honorary Medical Superintendent 2 Visiting Physicians and Surgeons | 4 Honorary Visiting Physicians |
| Spiritual staff | Sisters of St James Servants of the Poor Anglican clergyman | 2 Honorary Chaplains: 1. West London Mission minister 2. Anglican clergyman 2 honorary Clerical Visitors: 1. Church of Rome priest 2. Jewish Rabbi | Irish Sisters of Charity Catholic priest |
| Number of beds at date of foundation | 15 | 15-16 | 12 |
| Number of admissions in first full year for which data is available | 35 | 64 | 85 |

* Hostel of God = 1896 St Joseph's Hospice = 1906 St Luke's House = 1894

CHRONOLOGY

- 1879** Our Lady's Hospice for the Dying, the first 'hospice' in the British Isles. Founded in December in Dublin by the Irish Sisters of Charity. Roman Catholic institution.
- 1885** The Friedenheim, the first home for the dying in England, founded in Mildmay Park by Miss Frances Davidson. Anglican institution.
- 1888** Dr William Munk published *Euthanasia: or Medical Treatment in Aid of an Easy Death*. Textbook for physicians on medical management of the dying.
- 1891** Hostel of God, founded in Clapham, in response to an advertisement placed in *The Times* on 25 December by Colonel William Hoare, in collaboration with Mother Clara Maria Hole, Superior of St James' Servants of the Poor. To be run on Church of England principles and by members of the Church of England.
- 1893** St Luke's House founded in Regent's Park by Dr Howard Barrett, Medical Superintendent of the West London Mission. First patient received 1 August. Methodist run home.
- 1895** St Luke's Committee of Management formed - took on responsibility for running the Home.
- 1896** St James' Servants of the Poor ceased to be connected with the Church of England and handed over management of the Hostel of God to St Margaret's of East Grinstead.
- 1897** Hostel of God Council formed. Given financial and external control of the Home.
- 1900** 02 July: Irish Sisters of Charity established a foundation in Hackney.
November: St Luke's House moved into new, larger premises in Lawn Road.
- 1902** 16 January: St Luke's House closed temporarily because evicted from Lawn Road premises by landlord.
- 1903** 10 June: St Luke's House re-opened in Pembridge Square.
The Home of the Compassion of Jesus was founded in Deptford by the Anglican Community of the Compassion of Jesus.
- 1905** St Joseph's Hospice for the Dying opened on 15 January. Founded by Father Peter Gallwey, a Jesuit priest and run by the Irish Sisters of Charity. Roman Catholic institution.

- 1908** Private Nursing Home opened at St Joseph's Hospice for paying patients.
- 1909** Nursing Home for paying patients opened at Hostel of God. Contained twelve beds and an operating theatre to provide treatment for severe cases of illness or for persons about to undergo surgical operation.
- 1912** St Luke's House separated from the West London Mission and became an independent institution. The 'Constitution of St Luke's House' was drawn up.
- 1914** Howard Barrett resigned from post of Medical Superintendent at St Luke's House. Replaced by his son Dr Edmund Barrett.
- 1917** 22 December: St Luke's House changed to 'St Luke's Hospital for Advanced Cases'.
- 1922** New 48-bed hospital built by St Luke's at Hereford Road.
New extension added to St Joseph's Hospice. Accommodation now available for 75 patients.
- 1925** Death of Edmund Barrett. Replaced by Dr Charles Buttar as Medical Superintendent.
- 1930** Death of Charles Buttar. Replaced by Dr Edmund Furber.
- 1931** Property adjoining the Hostel of God purchased for the purpose of accommodating patients with more long-term conditions.
- 1933** Hostel of God accommodation increased to admit up to 55 patients.
- 1936** Voluntary Euthanasia Bill defeated in Parliament.
Medical Sub-Committee formed at St Luke's to deal with medical matters.

INTRODUCTION

The late Victorian era saw the creation of the first institutional provision specifically for the dying poor. Until then institutional care of the dying, where it existed, had only featured as part of a much broader programme of care which included chronic and incurable patients, most of whom had indeterminate prognoses. Even in early Christian and Medieval hospices, traditionally viewed as the forerunners of 'modern hospices', care of the dying occurred alongside care of the living.¹ It was not until the late nineteenth century that the two were differentiated; between 1879 and 1905 five homes were established in London, and another in Dublin, with the intention of providing a place of peace and comfort for the dying poor. The overall aim of this thesis is three-fold: to understand why these homes were set up during the late Victorian and early Edwardian era and the extent to which they can be seen to represent a new approach to care of the dying; secondly, to explore their foundation and development between 1878 and 1938; and thirdly to discover what they reveal about, and where they fit into, wider medical, social, religious and philanthropic changes during this period.

The late nineteenth and early twentieth century was a time of considerable transition; religion was being challenged by secularism, voluntarism was under threat from collectivism, moral assumptions about the 'respectable poor' and paupers were changing and attitudes towards death and dying were altering fundamentally. The homes for the dying, as religious-based, philanthropic institutions for the dying poor, were influenced profoundly by these wider changes and engaged with them in different ways. The themes of continuity and change, together with those of comparison and contrast, are therefore essential considerations for a study looking at the development of institutions over a period of time and as such provide a central focus for the thesis.

¹ Rawcliffe, C. (1999) *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital St Giles, Norwich, c1249-1550*. Stroud: Sutton Publishing Limited, pp.1-33 ; Sarnowsky, J. (1999) Regional problems in the history of mendicant and military orders, in J. Sarnowsky (ed) *Mendicants, Military Orders and Regionalism in Medieval Europe*. Aldershot: Ashgate, pp.1-15.

Traditionally, Christianity has had a profound influence upon care of the dying and the development of hospices - the latter grew out of the early Christian tradition of care for the sick and dying. The creation of homes for the dying in the late nineteenth century with a strong Christian emphasis suggests that it continued to be one of the principal determining factors in their evolution. Like many other Victorian charitable enterprises, the homes were first and foremost religious institutions and, as such, formed part of the Church's wider efforts during this period to respond to what it perceived as pervasive working class indifference to religion. Three out of the five early homes in London were run by religious orders, while the other two rested on solid religious underpinnings. Religious pluralism was well established in Victorian England² and meant that each home, while claiming publicly to be open to patients of all religions or none, had a distinct denominational basis which impacted significantly on the way in which care was delivered. This differentiation between the homes offered a good basis for a comparative enquiry and thus the focus of this study will be on three of the institutions set up in London.

The Hostel of God was founded in Clapham in 1891 by Colonel William Hoare, a local banker, and was run by an Anglican sisterhood, the Sisters of St Margaret's of East Grinstead. St Luke's House in Regents Park, was established two years later in 1893 by Dr Howard Barrett, the Medical Superintendent of the West London Mission, a Methodist-led organisation; although not run by a religious order, close contacts were maintained with the Mission and several of its Sisters visited the Home on a regular basis. The third institution was St Joseph's Hospice for the Dying founded in Hackney in 1905 by Father Peter Gallwey, a Jesuit priest, and run by a Catholic order, the Irish Sisters of Charity.

The homes were primarily a response to a perceived lack of institutional and spiritual provision for the dying poor in the late nineteenth century and to deficiencies within domiciliary care for this group. Despite experiencing an overall decline during the nineteenth century, mortality rates at the end of the Victorian era were still very high but, aside from the Poor Law infirmaries, there was virtually no formal provision for

² McLeod, H. (1996) *Religion and Society in England, 1850-1914*. London: Macmillan, p.1.

the care of the dying. Officially incurables and the dying were debarred from the voluntary hospitals, although in practice many patients died before they could be discharged. In 1851 a total of 14.6% of London deaths occurred in institutions, 5.7% of these were in metropolitan hospitals and 8.9% in Poor Law workhouses and infirmaries. By 1881 these figures had risen slightly to 9.8% and 10.7% respectively, but the large majority of deaths still occurred at home.³ The rich chose to be nursed in their homes but the dwellings of the poor were highly unsuitable for such purposes and they could not afford to pay the fees charged by physicians. However, since most of them sought to avoid the infirmaries because of their social stigma, they invariably had little choice but to die amidst the squalid and overcrowded conditions of their own domestic arrangements.

Although homes specifically intended for the dying poor represented a hitherto untried approach to care of the dying, their creation was very much part of wider medical, social, philanthropic and religious developments during this period. Charitable activity was one of the principal means by which middle and upper class Victorians expressed their concern for the poor and sought to bring them under their influence. This period saw the burgeoning of voluntary institutions which were targeted at members of the poor excluded from mainstream medical and social provisions.⁴ Ostensibly they aimed at catering for the physical and material needs of these various groups, but they were primarily intended as a means of controlling them through moral and spiritual reformation. Many had strong religious associations and formed part of a broader strategy among the Churches for countering perceived religious indifference among the poor.⁵ The homes for the dying were all founded and run by members of the middle and upper middle classes and aimed at providing spiritual care for those whose mortal life was at a close. As chapters 3 and 6 show, they add a new dimension to our understanding of the attitudes of these social groups towards death and dying and the poor during the late nineteenth and early twentieth century, suggesting a desire among

³ Mooney, G, Luckin, B and Tanner, A. (1999) Patient pathways: solving the problem of institutional mortality in London during the later nineteenth century, *Social History of Medicine*, Vol.12, No.2, p.237.

⁴ Prochaska, F.K. (1990) Philanthropy, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol.3. Cambridge University Press, pp.357-393.

⁵ Harris, J. (1993) *Private Lives, Public Spirit: Britain 1870-1914*. London: Penguin Ltd, p.157.

certain members to control the poor at the end of life, particularly their spiritual destiny.

The foundation of each home therefore rested upon a common philosophy. Those who were responsible for their establishment sought to provide medical, nursing and spiritual care, the emphasis upon the latter, for the dying respectable poor within a home-like atmosphere. As such they shared much of the same thinking which underlay other philanthropic institutions. At the same time, the homes can be regarded as novel because, for the first time, the 'dying' poor were being looked upon as requiring a special form of care which those who ran them felt could only be provided by trained medical, nursing and religious staff and through an institutional medium. They also signify the beginnings of a recognition of dying as a process, occurring over an identifiable period of time from the patient's diagnosis as 'dying' until the moment of death. The carefully defined social basis of each home's patient population, however, meant that this recognition only extended to the respectable poor.

Although the establishment of each home rested on a shared set of objectives, their subsequent development differed significantly. Until 1914 the primary focus of all three institutions was upon the provision of spiritual care and the attainment of the "Soul Cure."⁶ Every other aspect of their work was subordinated to this objective. Those who ran the homes believed that tending to patients' bodily and mental needs facilitated the transition to care of the soul, a way of thinking which formed part of a broader change in attitudes during the late nineteenth century; after the failure of attempts to spiritually reform the poor by concentrating directly on the soul, Victorian philanthropists became increasingly convinced that they would be more responsive to spiritual ministrations if they were preceded by, or accompanied with, material aid.⁷ During the inter-war period, however, St Luke's House began to move away from a primarily religious focus as the staff there became increasingly preoccupied with secular and medical issues. The different management structure of the Home and its more tenuous religious basis were particularly influential in this process. In contrast,

⁶ 'The Last Appeal for the Dying', newspaper unknown, (1913), St Joseph's Hospice Archive.

⁷ Williams, C.P. (1982) Healing and evangelism: the place of medicine in later Victorian Protestant missionary thinking, in W.J. Sheils (ed) *The Church and Healing*. Oxford: Basil Blackwell, p.285.

the very solid religious underpinnings of St Joseph's Hospice and the Hostel of God meant that they were able to retain their spiritual emphasis and continue to direct their energies into saving souls.

One of the most noticeable features that emerges from an analysis of the development of the homes for the dying in the late nineteenth and early twentieth century is their embodiment of a fundamental paradox: the persistence of strong traditional elements within an increasingly modernising institutional environment. Institutional care represented an innovative approach to caring for the dying and formed part of recent developments, such as the importance of providing the sick with medical care from trained physicians and nurses, and the use of the latest technological developments. At the same time, the founding philosophies of the homes were deeply entrenched in some of the more traditional aspects of care of the dying, the most important of which was the pre-eminence given to the soul. This inevitably set up tensions in the homes and had profound implications for their subsequent development. The staff of St Joseph's Hospice and the Hostel of God were effectively able to reconcile these tensions, but those at St Luke's were less successful in their efforts.

All three homes began life as small, community based institutions. St Joseph's was the smallest, with only 12 beds, while the Hostel of God and St Luke's each had accommodation for 15 patients. Most patients were sent to the homes from local religious-based sources, such as missionary organisations, religious sisterhoods, ministers and clergymen. St Joseph's, in particular, focused much of its work during this period on the local Irish population, many of whom were lapsed Catholics. By the end of the period, however, the homes had undergone considerable expansion and were recognised as being part of a much broader network of medical provision in London, with the majority of patients being admitted through hospital and county council recommendation. St Joseph's enlarged the most rapidly over the years and by 1938 it could accommodate up to 75 patients. St Luke's and the Hostel of God were smaller with 48 and 50 beds respectively. Although St Joseph's Hospice and the Hostel of God continued to be looked upon as homes, St Luke's House, after 1917,

assumed the status, and adopted the characteristics, of a small, special voluntary hospital.

The nursing care at St Joseph's and the Hostel of God was supplied primarily by the Sisters, with the help of a few lay nurses. In contrast, the nurses at St Luke's were all lay personnel. Each home relied on the services of honorary visiting medical personnel, the Hostel of God to a slightly lesser extent because it employed a salaried Medical Officer. All three received a markedly higher intake of female patients, between a third and a half more than men. The majority of patients suffered from phthisis (pulmonary tuberculosis) and cancer, the shift from the former to the latter being a discernible feature of the homes' development over the period studied here.

The homes also help to illuminate wider changes and developments during the late nineteenth and early twentieth century in attitudes towards care of the dying. Although incurable and dying cases were excluded from the voluntary hospitals, certain leading individuals in the medical profession began to recognise care of the dying as a separate and distinct area of practice in which patients required a more caring and supportive environment where they could be attended by qualified doctors and nurses. During the late nineteenth and early twentieth century spiritual concerns assumed an increasingly peripheral role in care of the dying as growing emphasis was placed on the importance of minimising patients' physical pain and suffering.⁸ The creation of homes with a primarily religious basis represented an attempt to reassert the value and pre-eminence of spiritual care for the dying.

The Homes for the Dying and the Historiography of Hospices

Historically care of the dying is often linked to the development of hospices.⁹ The meaning of the word 'hospice', however, has altered considerably over time. Traditionally hospices date back as far as early Christianity but, in the lay mind, they tend to be associated with the Middle Ages when they became particularly prevalent

⁸ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press, p.52.

⁹ Siebold, C. (1992) *The Hospice Movement: Easing Death's Pains*. New York: Twayne Publishers ; Manning, M (1984) *The Hospice Alternative: Living With Dying*. London: Souvenir ; Phipps, W.E. (1988) The origin of hospices / hospitals, *Death Studies*, Vol. 12, pp.91-99.

and played an important role in the development of the first hospitals. During these early periods they were regarded as places of shelter and care that ministered to a wide variety of people, including the poor, the sick and travellers.¹⁰ Care of the dying was only one part of this broader spectrum. In the 1960s the modern meaning of the word 'hospice' came into use with the founding of St. Christopher's Hospice in London. It was seen to herald a new and distinctive phase in the care for the dying which centred on the control of pain and the provision of a holistic style of care.¹¹ Little work, however, has been done on the intervening period between these two eras. It can be argued that there is a middle phase in the evolution of hospices that helps to explain how their traditional meaning was transformed into its modern definition. After the Middle Ages hospices entered a period of decline, but towards the end of the nineteenth century they underwent a form of revival. In the space of thirty years at least six homes were founded in the British Isles with the intention of providing care for the dying poor, two of which specifically called themselves 'hospices'. Four of the homes were run by religious orders who nursed the patients and managed their general day-to-day running.

These early homes can be seen to represent a link between the older, traditional hospices and the modern hospice movement. It was not until Our Lady's Hospice for the Dying was founded in 1879 that use of the term 'hospice' in the British Isles first came to be associated specifically with care of the dying. Cicely Saunders, the founder of St. Christopher's Hospice, drew much of her inspiration from her earlier experiences working in two of the homes for the dying in London: St. Luke's House and St. Joseph's Hospice.¹² It can be argued that it is here that the origins of what was later to become a movement can be found. These homes signify the first attempts in England and Ireland to separate out and distinguish care of the dying from care of the living. They provided the conditions for, and enabled the development of, a more specialised care of the terminally ill in the 1960s.

¹⁰ Ibid., pp.91-94.

¹¹ Clark, D. (1998) Originating a movement: Cicely Saunders and the development of St Christopher's Hospice, 1957-1967, *Mortality*, Vol.3, No.1, pp.43-63.

¹² Ibid. ; Clark, D. (1999) 'Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958-1967, *Social Science and Medicine*, Vol.49, pp.729 ; Saunders, C. (1993) Foreword, in D. Doyle, G.W.C. Hanks and N. MacDonald (eds) *Oxford Textbook of Palliative Medicine*. Oxford: Oxford University Press, p.vi.

Despite their importance to an understanding of the modern hospice movement, these homes have been severely neglected by both historians and others researching the historical development of hospices. A considerable amount of work has been done on medieval hospices because of their wider role within general hospital provision in the Middle Ages.¹³ Most historians, however, prefer to focus on the modern movement and tend to skim over, or outrightly ignore, the part played by the early homes for the dying. As a result the origins and early history of the modern hospices are poorly understood. The first homes for the dying have come to be regarded as merely a staging post on the way to the 'real' hospices. The findings from this research suggest that those interested in understanding the modern hospice movement might benefit from a much closer scrutiny of their Victorian and Edwardian roots. The immediate impact of the homes may have only been limited but their influence upon the work of Cicely Saunders and the creation of St Christopher's Hospice, particularly St Joseph's Hospice and St Luke's House, was far greater than has been realised until now, particularly in light of recent research by David Clark which has shown that Saunders spent a long time deliberating whether or not to found her new hospice as a religious community.¹⁴ The consequences for the so called 'modern' hospice movement if she had gone down this route would have been enormous.

It should also be noted that most historical accounts of hospices have been the work of those who are themselves significant players in the modern hospice movement and a general preoccupation with its modern beginnings has led them often to gloss over its Victorian antecedents. Even Cicely Saunders, the founder of the modern movement, despite acknowledging the debt she owes to St Joseph's and St Luke's, underplays the overall significance of the early homes for the dying, giving them only passing mention before moving on to her central focus: post-1950s hospice development.¹⁵ As a historian working in a palliative medicine department, it was impossible not to be aware of the possible dangers of judging the homes in the light of modern developments. However, because the intention of this thesis is to focus on the period

¹³ Rawcliffe, C. (1999) *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital St Giles, Norwich, c1249-1550*. Stroud: Sutton Publishing Limited ; Sarnowsky, J. (1999) (ed) *Mendicants, Military Orders and Regionalism in Medieval Europe*. Aldershot: Ashgate.

¹⁴ Clark, D. 'Originating a movement', pp.48-51.

¹⁵ Saunders, 'Foreword', p.vi.

1878-1938 rather than simply trying to understand how modern hospices evolved from early 'hospices', many of these pitfalls can be avoided. This thesis aims to treat the homes for the dying as a subject in their own right.

As mentioned earlier, there is considerable confusion over the significance of the term 'hospice' in relation to care of the dying. Most attempts to look at the history of hospices are concerned primarily with tracing the origins of the word 'hospice' and its development over time, and as a consequence make very little reference to the other homes for the dying that were set up in the late Victorian era.¹⁶ The Friedenheim and the Hostel Of God receive scant acknowledgement, while the Home of the Compassion of Jesus does not receive a mention anywhere. Most histories tend to focus on Our Lady's Hospice, Dublin, St Joseph's Hospice and St Luke's House. It is important to remember that only one of the first homes for the dying in England called itself a hospice. The significance of the other homes tends to be obfuscated by this emphasis upon hospice.

Many hospices, including some of the Victorian homes for the dying, have commissioned their own histories, but these are largely hagiographic narratives, from which any kind of rigorous analysis or critical voice is notably lacking. As well as contributing to the historiography of hospices, these histories can be viewed as source material in their own right. However, they must be treated with a degree of circumspection; as David Cantor argues, the writers of such histories find it very difficult to maintain critical distance because more often than not they are serving a particular agenda, usually that imposed by their patron.¹⁷

Until now, no comprehensive, in depth history of the early hospices has been written so this study will fill an important gap within the historiography. The latter shows that our understanding of nineteenth century hospices is largely inadequate and founded on many misconceptions. The development of hospices up until the Reformation is generally better understood than later developments. Hospices are traditionally traced

¹⁶ Phipps, 'The origin of hospices / hospitals', pp.91-99 ; Goldin, ' A protohospice at the turn of the century', pp.383-415 ; Siebold, *The Hospice Movement* ; Manning, *The Hospice Alternative*.

¹⁷ Cantor, D. (1992) Contracting cancer? the politics of commissioned histories, *Social History of Medicine*, Vol.5, No.1, pp.132-133.

back to the early Christian era when they were first founded as shelters for pilgrims and other travellers. From the eleventh century onwards they spread throughout Europe through the work of the Knight's Hospitallers and the establishment of the numerous monastery-based hospices, during which time care of the sick, wounded and dying became an integral part of their work. With the dissolution of the monasteries in the sixteenth century, however, the idea of hospice was temporarily abandoned.¹⁸

Confusion begins to arise over their revival in the nineteenth century, particularly the first use of the term hospice in a modern sense, specifically to mean care for the dying. Some of those investigating hospice development use the term hospice in a very *ad hoc* way to denote any form of hospital for incurables and the dying. M. Manning is under the misapprehension that St Vincent's Hospital in Dublin was the first hospice and Our Lady's in Dublin only the second.¹⁹ Others, such as Richard Lamerton and Cathy Siebold, believe that Mary Aikenhead was directly responsible for conceiving the notion of a hospice for the dying.²⁰ Siebold is also suffering from the illusion that St Joseph's Hospice was founded by Elizabeth Fry and that she was responsible for developing hospices in London through her religious group, the English Sisters of Charity.²¹

Those acquainted with the work of Cicely Saunders²² are better informed; they attribute the first use of the term in its modern meaning to the 'Calvaires' set up by a French widow, Jeanne Garnier, from 1843 onwards. The one very glaring exception is Grace Goldin, who despite collaborating with Saunders on her research into the history of St Luke's House, is still misinformed about the use of the word hospice in the nineteenth century. She believes that St Vincent's Hospital in Sydney was the first use of the word hospice in its modern sense. She incorrectly dates the beginnings of the hospital to the 1830s (it was not established until 1857) and is under the impression that it had a hospice attached to it at this time (the Sacred Heart Hospice

¹⁸ Phipps, W.E. 'The origin of hospices / hospitals', pp.91-95.

¹⁹ Manning, M. *The Hospice Alternative*, p.41.

²⁰ Lamerton, R. (1980) *Care of the Dying*. London: Penguin, p.17 ; Siebold, C. *The Hospice Movement*, p.20.

²¹ *Ibid.*, p.21.

²² Saunders, 'Foreword', pp.v-viii.

was not founded until 1890).²³ It is an interesting side-issue that none of the authors with inaccurate information cite any references. An almost self-perpetuating myth has developed; most of these historians rely on each other to provide supporting evidence and very few have consulted the original sources. For example, Manning, whose book was published three years after Goldin's article, has, in all probability, used the latter as a reference because she too states that St Vincent's Hospital, founded in Sydney in the 1830s, was the first hospice in Australia.²⁴ One of the aims of this thesis therefore is to demythologise the early 'hospices'.

The Homes for the Dying and the Historiography of Death and Dying

Within the last forty years death and dying has become a subject of significant historical interest. The seminal text is Geoffrey Gorer's *Death, Grief and Mourning in Contemporary Britain*, published in 1965. His pronouncement of the taboo of death in modern society precipitated an outpouring of discursive literature which in turn stimulated the interest of a number of historians to investigate attitudes towards death in the past. However, despite this growing interest in the history of death, there are still vast areas of uncharted territory. Much of the work done has tended to focus upon death and the dead body rather than the deathbed and dying person before death. The Victorian celebration of death - the reasons for it and the way in which it manifested itself - formed the subject of much of the early work of historians.²⁵ More recently attempts have been made to unravel the meaning of death, grief and bereavement among certain groups, such as paupers and the Victorian middle and upper classes.²⁶

Most historians writing about death in the nineteenth century have adopted a more specialist, focused approach in an attempt to understand the multiplicity of beliefs and perceptions that existed among individuals and groups. They have looked at such

²³ Goldin, 'A protohospice at the turn of the century', p.390 ; Stuart-Harris, R (1995) *The Sacred Heart Hospice: an Australian centre for palliative medicine*, *Support Care Cancer*, Vol.3, pp.280-284.

²⁴ Manning, M. *The Hospice Alternative*, p.41.

²⁵ Curl, J. (1972) *The Victorian Celebration of Death*. London: David and Charles ; Morley, J. (1971) *Death, Heaven and the Victorians*. University of Pittsburgh Press.

²⁶ Richardson, R. (1987) *Death, Dissection and the Destitute*. London: Routledge and Kegan Paul Ltd; Laquer, T. (1983) Bodies, death and pauper funerals, *Representations* 1:1, pp.109-131 ; Jalland, *Death in the Victorian Family* ; Cannadine, D. (1981) War and death, grief and mourning in modern Britain, in J. Whaley (ed) *Mirrors of Mortality*. London: Europa Publications Ltd, pp.187-242.

areas as Victorian eschatology, cremation, the impact of the First World War and attitudes towards death among the Secularist community.²⁷ This thesis, by following the same trend and focusing upon a specific context, helps to provide further insight into the complex interplay of beliefs about death and dying during this period.

Despite a growing awareness of class-based attitudes towards death, the majority of studies have focused on elite groups within Victorian society; the middle and upper classes. The only major piece of historical work on death and dying in the late nineteenth and early twentieth century is Pat Jalland's *Death in the Victorian Family*, which focuses on the Victorian and Edwardian middle and upper classes within the context of the family. Through an analysis of the diaries and journals of 55 families she attempts to understand what death and dying, grief and mourning meant to them.²⁸ However, it is debatable as to how representative these families were of the middle and upper classes during this period, an issue which Jalland only touches on briefly.

Jalland too has fallen prey to the temptation to relate some of her findings to developments within the modern hospice movement. For example, she compares the work of Victorian doctors on medical care of the dying with the attitudes and practices of modern day doctors, arguing that Dr William Munk, a pioneer in medical care of the dying during the late nineteenth century, was the Victorian equivalent of modern experts in the field of palliative medicine, such as John Hinton, Cicely Saunders and Elisabeth Kübler-Ross, and thereby anticipated much of their work.²⁹ Like many other historians, Jalland has also found it difficult to escape the reverberations of Gorer's arguments. Her work appears to be a reaction to the more critical studies of historians such as David Cannadine who have attacked the nostalgic view of Victorian Britain held by Gorer and the French historian, Phillipe Ariès. In contrast, Jalland's approach verges on the eulogistic and she finds little to censor in the way in which her Victorian families understood and handled death and grief. This study, by looking at middle and

²⁷ Rowell, G. (1974) *Hell and the Victorians*. Oxford: Clarendon Press ; Houlbrooke, R. (1989) (ed) *Death, Ritual and Bereavement*. London: Routledge ; Wheeler, M. (1990) *Death and the Future Life in Victorian Literature and Theology*. Cambridge University Press ; Nash, D. (1995) 'Look in her face and lose thy dread of dying': the ideological importance of death to the Secularist community in nineteenth century Britain, *The Journal of Religious History*, Vol. 19, No. 2, pp.158-180.

²⁸ Jalland, *Death in the Victorian Family*.

²⁹ *Ibid.*, pp.77, 96.

upper middle class attitudes towards death as it relates to care of the dying poor, has implications for some of Jalland's findings. In particular, it helps to qualify her conclusion that among these groups the importance of spiritual aspects of care of the dying had declined by the late nineteenth century and had given way to greater anxiety about physical suffering.

Little research has been done on the working classes, although pauper attitudes towards death and dying have begun to form the subject of historical inquiry,³⁰ and virtually no work has been done on provisions of care for the dying poor. Much research has been carried out on preventative measures for the consumptive poor (sanatoria) and provisions for the sick poor, paupers and the insane, but an investigation into the way in which the dying poor were looked after has yet to be undertaken. Similarly, care of the dying has attracted little interest among historians of nineteenth century philanthropy. Although the role played by women in charitable work during this period and the importance of religion as a motivating factor are readily acknowledged, philanthropic encounters with the dying poor, usually in the context of home-visits, receive only passing reference, despite the high mortality rates.³¹ Likewise, the work of religious orders, whose charitable endeavours expanded dramatically throughout the Victorian era, is afforded relatively little recognition.³² The expansion of institutional care in the nineteenth century and the development of institutions for virtually all forms of need is also emphasised by historians, but again not as it related to the dying poor. The very creation of homes for the latter in the 1880s and 1890s is revealing of the extent to which institutional care had come to be looked upon as fundamental to Victorian medicine and philanthropy and of the recognition, by certain individuals, that this group had special philanthropic needs which could only be met through an institutional medium.

³⁰ Richardson, *Death, Dissection and the Destitute* ; Laquer, 'Bodies, death and pauper funerals', p.109-131.

³¹ Prochaska, F.K. (1987) Body and soul: Bible nurses and the poor in Victorian London, *Historical Research*, 60, pp.336-348 ; Summers, A. (1991) The costs and benefits of caring, nursing charities, c1830-c1860, in J. Barry and C. Jones (eds) *Medicine and Charity Before the Welfare State*. London: Routledge, pp.133-148.

³² Prochaska, F.K. (1980) *Women and Philanthropy in Nineteenth Century England*. Oxford: Clarendon Press.

This study therefore attempts to fill a so far neglected area in both the historiographies of philanthropy and of death and dying in the nineteenth century by examining the creation of homes specifically designed to care for the dying poor. It will also contribute to furthering our understanding of middle and upper class attitudes towards death and dying not only within their own social context but, more specifically, in relation to their perceptions of members of the poor and their relationship with this group. Finally, this study has implications for several of the major issues discussed by historians researching death and dying in the late Victorian and Edwardian eras: the beginnings of the concealment of death from the 1850s onwards³³ and the declining importance of spiritual aspects of care of the dying.³⁴ As will be seen, those who ran the homes were concerned to revive the importance of spiritual care of the dying by helping patients to confront the reality of their death.

The decision to focus this study on three particular homes was dictated, in part, by the availability of primary sources, but it also offered a three way comparison of three institutions with very different denominational allegiances, each of which reflected an important aspect of the wider religious picture during this period. The other advantage of a comparative study was that it assisted in the examination of the homes at two different levels; firstly the common factors which shaped their evolution and, secondly, the more diverse and idiosyncratic influences which underlay their individual development.

Although the selection of primary material was determined principally by its availability - the Hostel of God, St Luke's House and St Joseph's Hospice having the greatest number and variety of sources - the somewhat limited nature of these records had implications for the way in which the research was conducted and shaped the type of questions that could be asked. The four principal types of record were annual reports; the Sisters of Charity Annals (six-yearly chronicles); committee minute books; and patient registers. The absence of any sources written directly by the

³³ Ariès, P. (1981) *The Hour of Our Death*. London: Allen Lane ; Leaney, J. Ashes to ashes: cremation and the celebration of death in nineteenth-century Britain, in R. Houlbrooke (ed) *Death, Ritual and Bereavement*. London: Routledge, pp.118-135 ; Cannadine, 'War and death, grief and mourning', p.187-242.

³⁴ Jalland, *Death in the Victorian Family*, p.52.

patients or their families meant that it was only ever possible to examine the homes from the perspective of those who ran them. However, because the material available was compiled within a number of different contexts and for a variety of purposes, it provides a range of viewpoints from which the homes can be examined. It was also possible to gain some insight into patient experiences from these records, although most of the information had to be inferred rather than taken as direct evidence.³⁵

The choice of London as the geographic area was determined by the distribution of the first homes for the dying in the British Isles; all but one were founded in London. The possibility of a comparative study between the Sisters of Charity hospices in London and Dublin was considered but it was decided that the first type of study offered much greater potential for examining the very different patterns of development that occurred in each of the London homes.

The starting date of 1878 was chosen because the first institutional provision for the dying in the British Isles was founded in 1879.³⁶ Taking the study up until 1938 permitted an examination of the development of the homes during a period which saw significant religious, social, political and medical changes. It also encompassed the First World War which had a profound effect on popular attitudes towards death and dying. It forced a confrontation with death on a scale and in a manner never previously experienced with which a whole generation had to try and come to terms. The attitudes of those who ran the homes are important because they did not seem to reflect these broader changes, although changes in popular attitudes might perhaps have played a part in limiting the influence of the homes within society and in shaping the development of St Luke's House.

A few comments need to be made on the use of certain terms and their changing meaning during this period. The terms phthisis or consumption are used interchangeably throughout the thesis. It should also be noted that those terms which

³⁵ See Appendix 1 for a more detailed discussion of the primary sources and their implications for the thesis.

³⁶ Although Our Lady's Hospice, Dublin, is not one of the three homes which form the focus of this present study, its foundation represented a watershed in care of the dying and it had an important influence upon the establishment of St Joseph's Hospice in London.

had a specific meaning to contemporaries have been placed in quotation marks and an attempt has been made not to use terms which they themselves did not use. For example, the modern concept of 'terminally ill' is avoided because it was not used by contemporaries; rather, they always referred to patients as 'dying' or in an 'advanced' stage.

During the late nineteenth century the use of the term 'Euthanasia' also changed. Historically, it has had three different meanings. Under its traditional classical usage it simply meant 'a calm and easy death'. However, during the eighteenth century its meaning altered slightly to denote the *means* of bringing about a gentle and easy death.³⁷ During the late nineteenth century its meaning began to change again. Most Victorian doctors continued to adhere to the traditional meaning of 'a calm and easy death', but by the turn of the century, certain medical professionals were applying a different definition to the term. For the first time serious consideration was being given to the possibility of actively *inducing* a gentle and easy death by terminating the life of a patient suffering extreme pain.³⁸

Structure of Thesis

The first two chapters aim to explain why the homes emerged when they did and the factors behind their creation. This is examined at two levels. Chapter one looks at the broader medical, religious, philanthropic and social contexts during the late nineteenth century. It argues that the homes were principally a response to three perceived deficiencies in care of the dying poor in London: the paucity of formal medical and nursing provision, inadequacies within domiciliary care and the lack of spiritual care. Towards the end of the nineteenth century certain individuals and groups became aware, for the first time, of the existence of large numbers of dying respectable poor who had nowhere to go where they could be cared for, medically or spiritually, in the last few weeks of their life and, as a result, they began to question the nature of this deficiency. At the same time, the foundation and development of the homes was very much shaped by wider contemporary forces and specific Victorian sensibilities, such

³⁷ *Oxford English Dictionary* (1989) 2nd edition, Vol.5. Oxford: Clarendon Press, p.444.

³⁸ *Ibid.* ; Jalland, *Death in the Victorian Family*, pp.93-94.

as middle and upper class attitudes towards the poor and the changing nature of Victorian Churches, as they attempted to counter perceived religious indifference among the masses by developing new strategies, including a greater dependence upon sisterhoods and a concern to provide social as well as spiritual care.³⁹

Chapter two takes the individual hospices as its theme and compares and contrasts the specific factors behind the creation of each, particularly those which influenced their subsequent pattern of development. Information is drawn mainly from the annual reports and annals (chronological accounts by the Sisters of Charity) and is thus, largely, a reconstruction of how the founders wished to portray the establishment of their respective homes. The influence of the denominational allegiance of each institution upon its foundation, underlying philosophy and later development is also very evident.

The thesis then moves on to address more specific issues such as the attitudes towards death and dying of those who ran the homes, the patient population, medical, nursing and spiritual roles in care of the dying and the way in which power and control was manifested. The objective of chapter three is to examine the beliefs about death and dying which underpinned the philosophies of each of the homes. These are important because they determined the way in which care was provided, particularly the interplay between religious and material concerns, and the ways in which the patients themselves were perceived. Again, these attitudes were very much determined by the denominational basis of each home. Perceptions of death and dying within the homes are also important because they challenge prevailing historical interpretations of attitudes towards death during the late nineteenth and early twentieth century.

³⁹ Rose, M.E. (1988) *The disappearing pauper: Victorian attitudes to the relief of the poor*, in E.M. Sigworth (ed) *In Search of Victorian Values*. Manchester University Press, pp.56-72 ; Harris, *Private Lives, Public Spirit*, p.157 ; Norman, E.R. (1976) *Church and Society in England 1770-1970*. Oxford: Clarendon Press, p.124 ; Fahey, T. (1987) *Nuns in the Catholic Church in Ireland in the nineteenth century*, in M. Cullen (ed) *Girls Don't Do Honours: Irish Women in Education in the Nineteenth and Twentieth Centuries*. Women's Education Bureau, p.7.

Increasing recognition is being given by historians to class-based differences in attitudes towards death during the nineteenth century,⁴⁰ but much less work has been done on religious differences. Most of those who have looked at death and dying during this period have focused upon the influence of Evangelicalism and the model of the good death which it provided.⁴¹ However, Evangelicalism did not provide a single model of death; rather it impacted upon the various Christian groupings in differing ways. Little allowance is made by other historians for the possible differences that existed within it or the possibility of other models of death. For example, David Nash has demonstrated the importance of the secular model of death to the non-religious.⁴² Likewise, those responsible for running the homes for the dying had very different understandings of the good death. In the same way, there is a notable lack of recognition of the growing religious plurality of this period, especially during the second half of the nineteenth century. With the decline of Evangelicalism after the 1860s sectarianism became increasingly apparent and was both responsible for, and reflective of, social and political allegiances. The influence of the denominational basis of each home becomes very evident when their perceptions of death and dying, particularly their evaluation of patients' experiences, are examined.

Jalland, in her study of death and dying among upper and middle class families found that from the second half of the nineteenth century onwards spiritual aspects of the deathbed held a decreasing significance. Instead, anxiety about physical suffering assumed greater importance.⁴³ In the creation of homes for the dying poor with a specifically religious basis by members of the middle and upper classes, this process is directly contravened; spiritual concerns remained at the forefront from the onset.

The first section of chapter three explores how those running the homes for the dying understood and evaluated death and the way in which this impacted upon their attitudes towards physical and spiritual care, pain and suffering. The second section

⁴⁰ Richardson, *Death, Dissection and the Destitute* ; Laquer, 'Bodies, death and pauper funerals', p.109-131 ; Jalland, *Death in the Victorian Family*.

⁴¹ Jalland, *Death in the Victorian Family* ; Cecil, R. (1982) Holy dying: Evangelical attitudes to death, *History Today*, Vol.32: 30-34.

⁴² Nash, 'Look in her face', pp.158-180.

⁴³ Jalland, *Death in the Victorian Family*, p.52.

examines staff perceptions of the patients and their experiences within the home through an analysis of the different accounts of patients that were contained in the annual reports and annals. The period 1893 to 1938 saw significant changes in the way in which these were written and is illuminative of the homes' development over the years. St Joseph's Hospice and the Hostel of God continued to emphasise the importance of spiritual care throughout the period, although the focus of this work at the former institution changed significantly during the early 1920s. At St Luke's spiritual aspects gradually became subsumed within more secular concerns. This section concludes that the management of the deathbed in all three homes in the first half of the period was primarily determined by spiritual objectives, principally the overriding aim of saving patients' souls, while the particular way in which this was effected was influenced by their denominational basis.

In chapter four the practical workings of the homes are examined. This chapter aims to provide a more patient-oriented perspective by looking at the demographic makeup of each institution and changing patterns of admission, epidemiology, length of stay, mortality and discharge through an empirical analysis of their patient data. Both St Joseph's Hospice and St Luke's House have patient registers which contain information on date of admission, age, occupation, religion, condition, outcome, date of death / discharge and the person recommending them. Although the information is based upon the doctors' / nuns' perceptions and does not provide direct insight into the patients' experiences, it is possible to look at them as a group and to explore changing trends over the years. Throughout the period each home experienced a fundamental shift in its epidemiological basis: a predominance of phthisis patients in the early years gradually gave way to a much higher proportion of cancer patients. This transition occurred at different times within each of the homes. The gradual increase in the age of inmates was also, in part, linked to this transition, while the changing patterns of mortality, discharge and length of stay are particularly revealing of the problems encountered in trying to maintain their status as homes for the *dying*.

Chapter five looks at the care provided in the homes within its broader context through an examination of how care of the dying was perceived among medical and

nursing professions in the late nineteenth and early twentieth century and the relationship of the homes to this broader picture. This period saw several new developments in the medical management of the dying: changes in attitude towards related areas such as pain; the emergence of medical care of the dying as a special area of medical interest; and the gradual re-prioritisation of medical, nursing and spiritual care.⁴⁴ The homes for the dying responded to, were shaped by, and contributed towards, many of these developments, although they did not necessarily conform to them.

Jalland is the only other historian who has looked at medical management of the dying during this period, albeit within the context of middle and upper class families. She found that in the Victorian and Edwardian era the doctor's role in the management of the deathbed increased as concerns about the patient's physical comfort assumed greater importance.⁴⁵ However, within the homes for the dying studied here the priority given to spiritual conversion meant that medical care was subordinated to religious ministrations.

The first section of chapter five looks at the wider context of medical and nursing management of the dying during the late nineteenth and early twentieth century through an examination of the emergent literature in this field. The period 1878 to 1938 witnessed significant changes in medical attitudes towards care of the dying. Spiritual issues, which had, until the late nineteenth century, been given priority at the deathbed assumed diminishing importance as doctors began to envisage a more active role for themselves in managing patients' pain and physical suffering. Physicians' perceptions of the scope of their role also changed. In the late Victorian era most doctors accepted that it was their moral duty to sustain the life of the patient as long as possible. However, discussion surrounding the Euthanasia Bill in the 1930s suggests that by the early decades of the twentieth century there was a growing acceptance among certain leading medical circles that in cases where patients were experiencing

⁴⁴ Ibid., pp.77-90 ; Rey, R. (1993) *The History of Pain*. Massachusetts: Harvard University Press, pp.131-139, 182.

⁴⁵ Jalland, *Death in the Victorian Family*, pp.77-86.

extreme pain the physician's priority was to minimise their suffering even at the cost of shortening their life.

The second section of chapter five examines how care was provided in each of the homes and how it changed over time by looking at the organisation of care and the attitudes of the various personnel responsible for caring for the patients. It will explore, in particular, the balance between medical, nursing and spiritual care and the way in which the staff responsible for these perceived their role. The significantly different structure of management and staff at St Luke's House had important implications for its development over the years. The final section moves away from the providers of care in an attempt to begin to understand what life might have been like for the patients in the homes. The more formally prescribed information in the annual reports and statutes provides a picture of how those who ran the homes thought they should function which can be compared with the insights on its practical workings contained in the minute books and annals.

Chapter six looks in more detail at the implications of some of the issues raised in chapters three and five. It discusses the ways in which patients were subjected to different forms of control in which both their bodies and the manner of their deaths were carefully managed in order to achieve the more important goal of conversion. The various ways in which patients were able to respond to these efforts and make their own impact on the homes, that is to form resistances, is also considered. The third part of the chapter examines the homes as small, but isolated, pockets of response to some of the wider changes and developments that were going on around them, particularly, the ways in which the dying were cared for (or not cared for) in Poor Law infirmaries, the voluntary hospitals and in their own homes. The final section addresses a claim by a recent historian that the beginnings of the institutionalisation of death began during the second half of the nineteenth century and considers the question of whether or not the homes can be seen as part of this process.⁴⁶

⁴⁶ Crowther, M.A. (1981) *The Workhouse System 1834-1929*. Batsford Academic and Educational Ltd, pp.57-58.

The conclusion examines the extent of the homes' impact, collectively as well as individually, by exploring some of the possible reasons why they failed to spread either locally, throughout London, or at a national level. The first part of this section assesses briefly the individual success of each home by evaluating its position at the end of 1938. The second part looks more closely at the broader impact of the homes and considers some of the possible reasons why it was so limited, arguing that by the second decade of the twentieth century social, medical and religious conditions had gradually begun to stabilise so that many of the circumstances which had given rise to the need for homes for the dying 'respectable' poor had largely disappeared or were no longer underpinned by the same sense of urgency. The inability of the homes to make a national impact also owed much to the fact that they were independent, idiosyncratic initiatives, each adopting a highly individualistic approach, particularly in the way in which spiritual care was provided.

CHAPTER 1

Contexts of Development: Britain in the Late Victorian Era

1. Medicine and care of the dying in the late nineteenth century

The first reason why the homes were set up was to provide institutional care for the dying who, along with incurables, were ineligible for admission to voluntary institutions and were inadequately provided for by state organisations. Provision of medical care for the dying in late Victorian England was structured along the lines of class and income. Aside from a possible visit to a convalescent home, the wealthy middle and upper classes were for the most part nursed at home, especially if they were in the advanced stages of an illness. Destitute scores of upper and middle class

The foundation of homes specifically for the dying poor in the late nineteenth and early twentieth century signified a new phenomenon - until now this group had not been identified as requiring special institutional care. The aim of this chapter is to identify and discuss those factors which gave rise to their establishment at this particular time. The creation of the homes was principally a response to three perceived deficiencies in care of the dying poor in late Victorian London: the lack of formal medical and nursing provision, inadequacies within domiciliary care and the paucity of spiritual ministrations. For the first time the existence of large numbers of the dying respectable poor who had nowhere to go to be cared for, medically or spiritually, came to the attention of certain individuals and groups who began to look upon this situation as problematic and to question some of the reasons behind it.

At the same time, the underlying ideologies of the homes were shaped by wider developments during this period. Their religious basis was very much part of broader religious and philanthropic trends, particularly the churches' concern to reach the working classes, many of whom were held to be indifferent to religion. Likewise, their confinement to the respectable poor was influenced by upper and middle class concerns about poverty and morality. Although the homes were, in part, a product of these broader developments, they also set out to directly challenge certain elements within them by initiating a new approach to care of the dying. The discussion which follows is essentially concerned with events which happened at a national level, but where appropriate the focus is upon the situation in London.

i. Medicine and care of the dying in the late nineteenth century

The first reason why the homes were set up was to provide institutional care for the dying who, along with incurables, were ineligible for admission to voluntary institutions and were inadequately provided for by state organisations. Provision of medical care for the dying in late Victorian England was structured along the lines of class and income. Aside from a possible visit to a convalescent home, the wealthy middle and upper classes were for the most part nursed at home, especially if they were in the advanced stages of an illness. Deathbed scenes of upper and middle class

Victorians almost always took place at home, usually in the presence of other family members.¹ For the respectable or deserving poor there were the voluntary hospitals, but many of these, particularly the major teaching and specialist hospitals, tended to give priority to patients who were considered useful for the research and education of medical practitioners. Although hospitals were increasingly committed to restoring patients to health, their status as community institutions meant that in practice they often found themselves involved in the day to day management of care. Persons known to be suffering from chronic and incurable conditions were refused admission. Similarly, those who did succeed in gaining entrance but were subsequently diagnosed as incurable, were immediately discharged. Doctors and governors were concerned to secure a reputation for the hospitals as institutions of health not death, not least because issues of funding were tied up in their ability to serve a restorative function within society. Chronic and incurable conditions were looked upon unfavourably because they were expensive to care for and their presence in large numbers did not promote a favourable image of hospitals or provide an attractive incentive to benefactors.²

The admissions policy of the voluntary hospitals reflected the wider Victorian philanthropic ethos which emphasised the importance of moral character. Charity was a gift freely bestowed aimed at enabling the poor to once again support themselves independently; to spend money on those with no prospect of improvement would only be a misapplication of that charity.³ On leaving the hospital incurable patients had no choice but to return home, or if this was not possible, to seek refuge in the workhouse or infirmary. District nurses, such as Ellen Ranyard's Bible Nurses, who visited the London poor in their homes, did provide a basic form of nursing care for those who

¹ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press.

² Abel-Smith, B (1964) *The Hospitals 1800 - 1948*. Cambridge, Massachusetts: Harvard University Press, pp.16, 39, 44 ; Woodward, J. (1974) *To Do the Sick No Harm: A study of the British voluntary hospital system to 1875*. London: Routledge and Kegan Paul, pp.45-60 ; Granshaw, L. (1992) The rise of the modern hospital in Britain, in A. Wear (ed) *Medicine in Society*. Cambridge University Press, pp.208-211.

³ Rivett, G. (1986) *The Development of the London Hospital System 1823-1982*. Oxford University Press, p.28.

were dying, but they could not provide full-time nursing and spiritual care or offer medical assistance.⁴

Ironically, in an age which saw the heyday of voluntarism, the State was virtually the sole provider of institutional care for incurable and dying persons. Poor Law infirmaries had been established in the 1870s to care for sick paupers - the undeserving poor who were forced to rely upon the Poor Law for economic and medical assistance - many of whom were suffering from chronic, incurable diseases. Although distinct from the workhouse, they were still part of its wider ethos: to discourage persons from becoming reliant upon the Poor Law by making conditions inside worse than those experienced by the labourer of the lowest class.⁵ The level of care provided by the infirmaries was therefore minimal and they became renowned as places of overcrowding and neglect. Standards in medical and nursing care in some London infirmaries did begin to improve during the nineteenth century as a result of reforms by the Metropolitan Asylums Board and the gradual introduction of resident Medical Superintendents and trained nurses.⁶ The quality of care delivered, however, was still very poor and offered little incentive against the stigma of pauperism and reputation for harshness and incompetence which prevailed.

ii. Tuberculosis and cancer provisions

In particular, homes for the dying poor were founded to provide for those dying of consumption (or phthisis as it was alternatively known) and cancer, particularly the former. Throughout the nineteenth century consumption was the leading cause of death. By 1900, despite a declining mortality rate, it was still the second single cause of death, after heart disease. During the first decade of the twentieth century it was responsible for around one in eight deaths and London, with average annual death rates in excess of those in England and Wales, had one of the highest mortality rates in

⁴ Prochaska, F.K. (1987) Body and soul: Bible nurses and the poor in Victorian London, *Historical Research*, Vol.60, pp.336-348.

⁵ Crowther, M.A. (1981) *The Workhouse System 1834-1929*. Batsford Academic and Educational Ltd, p.54 ; Longmate, N. (1974) *The Workhouse*. London: Temple Smith, p.55.

⁶ Twining, L. (1886) Workhouse cruelties, *Nineteenth Century*, Vol.20, pp.709-714.

the country.⁷ The attitudes of the medical profession towards the disease were shaped by broader medical thinking so that after the 1880s the emphasis shifted to treatment and prevention, with a view to restoring the patient to health. Phthisis cases were often refused admission to voluntary general hospitals because the latter could not afford to care for chronic cases and because they compromised their purpose as restorative institutions.⁸ Although there were four London hospitals specialising in consumption and chest ailments, they only provided sufficient beds for a very small percentage of the consumptive population and none of them would accept advanced cases. The workhouses and infirmaries were the only institutions which would accept dying consumptives, many of whom had been pauperised by the disease and forced to resort to the Poor Law.

During the late nineteenth century and the early years of the twentieth century renewed efforts were made to help consumptives through the establishment of sanatoria, but these were primarily conceived as curative and preventative institutions. They would only admit 'early cases'; those who were more likely to derive some benefit from the treatment offered. Sanatoria attached to Poor Law infirmaries were also set up. Many of the patients who entered these were in the advanced stage of the disease but, like the infirmaries, they were only looked upon as a last resort. By 1909 44% of all male and 32% of all female tuberculosis deaths in London occurred in Poor Law sanatoria.⁹

It appears that slightly more recognition was given to the needs of those dying of cancer, although provision for their care was still very inadequate. During the late nineteenth century mortality rates for cancer increased perceptibly. One contemporary noted that the death rate from the disease per million persons living in London rose from 610 to 786 between 1881 and 1890.¹⁰ The development of thoracic and

⁷ Bryder, L. (1988) *Below the Magic Mountain: A Social History of Tuberculosis in the Twentieth Century*. Oxford: Clarendon Press, p.1.

⁸ Smith, F.B. (1988) *The Retreat of Tuberculosis*. London: Croom Helm, p.62.

⁹ Worboys, M. (1992) The sanatorium treatment for consumption in Britain, 1890-1914, in J.V. Pickstone (ed) *Medical Innovations in Historical Perspective*. Basingstoke: Macmillan, pp.48-55 ; Smith, *The Retreat of Tuberculosis*, pp. 62, 105 ; Bryder, *Below the Magic Mountain*, pp.22-32 ; Dormandy, T. (1999) *The White Death: A History of Tuberculosis*. London: The Hambledon Press, pp.161-172.

¹⁰ Dunn, H.P. (1893) What London people die of, *Nineteenth Century*, Vol.34, p.890.

abdominal surgery in the 1880s, which had uncovered a whole new range of cancers, and a slowly ageing population were partly responsible for this increase.¹¹ Only a very small proportion of cancer sufferers were admitted to voluntary general hospitals because of the almost inevitable fatality of the disease. The late eighteenth and early nineteenth centuries did see a few isolated attempts to provide for dying cancer sufferers but these were wholly insufficient. In 1792 a cancer ward had been founded at the Middlesex Hospital and in 1851 the first specialist cancer hospital was set up: the London Cancer Hospital. Although both these initiatives were intended to provide care until death, by the later nineteenth century the principal focus of each was on research and treatment, with a view to finding a cure.¹²

Further recognition of the needs of those dying from cancer was demonstrated in the plans, reached independently, by the London, Glasgow and Manchester Hospitals in the 1890s to establish Friedenheims, in response to the rising pressure on existing beds from the growing use of radical surgery. These were to be homes of peace in the country, free from any religious associations, which would be modelled on the Friedenheim 'home of peace' set up for patients dying of tuberculosis in Germany in the 1880s. However, they failed to be established because, with the rise of aggressive treatment in the form of cancer surgery and radiotherapy, the focus of care shifted to patients who could be cured.¹³

There were only two other non-state provisions for the dying poor in London in 1880 - St Peter's Home in Kilburn and the Hospital of St John and St Elizabeth in Great Ormond Street - but their very existence demonstrates a growing recognition of the need to supply institutional care for this group. St Peter's Home, founded in 1861, by the Sisters of St Peter, an Anglican Sisterhood, was intended for the reception of the invalid poor, particularly those ineligible for hospitals and other homes. A few rooms were set apart for the reception of patients beyond recovery. St Peter's, like the later

¹¹ Smith, F.B. (1979) *The Peoples Health 1830-1910*. London: Croom Helm, p.329.

¹² Murphy, C. (1990) From Friedenheim to hospice: a century of cancer hospitals, in L. Granshaw and R. Porter (eds) *The Hospital in History*. London: Routledge, pp.223-225.

¹³ *Ibid.*, pp.221-2, 227 ; Murphy, C. (1986) 'A History of Radiotherapy to 1950: Cancer and Radiotherapy in Britain 1850-1950', unpublished thesis, University of Manchester, pp.1.1-1.6.

homes for the dying, was founded, in part, as a response to perceived deficiencies within existing hospital provision. A contemporary, writing in 1884, commented that:

“There are few homes for the reception of patients past recovery; and St Peter’s is especially intended for those obliged to leave the Brompton and other hospitals, who have nowhere to ‘die in’ but the workhouse infirmary.”¹⁴

However, the dying poor were only one of a range of different patients admitted to the Home; others included persons in various stages of invalidity, chronic incurables and chronically sick children.¹⁵ The Hospital of St John and St Elizabeth, the other institution which accepted dying patients, was established in 1856. The nursing care there was also provided by a religious order, the Catholic Sisters of Mercy. It was primarily founded to care for two classes of patient: those suffering from incurable disease, especially when near death, and those with chronic maladies which required long treatment. Before 1900 it only admitted female patients and children.¹⁶

Although these two institutions supplied medical and nursing care to patients, they were first and foremost, like the homes for the dying, religious institutions; both were run by religious sisterhoods and placed an emphasis upon spiritual care. This would suggest that the only real ongoing concern for the needs of the dying poor was shown by religious groups but, until the late nineteenth century, provision for their care was confined to part of a broader package of care in homes intended for a wide range of incurables and chronics. The work of St Peter’s Home, in particular, foreshadowed those institutions that would be set up with the single objective of caring for the dying poor. However, neither of these two efforts attracted a great deal of public attention. Their lack of publicity and the fact that advanced cases only formed one part of their patient intake, meant that they made little inroad into the task of caring for the dying poor.

Having established why there was a lack of medical and nursing provision for the dying respectable poor, the question still remains as to why it was not regarded as

¹⁴ Trench, M. (1884) English sisterhoods, *Nineteenth Century*, Vol.16, p.345.

¹⁵ Ibid.

¹⁶ *Hospital of St John and St Elizabeth: a Historical Tradition*, p.1 ; Canon L. Marteau (c1994) *Hospital of St John and St Elizabeth* (c1988), pp.6, 11,16.

problematic until the late nineteenth century? Part of the answer may lie in the changing prevalence of acute and chronic diseases in the late nineteenth century. During the late Victorian era there was a gradual shift from acute, infectious diseases, which had characterised pre-industrial society, to a predominance of chronic degenerative conditions, such as tuberculosis, cancer, and heart disease, which has been termed by demographers as an 'epidemiological transition'. There is, however, considerable debate between historians and demographers over the extent to which this was a real epidemiological shift or a change in contemporary perceptions. As Paul Weindling has argued, it is questionable whether or not morbidity and mortality patterns were fundamentally different before industrialisation, or whether only changes in perception have taken place.¹⁷ Tuberculosis was certainly responsible for more deaths earlier in the nineteenth century and cancer deaths were not uncommon (the numbers may have been a lot larger than the statistics suggest because of inaccuracies of diagnosis), but they were largely overshadowed by more acute, epidemic, infectious diseases such as cholera, scarlet fever and typhus fever. Although the death rate from tuberculosis was decreasing, its decline was not nearly so dramatic or sudden as that for more acute diseases. For example, after 1869 typhus fever ceased to be an epidemic; the number of deaths in London fell from 716 in 1869 to only 28 in 1885, and by 1906 the annual report of the London County Council stated that there were no deaths from the disease that year.¹⁸ The relatively rapid decline in mortality rates from acute diseases, in the wake of improvements in hygiene, nutrition and housing, meant that Victorians became increasingly aware of the presence of these more long-term diseases, although there was optimism that both tuberculosis and cancer could be arrested, if not cured. One of the changes which resulted from this epidemiological shift and which might have become apparent to contemporaries was a longer course of dying. Whereas previously patients had died within a matter of hours or days after diagnosis, chronic illnesses were generally characterised by a much longer time-span between diagnosis and death, often with an identifiable period at the end of life in which the patient was categorised as 'dying'. An awareness of growing

¹⁷ Weindling, P. (1992) From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries, in A. Wear (ed) *Medicine in Society*. Cambridge University Press, pp.305-307. Rosen, G. (1973) Disease, debility, and death, in H.J. Dyos and M. Wolff (eds) *The Victorian City: Images and Realities*. London: Routledge and Kegan Paul, p.633.

¹⁸ Rosen, 'Disease, debility, and death', p.633.

numbers of respectable poor who could be characterised as 'dying' would have become both singularly apparent and perceived as particularly problematic because of the lack of existing provisions in which they could be cared for.

iii. Institutionalisation of the dying poor

The second major reason why the London homes were set up was to provide care for those members of the dying poor who were unable to receive adequate medical, nursing and spiritual care within their own homes. As such they represented an institutional response to a domestic problem. Many of the patients came from poverty stricken areas in London, particularly the East End, where housing was overcrowded, insanitary and the facilities for caring for the sick and dying were virtually non-existent. Even district nurses and visiting sisterhoods could not provide the round the clock care that the dying required. The creation of homes into which the dying could be removed formed part of the wider movement by religious, secular, statutory or voluntary organisations towards providing institutional care for the objects of their charity in which the latter could be carefully supervised. As institutions began to lose their former association with policies of deterrence, they became accepted as the only suitable and efficient place for the treatment of certain conditions. It was also recognised by some that separate institutions should be set up to provide for the social and medical needs of specific types of patient.¹⁹ The specialisation of hospitals, the establishment of asylums, magdalen homes, convalescent homes, homes for the aged poor, Poor Law infirmaries, sanatoria and homes for various types of disabilities, such as cripples and the blind were all part of this process. Institutions also had the added advantage of helping to inspire charitable enthusiasm by providing a visible focus for philanthropic outpourings.²⁰ By the early 1880s institutions existed for virtually all forms of treatable and curable conditions, and even for incurable and chronic patients, but there was still no specific institutional provision for the multitude of sufferers in the advanced stage of disease.

¹⁹ Lawrence, C. (1994) *Medicine in the Making of Modern Britain 1700-1920*. London: Routledge, p.52 ; Crowther, *The Workhouse System*, p.56.

²⁰ Granshaw, L. (1989) Fame and Fortune by means of brick and mortar: the medical profession and specialist hospitals in Britain 1800-1948, in L. Granshaw and R. Porter (eds) *The Hospital in History*. London: Routledge, p.200.

M.A. Crowther has argued that another important social change occurred around this time in connection with the process of institutionalisation. In the same way that patients were gradually being removed from their homes into institutions, so death itself became institutionalised as increasing numbers of patients died in institutions.²¹ It may be that the squalid homes of the destitute poor with their insanitary and overcrowded conditions were partly responsible for moving death out of the home and into the institution, especially given that during the latter part of the nineteenth century there was a growing awareness of the process of infection and the need to establish separate institutions to safeguard the rest of society as well as to care for the individual.

Recognition of the need for institutions devoted solely to caring for the dying poor grew, in part, out of the establishment of homes and hospitals for incurables, the first of which was founded in the 1850s. During this decade concern was voiced in the two leading medical journals, *The British Medical Journal* and *The Lancet*, over the virtual absence of institutional provision for incurable patients from the deserving poor. It was argued that incurables required “special comforts and attentions,” such as “well-ventilated rooms, appropriate diet and experienced nurses” which could not be provided at home.²² Subsequent articles, such as the one written in 1861 by Misses Elliot and Cobb, helped to raise further awareness of the needs of this none too small section of the population; they argued that the number of deaths in England per annum was over 5,500 from cancer and 64,000 from tubercular diseases, two-thirds of which were ‘incurable poor’.²³ As the next chapter will show, one of the principal arguments used by those who founded the homes for the dying was that institutions existed to care for long-term incurable patients but there was no specific provision for those who were actually dying.

²¹ Crowther, *The Workhouse System*, pp.57-58.

²² ‘Hospital grants for incurables’, *The Lancet*, 1852, Vol.1, p.135.

²³ ‘Hospitals for convalescents and incurables’, *British Medical Journal*, 1861, Vol.1, pp.232-3.

iv. Religion

The other major reason why homes for the dying were established in the late Victorian era was to provide spiritual care for the respectable poor facing the end of their mortal life, particularly those whose souls had not been saved. The homes were all founded primarily as religious institutions and as such were influenced heavily by religious developments during this period.²⁴ Here the focus is upon the two important strands of nineteenth century religious history which had the most influence upon the foundation of the homes for the dying: firstly, the growing concern for, what contemporaries perceived to be, pervasive working class indifference to religion; and secondly, the declining institutional role of churches and the subsequent redirection of their energies into different channels, particularly the new reliance upon female religious orders engaged in philanthropic work.

The degree to which working class religious indifference existed has been the subject of considerable historical discussion. The apparent apathy and unconcern of the working classes was of a different kind to the more intellectually based scepticism of the middle and upper classes which increased considerably during this period and was largely a product of the new ideological and scientific challenges to religion. Contending with the problems of severe poverty and insecurity meant that most of the energies of the poor were expended directly upon the task of day-to-day survival, which left little time or incentive for more spiritual or philosophical reflections. However, as historians are beginning to recognise, despite non-attendance at, or non-membership of, a place of worship, and the consequent anxiety expressed by many contemporaries on the apparent absence of any religious beliefs among the poor, the working classes were not wholly devoid of religious sensibilities. The poor were exposed to religious influences through the numerous philanthropic enterprises in London and many working class children were in touch with religion through the

²⁴ Given the vast subject area this encompasses it would be impossible to examine every aspect. For an overview of religious changes during this period see: Harris, J. (1993) *Private Lives, Public Spirit: Britain 1870-1914*. London: Penguin Ltd ; McLeod, H. (1996) *Religion and Society in England, 1850-1914*. London: Macmillan.

Sunday Schools.²⁵ J. Kent has argued that the majority of urban workers retained something of a belief in the value of ritual, including religious ritual, for the celebration of special occasions, such as baptism, marriage and death. Although the performance of ritual does not necessarily signify any profound belief on the part of the participant, certain rites of passage continued to be associated with religious rituals in the working class mind.²⁶ Similarly, the elaborate style of working class funerals (at a time when middle and upper class funerals were becoming more moderate affairs) and popular fear and revulsion of cremation and pauper burials (still associated in the minds of many with medical dissection), suggest a continued belief in the resurrection of the body and eternal life.²⁷

During the nineteenth century the traditional role of organised institutional religion declined in significance and it could no longer assume the social position or influence it once had. This decline has been attributed to a number of factors, the most important of which were the growth of secular leisure, religious pluralism, the decline in paternalism and the marginalisation of churches, as secular and state agencies took over many of its traditional functions.²⁸ In response to this demise in their traditional role, all denominations were forced to diversify and extend their efforts into social welfare provision. Churches could no longer confine their work to saving souls as in earlier times; they had to demonstrate their relevance in an increasingly secularised society by being seen to save bodies as well.²⁹ By the late nineteenth century there was a growing consensus that physical suffering should be alleviated before attending to an individual's spiritual needs. Care of the soul was disappearing from the hospital but the Church found itself having to re-appropriate the body in order to fulfil its ultimate

²⁵ McLeod, H. (1974) *Class and Religion in the Late Victorian City*. London: Croom Helm, pp.42-60; Cox, J. (1982) *The English Churches in a Secular Society: Lambeth, 1870-1930*. Oxford University Press, p.268.

²⁶ Kent, J. (1973) Feelings and festivals: an interpretation of some working class religious attitudes, in H.J. Dyos and M. Wolff (eds) *The Victorian City: Images and Realities*. London: Routledge and Kegan Paul, p.864.

²⁷ Harris, J. *Private Lives, Public Spirit*, p.158.

²⁸ For a more detailed discussion of these see McLeod, *Religion and Society*, pp.196-222 ; Yeo, S. (1976) *Religion and Voluntary Organisations in Crisis*. London: Croom Helm, pp.291-331.

²⁹ Rawcliffe, C. (1999) *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital St Giles, Norwich, c1249-1550*. Stroud: Sutton Publishing Limited, pp.1-7 ; Risse, G. (1999) *Mending Bodies, Saving Souls*. Oxford University Press ; Harris, *Private Lives, Public Spirit*, p.157.

goal of salvation. Although spiritual care remained paramount, care of the body became its necessary expression and complement.³⁰

All but one of the first homes for the dying in London were connected in some way with a religious order, a feature of their development which formed part of wider religious changes. The nineteenth century saw the emergence and growth of active (as opposed to cloistered) female religious communities in England and Ireland and, as such, signalled a new and distinctive phase in Victorian religious history. The growth of religious orders engaged in evangelistic and philanthropic work during the nineteenth and early twentieth century constituted part of the churches' efforts to redefine and reassert the institutional role of religion within society, given that they themselves no longer had the same drawing power (as shown by the fall in attendance). The first Anglican sisterhood was founded in 1845. By 1900 there were around sixty in existence with a total of approximately 1,300 professed sisters in 1912.³¹ The number of Roman Catholic orders in England was also increasing and by the late nineteenth century Nonconformist religious orders had been formed.³² The rapid proliferation of religious communities and the various charitable institutions with which they were associated signified a new vitality on the part of the churches and as such represented an important challenge to the secularisation argument which historians so often use to explain religious developments in this period.

This growth of female religious communities also represented one of the ways in which the churches attempted to adapt to a rapidly changing society and to demonstrate their continued relevance.³³ The nineteenth century was a time of extensive religious revival. It also saw the establishment of a religious pluralism which threw the churches into a state of rivalry and competition to recruit members.³⁴

³⁰ Williams, C.P. (1982) Healing and evangelism: the place of medicine in later Victorian Protestant missionary thinking, in W.J. Sheils (ed) *The Church and Healing*. Oxford: Basil Blackwell, p.285.

³¹ Hill, M. (1973) *The Religious Order*. London: Heinemann Educational Books, pp.143, 280 ; McLeod, *Religion and Society*, p.166.

³² Fahey, T. (1987) Nuns in the Catholic Church in Ireland in the nineteenth century, in M. Cullen (ed) *Girls Don't Do Honours: Irish Women in Education in the Nineteenth and Twentieth Centuries*. Women's Education Bureau, p.9

³³ Allchin, A.m. (1958) *The Silent Rebellion: Anglican Religious Communities 1845-1900*. London: SCM Press Ltd, p.40 ; Hill, *The Religious Order*, p. 168.

³⁴ Fahey, 'Nuns in the Catholic Church', p.12.

Religious orders formed part of the churches response to the perceived spiritual and social needs of the masses, who were widely held to be irreligious. Those responsible for reviving religious communities believed they would be “powerful instruments against the ignorance, poverty and vice of our large cities.”³⁵ Initially the churches had tried to reach the people through church building programmes but these had failed. As a result female religious orders became an increasingly important source of evangelising power.³⁶ Sisterhoods were a new creation within the nineteenth century Anglican Church. They were formed as part of the Oxford Movement, which developed in the 1830s and later evolved into Anglo-Catholicism. The Oxford Movement sought to restore High Church ideals to the Church of England.³⁷ Anglo-Catholic churches differed from their Evangelical counterparts in the type of missionary approach they adopted to reach the poor. Whereas the latter distributed Bibles on every possible occasion and made use of emotionally charged sermons to rouse a response, the former sought to inculcate a sense of devotion among the poor through the use of visual acts, symbols and the ceremonial.³⁸

Female religious communities also formed part of the churches’ response to the social needs of the poor. The nineteenth century saw the movement towards a new type of female religious order as they turned away from their traditional, cloistered status and became engaged in practical work. Sisterhoods became closely associated with nursing, teaching and pastoral work and throughout the nineteenth century their activities extended into virtually all areas of social need. Emphasis was placed upon their practical work as a way to try and justify their establishment and because popular opinion favoured the practical and utilitarian. The changing nature of religious orders helped to alter popular conceptions of nuns, whilst their practical work was one of the main attractions to women to join. Florence Nightingale’s expedition to the Crimea in

³⁵ Trench, M. (1884) English sisterhoods, *Nineteenth Century*, Vol.16, p.340.

³⁶ Norman, E.R. (1976) *Church and Society in England 1770-1970*. Oxford: Clarendon Press, p.124 ; Fahey, ‘Nuns in the Catholic Church’, p.7.

³⁷ Chadwick, O. (1960) *The Mind of the Oxford Movement*. London: Adams and Charles Black, pp.27, 39, 48 ; Hill, *The Religious Order*, p.8 ; Shelton Reed, J. (1988) ‘Ritualism rampant in East London’: Anglo-Catholicism and the urban poor, *Victorian Studies*, Vol.31, No.3, p.375.

³⁸ Newsome, D. (1997) *The Victorian World Picture: perceptions and introspections in a world of change*. London: John Murray Ltd, p.219.

1854, which utilised the services of nursing sisters, helped to raise their social status and enabled their wider acceptance within society.³⁹

As communities of women living together, united by a desire to carry out God's work, several factors helped to facilitate their work. The collective and organised nature of their activities was an advantage as shown by the failure of individual charities in the cities to make any great impact. Within the Catholic Church the religious community was the only collective grouping of philanthropic women acceptable to the authorities, and as such they exercised a particularly important role within Catholic charity. Maria Luddy has argued that nuns "symbolised the perfect response of women to charity." They were thought to possess the ideal personal qualities necessary to undertake such work: benevolence, compassion, commitment, self-abnegation and religious vocation.⁴⁰

Religious orders also branched out into organised forms of care which centred upon institutional provision. By the late nineteenth and early twentieth century the association between sisterhoods and institutional work was seen, by many contemporaries, as both natural and inevitable. Charles Booth, writing in 1901, commented:

"The refuges, penitentiaries, hospitals, convalescent homes, homes for the dying, orphanages, and other institutions which are undertaken by the various Sisterhoods, are thus felt to be the natural outcome of these associations of ladies, bound together by a long noviciate and by the solemn vows of their order."⁴¹

The homes for the dying can also be seen as a response to changing attitudes towards death and dying in the late Victorian era, particularly the declining significance of spiritual issues. Historians argue that by the late nineteenth century, in response to medical advances, particularly greater pain control, and the diminishing importance of religion, death was becoming an increasingly secularised event in

³⁹ O'Brien, S. (1988) *Terra incognita: the nun in nineteenth century England*, *Past and Present*, 121p.114 ; Hill, *The Religious Order*, pp.171, 173-4, 289, 292.

⁴⁰ Hill, *The Religious Order*, pp. 171-2, 252 ; Luddy, M (1995) *Women and Philanthropy in Nineteenth Century Ireland*. Cambridge University Press. pp.24, 44.

⁴¹ Booth, C. (1902) *Life and Labour of the People in London*, 3rd Series. London: Macmillan and Co. Ltd, p.352.

which spiritual concerns assumed less and less significance.⁴² Increased life expectancy and a declining mortality rate reduced the immediacy of death; naturalistic explanations for disease and improved medical treatment undermined the need to minister to the soul; and new drugs and painkillers reduced the “transforming power” of death.⁴³ The creation of institutions committed to helping patients undergo spiritual preparation for death received added import because they specifically ran counter to these developments. In the same way that other religious based philanthropic institutions sought to bring about the spiritual reform of inmates so that they might live a more godly life on earth, so the homes intended that patients should meet death in full spiritual readiness in order that they could pass on to the next life.

v. The Catholic Church and the Irish in London

The foundation of St Joseph’s Hospice in Hackney as a Catholic institution in 1905 was, to a large extent, determined by wider developments in the English Catholic Church. Catholicism was a minority religion in Victorian London. Decades of legal subjection had rendered it tenuous and precarious, but during the early and mid-nineteenth century these laws were gradually revoked and it began tentatively to reassert itself. It was greatly assisted in this by the arrival of thousands of Catholic immigrants which helped to inject a new lease of life into the Church. Between 1800 and 1914 the number of Catholics in London expanded dramatically from 750,000 in 1851 to over 2 million in 1914. This huge statistical increase was caused primarily by a massive influx of Irish immigrants (most of whom were only nominal Catholics), but also immigrants from other Catholic countries, particularly Italy, France and Germany. The majority of Irish immigrants ended up in London where they congregated into ghettos, mainly in the East End. Their tendency to settle in particular areas helped to maintain their ethnic ties.⁴⁴

The arrival of hundreds of thousands of Irish in London and the attendant problem of ‘leakage’ was a cause of deep concern to the Catholic Church - many immigrants soon

⁴² Jalland, *Death in the Victorian Family*, pp.52-54 ; Gilbert, A. (1980) *The Making of Post-Christian Britain: A History of the Secularisation of Modern Society*. London: Macmillan, p.10.

⁴³ Prochaska, ‘Body and soul’, pp.346-347.

⁴⁴ Heimann, M. (1995) *Catholic Devotion in Victorian England*. Oxford: Clarendon Press, pp.12-13.

lost all contact with the Church - and gave rise to the need for a popular urban ministry on a scale hitherto unknown. Despite the dramatic expansion in numbers, Catholicism remained a minority religion, ostracised from the mainstream of religious life.⁴⁵ Protestant alarm at the sudden resurgence in Catholicism and the Church's renewed sense of mission to those who had 'lost the faith' was exacerbated by Anglo-Irish relations. Anti-Catholic hostility was not just a middle and upper class phenomenon; it manifested itself among all social classes.⁴⁶ This sense of isolation had a profound effect upon the Catholic Church which saw its survival as dependent upon its ability to maintain, at all costs, a separate identity within English society. The service of religious orders formed an extremely important part of this process. The Church believed that nuns were uniquely qualified to undertake philanthropic work and they had the additional advantage in that their labour was cheap. By the end of the nineteenth century there were almost one hundred convents in London, virtually all of which were engaged in philanthropic work.⁴⁷

The Catholic Church differed significantly from its Anglican counterpart in its attitude to charity and this was often apparent in the way in which St Joseph's was run. Although the Church attributed Irish spiritual and material poverty to a failure to observe respectable religious and moral standards, its adherence to the ancient Catholic virtue of 'Holy Poverty' meant that poverty was ultimately regarded as godly and therefore inevitable. As a result, Catholics were less disposed to cast judgement upon the undeserving poor and less concerned as to whether their gifts were received by the ungodly.⁴⁸ Charles Booth made a similar observation of the Catholic population

⁴⁵ Kitson Clark, G. (1973) *Churchman and the Condition of England 1832-1885*. London: Methuen and Co. Ltd, p.335 ; Gilley, S. (1969) *The Roman Catholic mission to the Irish in London, 1840-1860*, *Recusant History*, Vol.10, pp.134, 138, 141 ; Gilley, S. (1973) *Catholic faith of the Irish slums, London 1840-1870*, in H.J. Dyos and M. Wolff (eds) *The Victorian City: Images and Realities*. London: Routledge and Kegan Paul, p.837 ; Gilbert, A.D. (1976) *Religion and Society in Industrial England: Church, Chapel and Social Change, 1740-1914*. London: Longman, pp.47, 173.

⁴⁶ Gilbert, *Religion and Society*, pp.172-3 ; Obelkevich, J. (1990) *Religion*, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol. 3. Cambridge University Press, pp.335-6 ; McLeod, *Class and Religion*, pp.72-80.; Davies, G. (1991) *The Irish in Britain 1815-1914*. Dublin: Gill and Macmillan, p.145.

⁴⁷ O'Brien, S. (1988) *Terra incognita: the nuns in nineteenth century England, Past and Present*, Vol.121, p.115 ; McLeod, *Religion and Society*, p.167 ; Gilley, S. (1971) *Heretic London, holy poverty and the Irish poor, 1830-1870*, *Downside Review*, Vol.89, p.68 ; Booth, *Life and Labour*, p.251.

⁴⁸ Gilley, 'Heretic London', pp.64-67 ; Gilley, S. (1972) *Papists, Protestants and the Irish in London, 1835-70*, in G.J. Cuming and D. Baker (eds) *Popular Belief and Practice*. Cambridge University Press, p.260.

in London: "The ministrations of these churches touch the poorest, and to give freely in charity is the rule of their religion."⁴⁹

vi. The 'Respectable poor', the Poor Law and philanthropy

Each of the homes for the dying focused their efforts upon caring for a particular section of the population, the dying 'respectable' poor, and as such were influenced by wider Victorian social attitudes towards this group. The late nineteenth century saw an unprecedented degree of concern for the poor in London because, for the first time, public attention was drawn to the sheer scale of the problem. The publication of the hugely influential pamphlet *The Bitter Cry of Outcast London* in 1883 by the Reverend Andrew Mearns, a Congregationalist minister, and the incontrovertible statistical evidence produced by the survey of Charles Booth (1889) helped not only to raise awareness of the plight of the poor but to incite renewed efforts among Victorian social reformers and philanthropists. The work of these men and women was also influenced by the increasingly humanitarian climate of the nineteenth century; when instances of outright neglect were exposed public opinion demanded remedial action.⁵⁰ *The Bitter Cry* drew attention, in unequivocal terms, to the "vast mass of moral corruption, of heart-breaking misery and absolute godlessness" that is "seething in the very centre of our great cities." It was targeted primarily at the churches which, Mearns argued, had failed to fulfil their mission to the poor and whose responsibility it was to rectify the situation.⁵¹ The influence of the pamphlet extended far beyond the churches, but played an important role in re-directing their reform efforts away from an exclusive focus upon personal salvation to a greater realisation of the importance of the physical environment and social justice.

The dominant discourse on charity and social policy, formulated by the Poor Law publicists and the charity organisers, (most notably the Charity Organisation Society) differentiated sharply between poverty and pauperism. Poverty was viewed as the lot of most of the manual classes, or the 'respectable' poor as they were known, and for

⁴⁹ Booth, *Life and Labour*, p.38.

⁵⁰ Walvin, J. (1987) *Victorian Values*. London: Andre Deutsch Limited, p.98.

⁵¹ Mearns, A. ((first published 1883) *The Bitter Cry of Outcast London*. Leicester University Press (1970), pp.55-57.

much of the nineteenth century was seen as an inevitable and natural condition. Pauperism affected a much smaller percentage of the population but was associated with the degenerate and the morally degraded: those who had lost the will to self-help. The 1834 New Poor Law had been set up to address the problem of the latter and to serve as a deterrent to the respectable poor. Paupers were also associated with the 'casual residuum' which, although a social minority, became identified with the problem of chronic poverty, a condition greatly exacerbated by the environment in which they lived. Victorian social reformers saw them as a profound threat to the respectable poor who, they felt, had to be protected from their degenerating influence. As a result sharper distinctions were made between the self-respecting and non-respectable poor. The former began to be distanced from the Poor Law System and renewed efforts were made to help them by diminishing contact between the two groups.⁵²

In London the pre-dominance of non-industrial forms of capital meant that there was little direct contact between the rich and the poor. Apart from servants, the upper classes had little immediate dealing with the working classes and were concerned about the effects that might arise from this separation of classes, particularly the breakdown of social relationships and traditional methods of social control. Charitable activity, therefore, was felt to be particularly important because it served as a means for interpreting the behaviour of the poor and as a vehicle for trying to control them. The rapid expansion of indiscriminate charity in the mid-nineteenth century, it has been argued, had unforeseen effects both in providing opportunities for the 'clever pauper' and by demoralising the honest poor, and, as such, generated much anxiety among Victorians. To counter this a strict boundary was established between charity and the Poor Law and the former became subject to stiff regulation in order to prevent its abuse by recipients. It was felt essential that charity be seen as dependent upon certain moral standards and the Poor Law as a penalty for not fulfilling them.⁵³

⁵² Rose, M.E. (1988) The disappearing pauper: Victorian attitudes to the relief of the poor, in E.M. Sigworth (ed) *In Search Of Victorian Values*. Manchester University Press, pp.56-72.

⁵³ Stedman Jones, *Outcast London*, pp.239-240, 251-256.

However, as Alan Kidd has argued, the official theory of poor relief and charity never completely dominated the practice of private giving by individuals and societies. The middle classes' response to problems of poverty and social crisis was at the very least complex. The theory of charity enjoined by the Poor Law and charity organisers was not always adopted by those responsible for charity, as has been suggested by historians such as Gareth Stedman Jones.⁵⁴ In practice the strictly defined boundaries between the Poor Law and philanthropy often overlapped. Many of the newly founded charities in the second half of the nineteenth century, particularly those more evangelical in origin, extended their work to categories of the poor, who without their help, would have been forced to resort to parish relief.⁵⁵ For example, money raised by the Mansion House appeal in 1886 for the unemployed in London was allocated indiscriminately to the working classes and the casual poor.⁵⁶ Although the official discourse was not hegemonic, it nevertheless remained a powerful influence upon charitable endeavour during the Victorian era and most agencies - including the homes for the dying - felt obliged to defer to its principles, at least at a public level. This was particularly apparent in their use of language; admission policies often drew strict demarcations between the 'respectable' and 'non-respectable poor'. However, as the case of St Joseph's Hospice will show, such definitions were not always so rigorously applied in practice.

By the end of the nineteenth century living standards for at least part of the working class had improved and helped further to widen the gap between the respectable and non-respectable sections. Middle-class criticism of the Poor Law also began to change. Whereas previously the emphasis had been upon the harsh conditions of the workhouse, focus was now given to the social disgrace it conferred, particularly through the mixing of the respectable and non-respectable poor.⁵⁷ Although by the end of the Victorian era conditions within the workhouse were less punitive than earlier in the century, the social stigma attached to pauperism remained as powerful a deterrent

⁵⁴ Ibid.

⁵⁵ Kidd, A.J. (1985) 'Outcast Manchester': voluntary charity, poor relief and the casual poor 1860-1905, in A.J. Kidd and K.W. Roberts (eds) *City, Class and Culture: Studies of Social Policy and Cultural Production in Victorian Manchester*. Manchester University Press, pp.48-67.

⁵⁶ Stedman Jones, *Outcast London*, pp.298-300.

⁵⁷ Crowther, *The Workhouse System*, p.238.

as ever, forcing the poor to endure any hardship rather than apply for poor relief. The growing respectability of the working classes also made the whole Poor Law system more unacceptable to them.

The most common feature of popular antipathy to the Poor Law was fear of pauper funerals. The celebration of death was a rite deeply entrenched within Victorian society and among the working classes was perhaps the single most important event in a person's 'life'. To be denied the dignity of a respectable funeral greatly offended working class sensibilities. In an age in which respectability was as much demonstrated in death as it was in life, the pauper grave represented the ultimate degradation because it was anonymous and carried out with a minimum of ceremony. The body was placed in a communal grave with no personal markings which deprived the relatives of the opportunity of family mourning and rituals of remembrance.⁵⁸ As Thomas Laquer argues:

“Pauper funerals came to signify their absolute exclusion from the social body. Ignominy was even greater when contrasted to the ‘respectable’ funeral of the middle and upper classes which served as an expression of their pre-eminent position in society.”⁵⁹

The formation of working class burial clubs and their preoccupation with ensuring that funeral costs were provided for upon death bore testimony to the strength of working class feelings. Saving for burial expenses was felt by many to be more important than providing for care during life; any surplus money was channelled first and foremost into securing a decent interment. By the twentieth century, in response to public disapprobation, pauper burials had begun to improve. The Poor Law Commission conceded that they should not be worse than or better than those of lowest classes. However, this compromise still fell a long way short of meeting working class standards.⁶⁰

⁵⁸ Walvin, J. (1982) Dust to dust: celebrations of death in Victorian England, *Historical Reflections-Reflexions Historiques*, Vol.9, No.3, p. 355 ; Richardson, R. (1987) *Death, Dissection and the Destitute*. London: Routledge and Kegan Paul Ltd, pp.274-275.

⁵⁹ Laquer, T. (1983) Bodies, death and pauper funerals, *Representations* 1:1, p.109.

⁶⁰ Crowther, *The Workhouse System*, p.242 ; Fishman, W.J. (1988) *East End 1888: A Year in a London Borough Among the Labouring Poor*. London: Duckworth, p. xi.

As voluntary institutions, the homes for the dying were shaped by philanthropic developments during the nineteenth century. Charitable activity was one of the principal means by which middle and upper class Victorians expressed their concern for the poor. Between 1800 and 1900 it expanded into virtually all areas of life and assumed a wide variety of forms.⁶¹ The homes for the dying were a part of this longer tradition of Victorian philanthropy and were necessarily affected by the way in which it evolved during this period.

The place of religion in philanthropy was central. All Christian denominations emphasised the importance of charitable conduct, particularly the evangelicals who were enormously influential in the early and mid-Victorian period. Most philanthropic initiatives were inspired by religious and moral motives and aimed at the salvation of souls and the moral reformation of recipients. For example, rescue homes for fallen women sought, through love, prayer, religious example, the cultivation of a homely atmosphere and the provision of work and training, to transform the spiritual lives and moral characters of members.⁶² Medical charity formed an important part of Victorian philanthropic work - approximately half of Britain's charitable donations were channelled into this cause - and during the nineteenth century it too was heavily motivated by religious imperatives.⁶³ Body and soul were viewed as inseparable and moral and spiritual aid were felt to be as important as physical care and material assistance. Attending to the sick, therefore, provided an important opportunity for spiritual ministrations.⁶⁴

Until now the question of why the only homes for the dying set up in England before 1939 were all located in London has not been specifically addressed. Part of the explanation may relate to issues of finance and public status; the higher number of

⁶¹ Prochaska, F.K. (1990) Philanthropy, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol.3, Cambridge University Press, pp.357-393.

⁶² Heasman, K. (1962) *Evangelicals in Action: An Appraisal of their Social Work in the Victorian Era*. London: Geoffrey Bles, pp.148-68 ; Young, A.F. and Ashton, E.T. (1956) *British Social Work in the Nineteenth Century*. London: Routledge and Kegan Paul, pp.217-222.

⁶³ Mandler, P (1990) (ed) *The Uses of Charity: The Poor on Relief in the Nineteenth Century Metropolis*. Philadelphia: University of Pennsylvania Press, p.164.

⁶⁴ Prochaska, F.K. (1980) *Women and Philanthropy in Nineteenth Century England*. Oxford: Clarendon Press, pp.3-9, 17 ; Prochaska, 'Body and soul', p.336 ; Summers, A. (1991) The costs and benefits of caring, nursing charities, c1830-c1860, in J. Barry and C. Jones (eds) *Medicine and Charity Before the Welfare State*. London: Routledge, pp.134-36.

wealthier citizens ensured a more guaranteed supply of funding and London, as the capital city, necessarily attracted all the best institutions and the most skilled professionals. Most philanthropic initiatives during the Victorian era, if they did not begin in London invariably found their way there; all the problems associated with urban industrial life during this period were necessarily magnified there and the much higher numbers of poor meant that their problems appeared more urgent and distressing. There were only two attempts outside of London to establish homes for the dying: the Home of Comfort in Portsmouth in 1896⁶⁵ and Ernsborough House in Exeter in 1904.⁶⁶ However, neither home succeeded in confining itself solely to caring for the dying because they each had to cope with large numbers of longer-term patients. As a result both institutions eventually evolved into nursing homes for incurables and chronics.

vii. Conclusion

To sum up, homes for the dying emerged out of an awareness by certain individuals and groups, during the late nineteenth century, of growing numbers of dying respectable poor who were materially deprived and had nowhere to go to where they could receive medical and spiritual attention. Despite being the first of their kind in England, they were, at the same time, very much part of a broader network of philanthropic institutions in the Victorian era, many of which were targeted at groups

⁶⁵ The Home of Comfort was founded in Southsea in 1896 by Mother Emma, Superior of the Winchester Diocesan Deaconesses. It was intended for those who were incurably ill of progressive disease. The first annual report for Home (1898) stated that the Deaconesses felt that despite the existence of three homes for the dying in London, there was nothing for "that large class of people who are unable to provide for themselves the necessary comforts during a long and expensive illness." An advertisement in *The Lancet* in 1897 (Vol.1, p.925) described it as a home for the "receipt of better class patients, clergy, missionaries, nurses, governesses etc., who are suffering from progressive and incurable disease."

⁶⁶ According to a flyer produced before its opening, Ernsborough House was founded by Marian Lady Dunboyne in response to the absence of provision, aside from the workhouse or infirmary, for patients whose comfort and care very few households could provide for without the very greatest strain on their resources, both personal and financial, and for whom there is no reward in the shape of recovery. A newspaper article published in 1915 stated that it was first opened as a 'Home for the Dying' but had to change its name to 'A Home for those in the Last Stages of Illness' because many of the inmates showed "remarkable improvement." It appears that even in the early days Ernsborough House was more a home for incurables and the elderly who did not have sufficient means to nurse themselves because there are many references to such patients.

of individuals excluded from mainstream - both voluntary and state run - medical and social provisions who could not be cared for at home. Their creation at this particular time is revealing of the extent to which institutional care had come to be looked upon as fundamental to medicine and philanthropy during this period. Religious orders too were increasingly reliant upon institutions as a medium for their work. The latter served as a way to separate inmates from the rest of the population and to confine them to an environment in which they could be managed and cared for by those who ran them.

The novelty of the homes lay in the fact that they were intended to provide for a specific type of patient - the dying respectable poor - who hitherto had not been identified as having special needs which could be best met through an institutional medium. They also represented the beginnings of a recognition of dying as a process for this group, occurring over an identifiable period of time from their diagnosis as 'dying' until the moment of death. This growing awareness of a dying phase may relate to epidemiological changes during the late nineteenth century - the shift from acute infectious diseases to chronic degenerative conditions - which in turn would help to explain why the lack of provision for the dying respectable poor began, for the first time, to be perceived as problematic.

The foundation of the homes for the dying was also heavily motivated by religious imperatives. Although the homes provided nursing and medical care, they were not founded as medical institutions in the same way as the voluntary hospitals and Poor Law infirmaries. Rather, each home was just one of the multitude of small homes and institutions set up during the nineteenth century which intended to administer care and comfort for particular groups of patients. Most of these initiatives were inspired by religious motives and aimed at the spiritual and moral reformation of inmates. More specifically, St Joseph's Hospice and the Hostel of God were typical of the many other homes and refuges set up by religious orders during this period whose central preoccupation was the spiritual life of inmates and whose ultimate goal was to convert them to their particular branch of Christianity.

Their lives and lives of their children and poverty alone is not a sufficient reason for suffering. For the professional painter, grandfathered as he is to his profession, there is the Union Insurance, where he may spend his last days without feeling the lack of a working family member, but there is a crowd of poor and women, who though they must have always rather suffered at home at times, rather than go to the Union. What persons of this class are in need of help is not because, but when sickness comes and the shadow of death enters the feverish, when they lie waiting for the end, their case is awful indeed.

Quoted from an article in *The Woodstock Gazette* entitled "Sweet Rest at Last" in "The Report of St Luke's House", 5th West London Mission Annual Report, 1894, p.27.

"The spiritual welfare of the patients is also sedulously cared for and cared for with discretion. The Home is conducted on an absolutely unsectarian line. Patients of all denominations of religious opinion are of course, on an equal footing and all are treated with the same administration of a representative of the Holy Spirit."

(First Annual Report of St Luke's House, 1891, p.6) *The 7th West London Mission Annual Report, 1894, p.6.*

CHAPTER 2

“The Homing of the Death Stricken”: The Foundation and Early Development of Homes for the Dying

...for the soul as well as for the body. When the flame of life burns low, to be surrounded by those who are their whole lives in the service of God's year...and, as the last great hour approaches, to be lovingly helped and encouraged as only a Catholic can possibly help and encourage." (At least let them die in Peace', *The Tablet*, July 1943)

"The idea was to admit patients who had been discharged from the hospitals as incurable, and who were suffering from diseases which, in the natural course of events, would likely prove fatal within a period of a few months. It was also considered probable that in the poor and densely-populated areas within easy reach of the Homes many sufferers of a similar class would be found, who were unable to receive at their own homes the care and attention that such cases demand. Though the bodily sufferings of these poor creatures were thus to be as far as possible alleviated, and the remaining days or weeks of life made as comfortable as circumstances would permit, their spiritual wants were also to be attended by a Chaplain, who conducted daily services either in the wards or in the Chapel."

(*The National Free Home for the Dying Annual Report, 1896, pp 5-6.*)

The above quotes illustrate how the founding concepts of St Luke's House, the Hostel of God and St Joseph's Hospice were, in essence, the same and were grounded in two

“Not everyone may come, nor anybody; and poverty alone is not a sufficient reason for admittance. For the ‘professional pauper’, accustomed as he is to the workhouse, there is the Union Infirmary, where he may spend his last days without feeling the lack of anything really needful, but there is a class of men and women, who though very poor, have always rather suffered at home in silence.....rather than go to the Union. When persons of this class are in health.....life is just bearable; but when sickness comes, and the shadow of death enters the hovels where they lie waiting for the end, then their case is pitiful indeed.”

(Quoted from an article in *The Westminster Gazette* entitled ‘Sweet Rest at Last’ in ‘The Report of St Luke’s House’, 6th West London Mission Annual Report, 1893, p.22.)

“The spiritual welfare of the patients is also sedulously cared for and cared for with discretion. The House is conducted upon absolutely unsectarian lines. Patients of all denominations, of religious opinion and of none, are equally eligible; and all are free while with us to ask for and receive ministrations of a representative of whatever church they may happen to belong to.”

(First Annual Report of St Luke’s House, extracted from the 7th West London Mission Annual Report, 1894, p.6.)

“That is the purpose of St Joseph’s Hospice.....to take in and care for those who are near to death, and to save them from what they very often dread more than death itself - the ending of their days in the workhouse.....But the ultimate purpose is, of course, more than that - it is, in fact, to enable poor, dying humanity, not merely to avoid the indignity of “The House,” but to secure the loving attention and gentle encouragement of the Religious who can care for the soul as well as the poor, wasting body when the flame of life burns low.....to be surrounded by nuns who have devoted their whole lives to the service of God’s poor.....and, as the last great hour approaches, to be lovingly helped and encouraged as only a Catholic can possibly help and encourage.”

(‘At least let them Die in Peace’, *The Tablet*, July 1913)

“The idea was to admit patients who had been discharged from the hospitals as incurable, and who were suffering from diseases which, in the natural course of events, would likely prove fatal within a period of a few months. It was also considered probable that in the poor and densely-populated area within easy reach of the Hostel many sufferers of a similar class would be found, who were unable to receive at their own homes the care and attention that such cases demand. Though the bodily sufferings of these poor creatures were thus to be as far as possible alleviated, and the remaining days or weeks of life made as comfortable as circumstances would permit, their spiritual wants were also to be attended by a Chaplain, who conducted daily services either in the wards or in the Chapel.”

(The National Free Home for the Dying Annual Report, 1896, pp.5-6.)

The above quotes illustrate how the founding concepts of St Luke’s House, the Hostel of God and St Joseph’s Hospice were, in essence, the same and were grounded in two

of the fundamental pillars of Victorian society; religion and class. The major objective of each home was to provide physical and spiritual care for the respectable dying poor, who were medically ineligible for retention in the voluntary hospitals, morally unsuitable for admission to the workhouse infirmaries and who could not be cared for at home. The emphasis upon both bodily and spiritual care reflected the broader shift in the thinking and practice of late Victorian religious philanthropists who could no longer use salvation as their sole justification.

This chapter describes the establishment of the homes for the dying and the more specific factors behind the creation of each institution. Particular attention will be given to their underlying philosophies, especially the implications of their different religious affiliations and their place within the broader mission of their respective denomination. It will also look briefly at the practical development of each home up until 1915 by examining such issues as finance, management, expansion and the problems which these entailed. Much of the information on the founding of the homes is drawn from accounts written by those who ran them; the annual reports for the Hostel of God and St Luke's House provide insights into how and why they were established, while our understanding of the foundation of St Joseph's comes mainly from the Sisters of Charity annals. The particular purposes of these records and the audience for whom they were intended would have influenced the way in which they were written and the type of story they wished to portray. The purpose of the annual reports was to generate as much public interest in the homes as possible and their contents would have been written with this consideration in mind. Likewise, the information in the Sisters of Charity annals was intended to depict a particular account of their foundation and development to the Mother House. Unlike the annual reports they were not compiled for public viewing, but they too had a specific agenda: to prove to the Reverend Mother that they were fulfilling their commission in London. Thus the following account of the establishment of the homes is largely the story which those who ran them wished to tell. Although it does not reveal much about what actually happened in practice, it is still important because it helps to provide some understanding about the perceptions of those who managed the homes and how they wished to portray the foundation and development of their particular institution.

It is possible, however, to gain some insight into what happened in practice at the Hostel of God and St Luke's through information contained in their Committee minute books and comments and observations by contemporaries.

i. The Friedenheim: the first English home for the dying

The first home for the dying in England opened a few years before the three homes which form the focus of this thesis, but the thinking behind it reflected the same preoccupation with moral and religious concerns.¹ The Friedenheim, founded in Mildmay Park in 1885, was the inspiration of a Scottish lady, Miss Frances Davidson, who had been greatly impressed by the lack of accommodation in London for the dying poor, and it was set up as an experiment to prove both the feasibility of, and justification for, such an institution. According to a history of the Home written in 1915, it was established for "those whose hopeless condition does not justify their admission to, or retention in, ordinary hospitals, for those with no homes or having them are not in a condition, and have not the means, to be nursed there, through the last stages of mortal illness."² However, included in the copy of the minutes for the Committee meeting held on 23 May 1918, was a memo written by Miss Davidson noting that it had been primarily intended for dying consumptive patients, for whom little provision was made in London.³ Preference was given to those who had been in a better position, whose illness and misfortune had reduced them in circumstances, and to whom the workhouse infirmary was a dreaded last resort.⁴

The Friedenheim was run by a Council, which acted as a committee of management, under the supervision of Miss Davidson, the Lady Superintendent.⁵ Initially there were only eight beds but in 1892 it moved to a new premises in South Hampstead where it could provide accommodation for up to thirty-five patients.⁶ Admission was free,

¹ 'Friedenheim: a Home of Peace', November 1886, p.17.

² Streetly-Smith, L.A. (1915) *The Story of Friedenheim*, p.3.

³ Minute Book of the Council of the Friedenheim Hospital 14 January 1909 - 10 February 1920: 23/05/1918, p.236.

⁴ Streetly-Smith, *The Story of Friedenheim*, p.7.

⁵ E. Farish 'About Friedenheim', Charity Organisation Society (hereafter COS) Report, 1st November 1892, p.2, London Metropolitan Archives (hereafter LMA).

⁶ Streetly-Smith, *The Story of Friedenheim*, p. 9.

although payments were accepted, and patients admitted into the private ward had to pay a charge.⁷ The Home was not attached to any specific religious organisation but it had a solid Anglican basis and the provision of spiritual comfort for its patients was its foremost priority:

“...while providing all needful comforts, tender nursing, and medical aid for the body, the spiritual welfare of the inmates will be made its highest object.”⁸

In 1891 the Medical Officer at the Friedenheim, Dr Alfred Schofield, wrote a short article for the *Contemporary Review* which was intended to show the urgent need which still existed for charitable care of the dying; no single institution in London being able to meet this need.⁹ He began by saying that refuges, homes and hospitals existed for every form of curable disease and for incurable patients, but there was nothing outside of the workhouse for those who were actually dying. A brief acknowledgement was made of the work of the Cancer Charity ward at the Middlesex Hospital and St Peter's Nursing Home in Kilburn, both of which had given over some of their accommodation to the care advanced cases, but their contribution was only seen as minimal because neither institution had devoted itself solely to the care of the dying. By contrast, the foundation of a 'Hospital for the Dying',¹⁰ by the Sisters of Charity in Dublin was warmly commended and Schofield lamented the fact that a similar initiative had not been taken in London until 1885.¹¹ With around 8,000 deaths from consumption in London each year, he felt there was a need for further provision, not only for the comfort of the dying, but also for the safety of the living. He argued that the workhouse “though an undoubted boon to many, is nevertheless a hardship almost worse than death itself to others, who, as is so often the case with consumptive patients, may be of gentle birth, and have often occupied useful and honourable positions in society.”¹²

⁷ 'Friedenheim: a Home of Peace' November 1886, p.16.

⁸ Quote from Miss F. Davidson in Streetly-Smith, *The Story of Friedenheim*, p.11.

⁹ Schofield, Dr A.T. (1891) A home for the dying, *Contemporary Review*, p.427.

¹⁰ Schofield is referring to Our Lady's Hospice for the Dying.

¹¹ Schofield, 'A home for the dying', p.423.

¹² *Ibid.*, p.425.

Over the next fourteen years four more homes for the dying were founded in London: the Hostel of God in 1892, St Luke's House in 1893, the Home of the Compassion of Jesus in 1903 and St Joseph's Hospice for the Dying in 1905. Each one appears to have been an independent initiative and none of them seem to have been a direct response to Dr Schofield's appeal. Only a small number of records remain for the early history of the Home of the Compassion of Jesus, but these are sufficient to show that its underlying philosophy was the same as the other four homes. It was established in April 1903 in Deptford by the Anglican Community of the Compassion of Jesus. In 1905 it moved to Paddington and then in 1912 to Thames Ditton. It was run by a Lady Superintendent and a committee. A circular issued by the Home stated that it was set up to provide for "the *free* reception of the saddest cases among the dying poor" and to "take in and care for (body and soul) the worst cases of those whose last opportunity has nearly gone forever."¹³ It was only intended for the "superior poor" who "object to the Infirmary....and the more lonely and destitute of friends they are the more suitable they are."¹⁴

The three homes which form the focus of this thesis were all 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. As such they were very much caught up in the broader objectives of these. The Sisters of Charity and St Margaret's of East Grinstead have a long tradition of caring for the sick poor, both in their homes and through the establishment of institutions catering for specific types of need. Like virtually all philanthropic endeavours during the Victorian era, those who ran the homes did not make any attempt to address the social and economic causes which underlay the problems of poverty and destitution or to question the hierarchical structure of society. Poverty was looked upon as primarily a moral and individualistic problem; the poor person being seen as someone who had to be redeemed, morally, religiously and socially.¹⁵

¹³ 'Home of the Compassion of Jesus (a free Home for the Dying Poor, chiefly of South and East London)', pp.1-2, [LMA].

¹⁴ 'Report on the Home of the Compassion of Jesus by Secretary of Paddington Committee of COS to Secretary of COS Central Committee', 15 March 1903, p.3, [LMA].

¹⁵ Kidd, A.J. (1985) 'Outcast Manchester': voluntary charity, poor relief and the casual poor 1860-1905, in A.J. Kidd and K.W. Roberts (eds) *City, Class and Culture: Studies of Social Policy and Cultural Production in Victorian Manchester*. Manchester University Press, p.49.

ii. The Irish Sisters of Charity and St Joseph's Hospice for the Dying

St Joseph's Hospice for the Dying was founded in London in 1900 as an offshoot of the first Irish Sisters of Charity foundation. The Sisters of Charity was, and still is, a Catholic order, founded in 1815 in Ireland by Mary Aikenhead.¹⁶ In addition to the traditional three vows the Sisters took an extra vow to "perpetually bind themselves to the service of the poor," and in particular, the sick poor.¹⁷ The Congregation had a centralised structure: the Mother House in Dublin governed all the branch houses and served as a base for the central noviciate. The 'Mission', or visitation of the poor, formed an essential part of the work in every Sisters of Charity foundation. It involved a mixture of religious and social activities, including religious instruction; the reconciliation of lapsed Catholics; the setting up of numerous guilds and solidarities; caring for the sick in their homes and local hospitals and infirmaries; feeding the hungry; supporting mothers; and other similar works of mercy.¹⁸ The Congregation soon expanded its efforts into a variety of different institutional provisions. In 1834 it established St Vincent's Hospital in Dublin, the first Catholic hospital in Ireland for the sick poor.¹⁹ Other institutions founded by the Sisters included a convalescent home, schools, a hospital for incurables, homes for training girls for domestic duty, a Magdalen asylum, homes for the blind, and orphanages. By 1900 they had also extended their services overseas, setting up communities in both England and Australia.

The Sisters of Charity can be credited with the achievement of establishing the first institutional provision for the dying in the British Isles - Our Lady's Hospice for the Dying, founded in Dublin in December 1879. Late nineteenth-century Dublin, like

¹⁶ Mary Aikenhead was born in Cork in 1787. At the age of 15 she became a Catholic. Much of her time was spent visiting the poor and later on she wished to become a nun so that she might continue to serve the needy and the suffering. In 1808 she met Father Daniel Murray, a Dublin priest, who helped her to fulfil her dream. They both realised the need for a body of religious women who would visit the poor in their own homes. Father Murray felt that she would make the ideal superior for such a Congregation. In 1810 Mary went over to York, England to train as a novice in preparation for establishing the Sisters of Charity.

¹⁷ *Rules and Constitutions of the Congregation of the Sisters of Charity*. Roma Tippografia (1912), p.6.

¹⁸ *The Sisters of Charity Celebrating 150 Years* (1995), p.11.

¹⁹ Taylor, F. (1867) *Irish Homes and Irish Hearts*. London: Longman, Green, and Co, p.11.

London, was plagued by extensive poverty and disease and the Sisters believed it “was a new and untried effort of charity to prepare a quiet spot to which souls nearing the shores of eternity might retire to pass through the sorrows of death from the turmoils of a receding world, and in which all the alleviations that could be brought to the succour of their condition might be applied.”²⁰

The foundation of a hospice was inspired primarily by the Sisters’ work at St Vincent’s Hospital, where for several years they had been praying for an asylum or refuge for the exclusive benefit of the dying poor who were discharged from the hospitals.²¹ The Sisters’ experience in visiting the sick poor in their homes, where they witnessed many death scenes, had further convinced them of the great need that existed for a place for the sick poor with no hope of recovery to spend their last days. The lack of space in any of the Dublin convents, however, prevented the immediate commencement of such an apostolate.²²

The opportunity did not occur until 1879 when the Mother House and Noviciate moved from their former location in Harold’s Cross, just south of Dublin to Milltown, another village on the outskirts of the city. With the help of a £600 donation from two Dublin ladies,²³ Mother Mary John Gaynor set about converting the old Noviciate house into a home suitable for the reception of dying patients.²⁴ Sister Katharine Butler has suggested that it was given the title ‘hospice’ rather than ‘home’ because the latter suggested some sort of permanency rather than a short stopping place on the passage to eternity.²⁵ However, unfortunately, there is no direct evidence with which to corroborate this reason for the choice of name. The Hospice provided accommodation for twenty-seven patients and was open to every class, creed and nationality. A few rooms were set apart for persons of higher rank but it was primarily

²⁰ Report of Our Lady’s Hospice for the Dying, September 1881 to September 1882, p.3.

²¹ A Member of the Congregation (1925) *The Life and Work of Mary Aikenhead*. London: Longmans, Green and Co., p.435.

²² Author and title unknown, *Freeman’s Journal*, June 1880 ; ‘Our Lady’s Hospice for the Dying, Under the Care of the Sisters of Charity, Harold’s Cross, Dublin, 1879’, Our Lady’s Hospice Archive; Butler, Sister K. (1979) *We Help Them Home*, p.10 ; *The Sisters of Charity Celebrating 150 Years* (1995), p.19.

²³ The name of only one of these ladies is known: Miss Sweetman.

²⁴ Author unknown, ‘The Late Sister Mary John Gaynor’, newspaper unknown, 1899, Our Lady’s Hospice Archive ; Butler, *We Help Them Home*, pp.12-14.

²⁵ Butler, *We Help Them Home*, p.16.

for the poor and the friendless.²⁶ Although physical care was important, the spiritual preparation of the patients for death was the Sisters' overriding objective. The Hospice aimed to provide:

“....a quiet spot where light and peace, and the joy of hope may gather around the deathbed of the least of God's creatures, and the trembling sinner can prepare to stand in humble confidence before God's judgement seat.”²⁷

The Sisters claimed the Hospice to be the “first institution in the world established for its special object.”²⁸ However, whilst this was certainly true within the British Isles, the Sisters cannot take credit for establishing the first institutional provision for the dying in the world, or even Europe. As early as 1843 a French philanthropist, Madame Jeanne Garnier, had set up a home for poor homeless persons in Lyons dying of cancer. It was known as ‘Hospice des Dames du Calvaire’ and was run by L'Association des Dames du Calvaires, a group of French widows. Jeanne Garnier later went on to found similar establishments throughout France during the nineteenth century.²⁹

The Irish Sisters of Charity founded a second hospice for the dying in Sydney, Australia, in 1890: the Sacred Heart Hospice. The Sisters first went to Australia in 1838 at the invitation of Dr John Polding, who later became the Archbishop of Sydney. In 1857 they opened a hospital in the city and, after the founding of Our Lady's Hospice in Ireland, became determined to set up a similar institution for the dying poor in Sydney. A block of land adjacent to the hospital was bought in 1889 by a benefactor and presented to the Sisters who decided to use it to build the hospice. A year later the 12-bed Hospice was opened.³⁰

St Joseph's Hospice for the Dying was therefore the third Hospice for the Dying established by the Irish Sisters of Charity. According to the annals, the Sisters were

²⁶ Report of Our Lady's Hospice for the Dying, September 1881 to September 1882, p.5.

²⁷ Report of Our Lady's Hospice for the Dying, September 1884 to September 1885, p.5.

²⁸ Report of Our Lady's Hospice for the Dying, September 1893 to September 1894, p.4.

²⁹ Pinell, P and Brossat, S. (1988) The birth of cancer policies in France. *Sociology of Health and Illness*, Vol. 10, No.4, p.582.

³⁰ Stuart-Harris, R (1995) The Sacred Heart Hospice: an Australian centre for palliative medicine, *Support Care Cancer*, Vol.3, p.280.

invited to London by Father Peter Gallwey, a Jesuit priest and Rector of Farm Street, the Society of Jesus headquarters in London. He had first encountered the Sisters in Cork where he had spent a year for health reasons, and had continued to be interested in them after his return to England. It was not until 1900 that he was able raise sufficient funds (£250 per annum) to establish a foundation. The money was provided by Miss Grace Goldsmid, a Jewish convert, who had been instructed by Father Gallwey, and at his advice agreed to set up a foundation as a thanks offering for the gift of faith. She also gave two annual payments of fifty pounds to fund the visitation of the poor in Hackney and Hoxton and to pay for the services of a chaplain.³¹

The thinking behind the decision to establish a congregation in North East London formed part of the wider practice of the Catholic Church in the second half of the nineteenth century as it sought new ways to reach the urban poor. Father Gallwey believed that as long as there were poor persons the services of the religious would always be needed because "they chose poverty for their own portion, and therefore know how to make poverty tolerable and dear to those who have no choice but poverty."³² The annalist for 1900-1905 noted that the Sisters were invited specifically to Hackney because the Mission Rector of the local Catholic Church had requested an urgent need for nuns. Cardinal Herbert Vaughan, the Archbishop of Westminster, asked them to extend their labours to the neighbouring district of Hoxton where they "would find many of our countrymen sunk into a state of carelessness and sin, and consequently a cause of much anxiety to their priests and pastor."³³ As well as Irish Catholics, there were Poles, Germans and Italians. The Superior of the Augustinian Fathers who ran the Mission in Hoxton had also petitioned the Cardinal specifically for nuns to work among the poor in the district.³⁴

Charles Booth identified the same problems in his surveys of Hackney and Hoxton. He noted that religious observance among both the working classes and the very poor was minimal and that the scattered and shifting Catholic population, predominantly

³¹ St Joseph's Hospice Annals (hereafter SJHA), 1900-1905.

³² 'Convent Life in England in the Nineteenth Century. Two Sermons by Father Gallwey. London: Burns and Oates, 7 March 1869, pp.10-11.

³³ SJHA 1900-1905.

³⁴ Ibid.

made up of Irish immigrants, had been subject to extensive 'leakage'.³⁵ Father Gallwey had particularly requested *Irish* Sisters because he felt they were the most appropriate persons to undertake mission work to a predominantly Irish Catholic population; "the feeling of their own Sisters being amongst them would appeal to their hearts."³⁶

During the first few years the work of the Sisters focused primarily on the visitation of the Catholic poor in Hackney and Hoxton. The annalist recorded that it was no easy task finding Catholic inhabitants within the two districts because they were "hidden away among this mass." Their difficulties were compounded by local popular resistance, engendered by both anti-Catholic and anti-Irish feeling: " 'no Catholics here thank God - no we are Christians - ah no - we aint Irish' " was noted by the annalist as a typical response.³⁷ As part of their 'Mission' the Sisters visited the two local Infirmaries and Victoria Park Chest Hospital where it was their task to "instruct and console the Catholic inmates." As they became more settled they extended their work into other areas; guilds and sodalities were set up, Mothers meetings held, Evening Instruction classes given and a Sunday School was run in Hackney.³⁸

The idea of founding a hospice was, according to the annals, a long-held dream of Father Gallwey, but his hopes were thwarted for a long-time through lack of funds.³⁹ He wanted the Hospice to be run by the nuns because "tender and tactful kindness" was their "special gift and prerogative."⁴⁰ The Sisters of Charity, during their many home visits to the poor and to the local infirmaries, had also been convinced of the need for an institution in which those who were dying could be properly cared for.⁴¹ In 1904 this was at last realised when an anonymous benefactor bought the whole of the Cambridge Lodge estate (the Sisters had moved into one of the villas on the premises

³⁵ Booth, C. (1902) *Life and Labour, of the People of London*. London: Macmillan and Co. Ltd, 3rd Series, pp.80-83, 111-115, 128-129.

³⁶ St Joseph's Hospice for the Dying Report 1907, p.4 ; Gavin, Father M. (1913) *Memoirs of Father P. Gallwey, SJ*. London: Burnes and Oates Limited, p.46.

³⁷ SJHA 1900-1905.

³⁸ Ibid.

³⁹ Gavin, *Memoirs of Father P. Gallwey, SJ*, p.44.

⁴⁰ Wilfred Wilberforce, 'St Joseph's Hospice, Mare Street, Hackney', *The Catholic Weekly*, date unknown, p.2.

⁴¹ Sister M. Alban 'Annals of St Joseph's Convent, Hackney', p.7 ; Title unknown, *The Daily Graphic* 4 October 1913.

in 1903) and presented it to the Community to use as a hospice for the dying which was officially opened on 15 January 1905.

Initially there were only twelve beds at the Hospice, but the growing number of applications put pressure on the Sisters to expand and by 1907 there were twenty-five beds in constant use.⁴² In 1908 one of the villas was converted into a private Nursing Home whose proceeds were used to help towards the support of the Hospice. It was not a condition that the patients were dying but most were incurable and ended up dying in the Home so that its work soon became an extension of the Hospice. It also provided extra beds for when the Hospice was full.⁴³ The Sisters of Charity often moved between their various foundations and institutions and it would be reasonable to conjecture that some of the Sisters who came over to St Joseph's would have had prior experience working at Our Lady's Hospice in Dublin.

The distribution of executive authority in the Hospice was significantly different to the other two homes. There was a Committee but it acted in a purely advisory capacity and the actual management of the Home was carried out by the Sisters. Unfortunately, the existence of only three annual reports and the absence of any minute books makes it difficult to assess the exact balance of power relations, although, on the basis of evidence in the Annals, it would appear that the Sisters had virtually a free hand in running the Hospice.

iii. St Luke's House and the West London Mission

St Luke's House was not founded by a religious order but as a branch of the West London Mission, an organisation which grew out of the Methodist 'Forward Movement'. This Movement was in turn a product of the broader shift within Methodism in the late nineteenth century which, confronted with the problem of dwindling numbers, was forced to seek new direction.⁴⁴ *The Bitter Cry of Outcast London* had a particularly profound influence upon Methodism and was an important

⁴² SJHA, 1900-1905 ; May 1905 to May 1909.

⁴³ SJHA, May 1905 to May 1909.

⁴⁴ *The Life of Hugh Price Hughes* by his Daughter (1904) London: Hodder and Stroughton, pp.172, 191.

factor in precipitating this change. The 'Forward Movement' originated in a revolt led by a group of Methodists against traditional Victorian Methodism which focused almost exclusively upon the importance of personal salvation. The Movement, pioneered by Hugh Price Hughes, a Methodist minister, asserted that Methodists should also concern themselves with social problems.⁴⁵

The West London Mission was established in 1887 as a branch of the London Wesleyan Methodist Mission, which had already established two other Missions in Central and East London. The 1894 annual report of the Mission stated that Hughes, the first Superintendent, believed that late nineteenth-century London was the embodiment of all that was sinful and miserable and was the place where "the decisive battle of Christianity must be fought, won and lost."⁴⁶ In her biography, Hughes' daughter noted that he was particularly interested in the "intelligent artisan" for whom Methodism had essentially been created, and was concerned that the Church was failing in its mission to reach out to this class. Although his principal objective was the evangelisation of the people of inner London, he believed that the work of the body and soul were inseparable and that if men were to be saved, their bodies must share in the process.⁴⁷ Despite its Methodist origins, the Mission claimed not to be non-sectarian in its aims or its constitution; "it exists to persuade all those who are *outside all churches* to obey and imitate our Lord Jesus Christ."⁴⁸ The Mission was a social as well as a religious organisation and during the first few years after its foundation its work expanded rapidly.⁴⁹ The services it provided included youth clubs, a crèche, Mothers' Meetings, a home for prostitutes, a guild for the mentally and physically disabled, a labour yard for men, a convalescent home and a 'poor man's lawyer' service. In 1888 a Medical Department was opened under the honorary superintendency of Dr Howard Barrett, brother-in-law to Hughes, whose task was to care for the sick poor.

⁴⁵ Bagwell, P. (1987) *Outcast London: a Christian Response: the West London Mission of the Methodist Church 1887 - 1987*. London: Epworth, pp.xi, 2-6.

⁴⁶ 7th West London Mission Annual Report (hereafter WLMAR), 1894, pp.10-11.

⁴⁷ *The Life of Hugh Price Hughes*, pp.194, 203.

⁴⁸ 10th WLMAR, 1897.

⁴⁹ Bagwell, *Outcast London*, p.21.

The West London Mission also drew heavily upon the services of a sisterhood of women. The Sisters of the People were founded by Hugh Price's wife, Katherine, in 1887.⁵⁰ Charles Booth wrote that they were the most important of all the Nonconformist church sisterhoods.⁵¹ The creation of the Sisters of the People was partly a response to the mobilisation of sisterhoods by the Anglican and Catholic churches. Katherine Price Hughes wanted to form an organisation which would reach the educated young women of the Wesleyan Methodist Church and recruit "ladies of leisure, culture, refinement and devotion."⁵² The Sisters were to be made up of members of Protestant Evangelical Churches who were willing to work in the spirit of John Wesley but, 'unlike the Sisters of Charity and St Margaret's of East Grinstead, they were not bound together by vows; the term 'Sister' was intended as an expression of "a truly human relationship as in the sight of God, and not as an ecclesiastical position."⁵³ Their work was divided into two main categories: (1) pastoral and evangelical and (2) social welfare.⁵⁴ The Sisters played a key role in all of the services provided by the Mission, particularly the Medical Department where they were very active in visiting the homes of the sick poor.⁵⁵ The annual report for 1897 stated that one of their most important tasks was to nurse dying cases and to provide spiritual ministrations by awakening them "to the fact that there is need for preparation for the life beyond" and "pointing them to the way of salvation."⁵⁶

The annual reports for St Luke's House record how a Home for the Dying was a scheme which had long occupied the mind of Howard Barrett. His experience working as a young doctor in the East End had first exposed him to the plight of large numbers of 'respectable' and 'self-respecting poor', who had no choice but to suffer in conditions of extreme misery and degradation. However, because he was young and did not have the necessary financial resources or sufficient body of influence behind him, he was unable at that stage to do anything about it. The opportunity did not arise

⁵⁰ Ibid., pp.24-25.

⁵¹ Booth, *Life and Labour*, 3rd Series, p.354.

⁵² Bagwell, *Outcast London*, p.26.

⁵³ Quoted from *West London Mission: The Story of Our Work*, 1907, p.26, in Bagwell, *Outcast London*, p.28.

⁵⁴ Bagwell, *Outcast London*, p.29.

⁵⁵ Ibid., p.37.

⁵⁶ 10th WLMAR, 1897, pp.80, 85.

until the foundation of the West London Mission twenty seven years later, an organisation which could supply both these requirements. Within five years the Mission had sufficiently established itself for Howard Barrett to approach the Chief Missioner with a proposal to set up a home for the dying poor as a branch house of the West London Mission. It took two years to raise the necessary funds and to find a suitable premises.⁵⁷ Barrett wanted the home to be situated within 1.5 miles of the West London Mission Centre, which necessarily limited the area in which a property could be sought.⁵⁸ It was named after the Biblical physician, St Luke, and opened with fifteen to sixteen beds, contained in four wards.⁵⁹

The management of St Luke's differed considerably from that of the other two homes. In 1893, when the Home opened, Barrett gave up his Directorship of the Medical Department at the West London Mission to take on the full time positions of manager and Medical Superintendent. However, once the organisation of the Home was complete, he felt that some of the responsibilities should be delegated to other persons and that possible successors to himself should be educated in the work. In 1895, therefore, a small but influential Committee of Management was formed with the power to add to its numbers.⁶⁰

During the first few years of its existence St Luke's retained strong links with the West London Mission. Barrett had a seat on the Mission's Executive Committee and Katherine and Hugh Price Hughes were *ex officio* members of the St Luke's Management Committee, while a minister of the Mission was both a member of the St Luke's Committee and one of the honorary clergymen to the Home. St Luke's was also answerable to the Mission in certain matters and had to obtain the formal approval of the Executive Committee when making important decisions such as moving premises.⁶¹ By the early years of the twentieth century, however, its relationship with the West London Mission had cooled somewhat (although why this

⁵⁷ 21st St Luke's House Annual Report (hereafter SLHAR), 1914, pp.25-27.

⁵⁸ 4th WLMAR, 1891, p.12.

⁵⁹ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24.

⁶⁰ 'St Luke's House', in West London Mission: The Story of Our Work During 1896, pp.66-67.

⁶¹ West London Mission Minute Book of the Executive Committee 7 April 1899 - 28 December 1900: 16/11/1900, p.171.

happened is not entirely clear) and in 1911 the Committee decided to break away and establish itself as an independent institution. A constitution was drawn up and the Committee was given the "entire superintendence, control and management of the Home and its property and affairs."⁶² After 1912 a somewhat tenuous connection with the West London Mission did continue - it still appointed one of the Honorary clergy of the Home, its Visiting Sisters continued to attend the Home and Katherine Price Hughes remained on the Management Committee - but St Luke's was very protective of its new independent status and resented any attempts by the Mission to reassert even a hint of its former claim.⁶³

The Barrett family had a strong presence in the management of the Home. Mrs Charles Barrett (Barrett's sister-in-law) was a member of the Committee and Miss A. Barrett was the first Secretary. In 1909 Barrett's nephew, Alfred Nutter, was appointed Treasurer and in 1925 Charles Barrett joined the Committee.⁶⁴ Howard Barrett resigned as Medical Superintendent in 1913 and was replaced by his son Edmund. Barrett senior continued to have a strong interest and influential presence in the Home, as both a Trustee and Vice-President, until his death in 1921, and when his son was away at the Front during the War he once again resumed the position of Medical Superintendent.

The growing numbers of applicants and the need to modernise their facilities soon put pressure on the staff to expand the size of their accommodation. St Luke's moved location twice between its opening and the outbreak of the First World War and each time the staff encountered numerous problems in trying to find new premises. One of the principal difficulties was finding a site where the neighbours or the landlord did not object to it being used as a home for the dying. In February 1900 the Committee decided to move from Osnaborough Road, Regent's Park, to other premises because the existing house was too cramped, the accommodation unsatisfactory and there was

⁶² 19th SLHAR, 1912, p.17.

⁶³ Minute Book of St Luke's House Committee of Management 18 June 1912 to 27 May 1918: 18/06/1912, p.1.

⁶⁴ Minute Book of St Luke's House Committee of Management, 11 October 1905 - 21 May 1912: 21/04/1909, p.163; Minute Book of St Luke's Hospital for Advanced Cases Committee of Management, 30 April 1925 - 26 February 1931: 24/11/1925, p.46.

no garden for the patients.⁶⁵ A new home was not found until November because many of the landlords they approached objected to the property being used as a home for the dying.⁶⁶

The same objection necessitated the Home's closure less than a year after it had re-opened - the ground landlord had received a complaint from a local builder that he was unable to sell the properties opposite the Home. Finding yet another premises proved even more difficult; the annual report for 1902 noted that the Committee had 60 agents working for them and 187 houses were inspected.⁶⁷ When the lease for the new premises in Pembridge Square, Bayswater, was finally signed in 1903 the term "to be used as a 'Nursing Home for Incurables'" was inserted because it was felt that 'a home for the dying' would lessen their chances of securing the lease. It was also decided not to have a public re-opening ceremony or even to announce the re-opening in case the local residents became unduly alarmed.⁶⁸

In addition to location problems, St Luke's appears to have experienced an ongoing tension between the need to ensure that local residents were not upset by the existence of a home for the dying and the need to ensure that the true purposes of the home were known to the wider public. Thus any advertisements for the Home included its full title and address but there was no sign on the premises itself of the purpose for which it was being used.⁶⁹ The need to balance these two concerns was compounded by another of the Home's objectives; to conceal from patients the true nature of the institution.

During its early history St Luke's twice faced the predicament of whether or not to close down. The first occasion was in 1901 after it was evicted from its second premises. Although the Committee agreed unanimously to continue, Howard Barrett would only sanction it if there was a rearrangement in the managerial provision. He

⁶⁵ 7th SLHAR, 1900, p.4.

⁶⁶ 8th SLHAR, 1901, p.17.

⁶⁷ 10th SLHAR, 1903, p.10.

⁶⁸ Minute Book of St Luke's House Committee of Management 15 November 1895 to 19 July 1905: 27/01/1903 ; 14/05/1903.

⁶⁹ Minute Book of St Luke's House Committee of Management 11 October 1905 to 21 May 1912: 12/12/1906, pp.60-62.

wanted to resign as both chairman and General Director and to divide up these responsibilities.⁷⁰ The other occasion was in 1917 when the difficulties created by the War, particularly the problem of finding nurses and servants, necessitated a special meeting to consider the advisability of closing. The outcome was that, although it was agreed to try and continue, special weekly meetings would have to be held to ensure that the Home was being run efficiently.⁷¹ It was not until 1919 that the crisis ended.⁷²

iv. The Hostel of God

The Hostel of God was founded as a result of an appeal in *The Times* on Christmas Day 1891 by Colonel William Hoare, a local banker, and Clara Maria Hole, Superior of the Order of St James' Servants of the Poor, an Anglican sisterhood.⁷³ Little is known about this order except that they had been formed in the 1880s by Sister Clara Maria Hole in Kilkhampton, Cornwall, where they ran orphanages and undertook nursing and parochial work.⁷⁴

According to the annual report written in 1930, the actual idea of a home for the dying originated with Mrs William Hoare who, never in strong health herself, had sympathised greatly with those whose health and strength were failing and who did not have the means to obtain the necessary comfort and alleviation.⁷⁵ A house was found in Clapham in South East London which opened in May 1892 with fifteen beds and was named after the 'Hotel Dieu' in Paris.

The Sisters of St James' Servants of the Poor ran the Home from 1892 to 1896 when they were replaced by the Sisters of St Margaret's of East Grinstead. The latter was one of the earliest of the Anglican Sisterhoods.⁷⁶ Their founder was Dr John Mason

⁷⁰ Minute Book of St Luke's House Committee of Management 15 November 1895 to 19 July 1905: 18/10/1901 ; 11/11/1901.

⁷¹ Minute Book of St Luke's House Committee of Management 18 June 1912 to 27 May 1918: 12/12/1916, p.245 ; 05/01/1917, pp.248-250.

⁷² 26th SLHAR, 1919, p.9.

⁷³ Hoare, W. 'Help for the dying', *The Times*, 25 December 1891, p.8.

⁷⁴ Anson, P.F. (1955) *The Call of the Cloister: Religious Communities and Kindred Bodies in the Anglican Community*. London: SPCK, p.530.

⁷⁵ Hostel of God Annual Report (hereafter HOGAR), 1929, p.6.

⁷⁶ *Ibid.*, p.337.

Neale, Warden of Sackville College in East Grinstead, who had come under Tractarian influence during his time at Cambridge. In 1855, in response to local conditions of sickness and poverty, he conceived the idea of forming a community of women whose principal work would be to go out and nurse the sick poor in their homes, caring not only for their bodies but also their souls.⁷⁷ As well as tending to the poor in their homes, the Sisters also branched into various forms of institutional care, including orphanages, homes of rest, houses of refuge, a convalescent home, a hospital, a nursing home and a home for incurables. The sisterhood expanded considerably over the years, undertaking extensive work in London, and establishing other branch houses throughout England, Scotland and overseas.⁷⁸

The first Hostel of God premises, a five-storied house with a capacity for fifteen beds, was only taken on a three year lease. When this expired it was decided to move to a larger house with fewer stories, to lessen the strain on the staff and where it would be possible to have a mortuary.⁷⁹ The new home situated on Clapham Common was opened in 1900 and provided accommodation for 36 patients. In 1909, one year after St Joseph's undertook a similar initiative, a nursing home with twelve beds and an operating theatre was set up for paying patients. It provided treatment of severe cases of illness or for persons about to undergo surgical operation each of whom would be attended by their own medical men.⁸⁰

The Hoare family had a significant presence in the Hostel of God, although it was not as influential as that of the Barretts at St Luke's. William Hoare was Treasurer of the Home for many years and Mrs Hoare a vice-president until her death in 1930. In 1923 their son, Colonel Geoffrey Hoare, became Chairman of the Committee.⁸¹ Under the Sisters of St James' Servants of the Poor there was no committee of management. However, in 1896 the Sisterhood gave up the management of the Home and it was taken over by the Sisters of St Margaret's of East Grinstead at the request of Clara

⁷⁷ Hutton, R.E. (1959) *St Margaret's Convent East Grinstead: An Account of the Community and its Work*, revised edition, p.4.

⁷⁸ Anson, *The Call of the Cloister*, pp.350-355.

⁷⁹ HOGAR, 1893-1894, p.7.

⁸⁰ Minute Book, Free home for the Dying. Council Meetings April 1897 to 17 February 1914: 18/02/1909.

⁸¹ HOGAR, 1923, p.4.

Hole, the Sister Superior, who had joined the Catholic Church. Under the new Sisters there was a division of executive responsibilities between a Council, formed in 1897, whose members were invested with the financial and general control of the Home and the Sister Superior, appointed by the Mother Superior of the Community, who was responsible for its internal management and discipline.⁸² The Council did not have any power to intervene in the internal management but they could enquire into matters they thought warranted investigation.⁸³

v. Founding philosophies and admission policies

In common with many other Victorian philanthropic endeavours, the homes were founded primarily as religious institutions and aimed at the spiritual reformation of patients. Barrett in his report for 1892 described St Luke's House as a "religious charity" with a "strong religious motive"⁸⁴ which aimed to "provide as far as we can that their undying spirits should come to know their Father which is in Heaven and Jesus Christ, whom He hath sent."⁸⁵ Likewise, the Hostel of God was referred to by the Chaplain as a "Church Home"⁸⁶ seeking to help patients find "union with Our Lord."⁸⁷ Each home advertised itself as non-sectarian, open to all religions and none, but their distinct denominational basis inevitably impacted upon the religious affiliation of inmates. Barrett was particularly anxious to emphasise to the public the non-sectarian basis of St Luke's, where a Methodist minister, an Anglican vicar, a Catholic priest and a Jewish Rabbi were all permitted to visit the patients.⁸⁸ However, as chapter 3 will show, this was a rhetorical statement intended as a way to help raise support for the Home.

All three homes sought to create a "home-like atmosphere" for the patients. One of the visiting chaplains to St Luke's House described its purpose as the "Homing of the

⁸² Minute Book Free Home for the Dying. Council Meetings April 1897-February 17th 1914: 01/07/1897.

⁸³ Hostel of God Statutes, 1917, p.11.

⁸⁴ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.29 ; 7th SLHAR, 1900, p.7.

⁸⁵ 20th SLHAR, 1913, p.21.

⁸⁶ HOGAR, 1896, p.9.

⁸⁷ Ibid., 1906, p.8.

⁸⁸ 'The Report of St Luke's House', taken from 6th WLMAR, 1893,

Death-Stricken.” The provision of a home, rather than a hospital, for the patients was felt to be as much dependent upon the love and compassion of the staff as the comfort and refinement of the furnishings and to be more conducive to spiritual reflection.⁸⁹

The attitude towards the poor of those who founded and ran the homes reflected their social origins. As members of the educated and professional middle classes their arguments echoed the wider discourses of these groups. All three homes, in their public appeals, drew a clear distinction between the respectable and the non-respectable poor, specifying that their institutions were intended solely for the former class because the workhouse infirmaries provided suitable accommodation for the undeserving poor. As the 1895 annual report for the Hostel of God remarked:

“Sorry as we were to have to shut our doors upon the lowest class, still in view of the excellent accommodation provided for them in the infirmary, we felt that no real harm was done to them by confining ourselves to patients of a somewhat higher social standing.”⁹⁰

No-one was more emphatic about this point than Howard Barrett. He wrote that the division between the ‘worthy’ and ‘unworthy’ poor was the “leading principle” at St Luke’s.⁹¹ infirmaries existed for the non-respectable poor or the “submerged tenth,” but there was a large class for whom, “on the grounds of superior refinement and the sterling record of uprightness and honourable independence through the whole of their previous lives the workhouse is an unfit place for.....Hence the value and absolute necessity of homes like St Luke’s House.”⁹² Barrett also believed that the respectable poor feared the workhouse even more than death. In 1891 he referred to many who have “seen better days” and “recoil from ending their days in the parish Infirmary more than they do from death.”⁹³

Barrett strove to uphold his vision of the type of inmate who would be welcome at St Luke’s and many patients had to be refused admission because they did not fulfil the necessary moral and social requirements.⁹⁴ Both the Hostel of God and St Joseph’s

⁸⁹ 13th SLHAR, 1906, p.29 ; HOGAR, 1896, p.8 ; SJHA, May 1905 - May 1909.

⁹⁰ HOGAR for the Year Ending 30 April 1895, p.3.

⁹¹ 2nd SLHAR, taken from 7th WLMAR, 1895, p.4.

⁹² Ibid., pp.4-5 ; 7th SLHAR, 1900, p.8.

⁹³ 4th WLMAR, 1891, pp.11-12.

⁹⁴ ‘Report of St Luke’s House’, taken from 8th WLMAR, 1895, p.143.

were also founded to receive the 'respectable poor' but their attitude was less dogmatic. The Sisters at St Joseph's, despite a theoretical adherence to this maxim, operated by far the most flexible admissions policy, and the list of inmates over the years included many from the bottom end of the social scale, such as thieves and prostitutes.

All applicants to the homes were admitted solely on the basis of their merits, although certain conditions were still attached, both medical and social, which restricted the number of successful applicants. Each home was very specific about the types of ailments that would not be accepted. Incurable, chronic, infectious diseases or mental disorders were all debarred. The latter two categories would have required special staffing and medical services that the homes were not equipped to provide. In addition to these restrictions, St Joseph's would not admit cases of epilepsy or paralysis, although a glance at the patient registers shows that on occasion such patients did find their way into the Hospice.⁹⁵

At St Luke's House, as well as recognising the individual advantages for the patient of removal to an institution, there was also an awareness of the wider health and social benefits which would be conferred upon the public as a whole. Barrett wrote that the transferral of patients suffering from tuberculosis would help prevent the risk of infection which was most likely to occur in the last stages. Similarly, cancer patients would become very insanitary unless they received skilled nursing, while heart disease and conditions of the nervous system needed a tranquil environment where there would be a minimum of disturbance. Furthermore, he argued, the patient would cease to be a financial burden upon the family because, no longer being required to nurse the patient, they would be free to go out as wage earners.⁹⁶

During the early years of their history the homes appear to have only had a limited awareness of each other's existence or of the other two homes in London. When it was founded those at the Hostel of God had no knowledge about the existence of the

⁹⁵ 5th SLHAR, 1889, p.6; E. Farish, 'Report on the Hostel of God', 30 March 1894 [LMA]; St Joseph's Hospice For the Dying Report, 1907, p.3.

⁹⁶ 6th SLHAR, 1899, p.8; 20th SLHAR, 1913, p.11.

Friedenheim. Thus the Hostel claimed to be the first scheme of its kind which “until then had not been put into practice in this country.”⁹⁷ At St Luke’s the staff seemed to be better acquainted with what other provision there was in the city. In 1891, two years before St Luke’s opened, Barrett was aware of both the Friedenheim and the Hospital of St John and St Elizabeth and knew about the Cancer Charity Ward at the Middlesex Hospital for dying cancer patients.⁹⁸

Over the years there was virtually no collaboration between the homes aside from a few patient referrals. In fact between St Luke’s House and the Friedenheim there was an almost competitive relationship, particularly on the side of the former, which might possibly have been caused by their relatively close proximity. At the St Luke’s House Committee of Management meetings the accounts of both institutions were often compared and the fact that St Luke’s usually fared better was conscientiously pointed out. For example, at one of the meetings in 1909 Howard Barrett gave a comparison of working figures for the Friedenheim and St Luke’s which he said were much to the advantage of the latter, but pointed out that, although St Luke’s was run more economically, the Friedenheim seemed able to raise a much higher income. Ironically, St Luke’s did actually consider the possibility of an amalgamation with the Friedenheim at one point, in 1914, although nothing was ever done about it.⁹⁹

vi. Public support for homes for the dying

The homes for the dying did not receive unanimous support from all quarters and the question of the social group at which they were aimed was a particular cause of contention. One rather unexpected source of criticism was a letter sent by Louisa Twining, the long term social campaigner for reforms in workhouses and infirmaries, to the Editor of *The Times* in January 1895. She argued that since Poor Law infirmaries in the Metropolitan area were now considered by all competent judges to be equal to voluntary hospitals in care and nursing there was a far more urgent need for those who were able to pay some portion of their expenses and for whom neither

⁹⁷ HOGAR, 1896, p.6.

⁹⁸ 4th WLMAR, 1891, p.12 ; 1st SLHAR, taken from 7th WLMAR, 1894, p.5.

⁹⁹ Minute Book of St Luke’s House Committee of Management, 18 June 1912 - 27 May 1918: 19/05/1914, pp.110-111.

the infirmaries or hospitals were intended.¹⁰⁰ However, since not all of Miss Twinings' contemporaries concurred with her opinions on the workhouses, the writing of this letter might have stemmed more from a sense of personal affront; the moral justifications employed by those responsible for setting up the homes seemed to cast doubt upon the success of her own efforts.

Miss Twining's letter prompted a swift reply from C.H. Bowden, the Chaplain at Guy's Hospital. He disagreed with her opinion of voluntary hospitals and Poor Law infirmaries stating that in his experience they were not 'equal'. Using the example of doctors' work, he argued that in Poor Law infirmaries there was usually only one doctor looking after two hundred patients, while in voluntary hospitals no doctor had more than thirty patients in his charge. He also felt that the infirmary doctor had a tendency to exercise a despotic power, while that of the hospital doctor was safeguarded by the presence of students anxious to learn from him. This meant that while there was a pressing need for patients who had the means or friends to contribute towards their support, there was still an urgent need for "respectable folk whose past history makes them shudder at the prospect of sending them to lie and die amongst the ordinary clients of the Poor Law."¹⁰¹

vi. Finance

As voluntary institutions the homes were principally reliant upon the charitable benevolence of the general public. Inviting people of high social-standing and influence to join the Committee was an important means of attracting financial and material support. In his report for 1897 Howard Barrett lamented that there were not more subscribers to the Home but noted that those who were held "honoured and conspicuous positions in the professions and the world."¹⁰² At a Committee meeting in 1904, in an attempt to improve their financial position, he suggested that influential people such as Lady Battersea be asked to give drawing room meetings.¹⁰³ Similarly,

¹⁰⁰ Twining, L. 'Free homes for the dying', *The Times*, 11 Jan 1895, p.11.

¹⁰¹ Bowden, C.H. 'Free homes for the dying', *The Times*, 14 Jan 1895, p.7.

¹⁰² 4th SLHAR, taken from 10th WLMAR, 1897, p.11.

¹⁰³ Minute Book of St Luke's House Committee of Management 15 November 1895 to 19 July 1905: 09/05/1904.

at one of the early meetings of the Hostel of God Council in 1897, William Hoare proposed that the names of several officials of various hospitals should be added to the list of vice-presidents.¹⁰⁴ All three homes enjoyed royal patronage from early on in their history and were anxious that it should be maintained.

Table 1: Sources of Income and Expenditure in the Early Years, 1894 to 1916

| | St Luke's House | | | Hostel of God | | St Joseph's Hospice | |
|------------------------------------|-----------------|---------------|---------------|---------------|---------------|---------------------|---------------|
| | 1894 | 1910 | 1915 | 1895 | 1906 | 1905 | 1916 |
| Income | £1,142 | £2,608 | £2,162 | £1,477 | £3,488 | £2,414 | £5,456 |
| Subscriptions and donations | £648 | £1,964 | £1252 | £1,243 | £2878 | £879 | £1,398 |
| Congregational collections | | £8 | | £33 | £66 | | |
| Patient contributions | £65 | £315 | £214 | | | £62 | |
| Private Nursing Home (St Joseph's) | | | | | | | £1,325 |
| Support of Community (St Joseph's) | | | | | | £420 | £314 |
| King Edward Hospital Fund | | £50 | £25 | | | | |
| Hospital Sunday Fund | | £154 | £141 | | £121 | | |
| Hospital Saturday Fund | | | £35 | | £20 | | |
| Bequests | | | | | | | £1,400 |
| Invested property | | £87 | £395 | | | | |
| | | | | | | | |
| Expenditure | £853 | £2,230 | £2,143 | £848 | £3,417 | £2,281 | £4,443 |
| Surgery and dispensary | £49 | £68 | £58 | £44 | £58 | £20 | £107 |
| Domestic | £170 | £413 | £435 | £380 | £385 | £347 | £651 |
| Provisions | £303 | £670 | £630 | | £391 | £268 | £2,243 |
| Salaries and wages | £147 | £354 | £416 | | £371 | £126 | £476 |
| | | | | | | | |
| Balance | £289 | £293 | -£19 | £73 | £71 | £291 | £513 |

¹⁰⁴ Minute Book, Free Home for the Dying, Council Meetings April 1897 to 17 February 1914: 01/07/1897.

Subscription and donation lists were a popular device for generating financial gifts and were of particular appeal to a highly class conscious Victorian and Edwardian society whose more humble members took great social pride in having their names associated with the more well-to-do. At St Joseph's there was an additional incentive for any subscribers of £30 p.a. and above who were entitled to the privilege of having a patient in the Hospice during that year.¹⁰⁵ All three homes employed similar methods in raising money; bazaars, concerts, church collections, Matron's Pound Day, the endowment of beds and the Princess Alexander Rose Day.

St Joseph's dependence upon the generosity of wealthy Catholics in London, particularly in the form of bequests, helped to provide a relatively stable financial position over the years. It was significantly aided in this by the Catholic notion of 'Holy Poverty' and the belief that 'good works', in this case the giving of alms, was a way of securing one's own spiritual status. A quote from Father Gallwey in the 1907 annual report is typical of the rhetoric employed by the Catholic clergy when appealing for funds:

"If thou has much give abundantly; if thou has little, take care even so to bestow willingly a little....For alms deliver from all sin and from death, and will not suffer the soul to go into darkness."¹⁰⁶

The Jesuits at Farm Street were particularly instrumental in recruiting wealthy and prominent people to patronise the various fund-raising events held on behalf of the Hospice and the Sisters could also appeal to local ethnic benevolence by putting on events such as Irish concerts. During the early years of the Home it cost £500 to endow a bed which could bear the donor's name, but by 1916 the sum had been raised to £1,000 because £500 did not provide sufficient interest to support a patient.¹⁰⁷ The payments received from patients admitted to the private Nursing Home also helped to provide the Hospice with a strong financial backbone.¹⁰⁸ For example, as Table 1 shows, in 1916 it provided a quarter of the receipts for that year.¹⁰⁹ The Hospice also received a regular income from the Sisters of Charity Community, although each year

¹⁰⁵ 'St Joseph Hospice for the Dying Report 1907', p.2.

¹⁰⁶ *Ibid.*, p.6.

¹⁰⁷ *Ibid.*, p.2 ; 'Report of St Joseph's Hospice for the Dying 1916', p.8.

¹⁰⁸ SJHA May 1905 - May 1909.

¹⁰⁹ 'Report of St Joseph's Hospice for the Dying 1916', p.13.

it accounted for a smaller proportion of the overall income. In 1905 it amounted to £420, just over one-sixth of the total income for that year.¹¹⁰ By 1916 it had decreased slightly to £314, but only formed 6% of the total money received that year.¹¹¹

At the Hostel of God the largest source of income came from subscriptions and donations (see Table 1). The most generous financial gifts were from the Freemasons, including many from their overseas lodges. The Freemasons were renowned for their charitable benevolence and their continuous and regular donations helped to provide a solid financial basis for the Home.¹¹² Another very important source of income was the money generated by the Endowment Fund. Although the Home's expenditure never exceeded its income, the balance remaining at the end of each year was usually small. The substantial funds channelled into the Endowment Fund, however, ensured that the Home always had a large reserve of money to draw upon in emergencies. The Fund grew rapidly over the years; in 1896 it had only £56 but by 1911 it contained £3,051.¹¹³ It cost £1,000 to endow a bed for perpetuity and £500 during the life of the donor which conferred the privilege of being able to nominate patients and name the bed.¹¹⁴ The Freemasons had endowed two beds for the accommodation of their own members and their families, and the army and navy also had a special bed each.¹¹⁵

In contrast, St Luke's House seems to have encountered considerable financial difficulties over the years. Despite being located in the "blissful region sacred to the monied and leisured class,"¹¹⁶ the Annual Reports and Minute Books document an almost continuous struggle for funds. Although the general fund of the West London Mission was ultimately responsible for the maintenance of the Home up until its separation in 1911, the day-to-day running costs were financed through independent means.¹¹⁷ Subscriptions and donations were particularly low in the early years, for example, in 1894 only £750 was raised, compared to £1,243 at the Hostel of God in

¹¹⁰ 'St Joseph Hospice for the Dying Report 1907', p.8.

¹¹¹ 'Report of St Joseph's Hospice for the Dying 1916', p.13.

¹¹² Jacob, M.C. (1981) *The Radical Enlightenment: Pantheists, Freemasons and Republicans*. London: George Allen and Unwin, p.113.

¹¹³ HOGAR's, 1896, p.16 ; 1911, p.16.

¹¹⁴ HOGAR, 1908, p.46.

¹¹⁵ HOGAR, 1897, pp.12-13.

¹¹⁶ 10th SLHAR, 1903, pp.10-11.

¹¹⁷ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.28.

1895.¹¹⁸ Unlike the other two homes, St Luke's House became increasingly dependent upon patient payments. Although payment was not demanded directly from any patients, Barrett strongly believed that those who were in a position to contribute financially or had friends or relatives with the means to support them, should be expected to do so.¹¹⁹ In 1895 £65 was received from patient payments and by 1915 this had risen to £214.¹²⁰ As early as 1905 Barrett suggested that one of the Relief Sisters from the West London Mission should act as an 'Investigatory Department' and visit the patients to assess whether or not they were in a position to make some form of weekly or monthly payment.¹²¹ No admission was completely free of charge; a weekly payment for washing had to be given by all the inmates.¹²²

Patients at the Hostel of God were not expected to make any form of payment: "poverty and a reliable recommendation, backed by a medical certificate, and evidence of respectability" were the principle requirements.¹²³ The only source of patient income was from the Nursing Home. Similarly, at St Joseph's Hospice there was no fixed charge for patients, although they sometimes offered a payment of a few shillings a week. They were, however, expected to provide their own bed-gowns, towels, comb and slippers.¹²⁴ The only regular patient payments were those received from patients in the Private Nursing Home. By 1916 this amounted to £1,325 and was only slightly less than that yielded by subscriptions and donations (£1,398).¹²⁵

The issue of patient payments was one that all voluntary hospitals had to deal with by the early years of the twentieth century, particularly in the aftermath of the First World War, when their financial position was extremely precarious. Stephen Cherry has conducted a detailed study of the financial situation of the voluntary hospitals between 1860 and 1939 which has led him to conclude that this was a period in which there

¹¹⁸ 2nd SLHAR, taken from 8th WLMAR, 1895, p.19 ; HOGAR, 1895, p.7.

¹¹⁹ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.25.

¹²⁰ 2nd SLHAR, taken from 8th WLMAR, 1895, p.14 ; 23rd SLHAR, 1916, p.36.

¹²¹ Minute Book of St Luke's House Committee of Management 15 November 1895 to 19 July 1905: 15/05/1905.

¹²² Minute Book of St Luke's House Committee of Management 15 November 1895 to 19 July 1905: 19/10/1904.

¹²³ HOGAR, 1897, p.4.

¹²⁴ 'St Joseph Hospice for the Dying Report 1907', p.5.

¹²⁵ 'Report of St Joseph's Hospice for the Dying 1916', p.13.

was a fundamental remodelling of the philanthropic base of voluntary hospitals, in response to constructional defects, rising treatment costs and renewed emphases upon self-help.¹²⁶ As institutions founded upon a voluntary basis, the homes for the dying could not help but be affected to some degree by these broader changes. Like all the voluntary hospitals, the homes gradually lost their traditional philanthropic base and adopted a system whereby payment was received from patient charges, contributory schemes (such as the Hospital Savings Association) and public authority funding. Recently developed initiatives such as the King Edward Hospital Fund (formerly the Prince of Wales Hospital Fund), established in 1897 to provide funding grants for voluntary hospitals; the Hospital Sunday Fund, which ran an annual church and chapel collection on a Sunday in June; and the Hospital Saturday Fund, which was based on hospital workplace collections, were also utilised.¹²⁷

viii. Conclusion

The focus of this chapter has been primarily upon the founding era of the homes but, as subsequent chapters show, many of the issues that have been discussed had important consequences for their later development. The establishment of homes for the dying poor rested on a common underlying philosophy; to provide bodily and spiritual care within a home-like atmosphere for the respectable poor who were medically certified as being in the advanced stages of disease - a condition which precluded their admission to the voluntary hospitals - and whose domestic and family circumstances meant that they could not be nursed at home. St Joseph's was the third hospice founded by the Irish Sisters of Charity and thus constituted part of a continuing interest in care of the dying by the Sisters. It also meant that they had considerable prior experience in institutional care of the dying poor.

The way in which the three homes were managed, particularly the division of executive power, was especially important because it had a profound influence upon

¹²⁶ Cherry, S. (1996) Accountability, entitlement, and control issues and voluntary hospital funding c1860-1939, *Social History of Medicine*, Vol.9, No.2, p.216.

¹²⁷ Rivett, G. (1986) *The Development of the London Hospital System 1823-1982*. Oxford University Press, pp.121-122 ; 146, 150-152 ; Cherry, 'Accountability, entitlement, and control issues', pp.218-219.

their subsequent development. Management at St Joseph's and the Hostel of God was structured along more similar lines. In both homes internal management was carried out by a religious order. However, it would appear that while the Sisters of Charity had full executive responsibility for the running of the Home - the Committee was only an advisory body - the Sisters of East Grinstead had to defer to a Council in matters relating to the external management of the Hostel. In contrast, St Luke's, although founded as a branch of the West London Mission in the early years, was not actually managed by this or any other religious organisation; the Home was run by the Medical Superintendent with the help of a Committee of Management. Despite being only affiliated to the Mission, it was the only home which, in 1911, sought to free itself of all formal religious connections by establishing itself as an independent institution. Subsequent chapters demonstrate that the different management set-up of the homes was an important factor in determining their long-term status, both as homes for the dying and as religious institutions.

St Luke's also seemed to encounter the most difficulties in regards to pragmatic issues, such as finding a premises where a home for the dying would be accepted by the local community and generating sufficient financial support. All three homes gradually lost their philanthropic bases and became reliant upon contributory schemes and public authority funding but St Luke's, unlike the other two homes, was also increasingly dependent upon patient payments. As chapter four shows the changing way in which the homes were funded had important implications for their later development, particularly their position within wider medical and hospital networks.

Finally, the homes were all founded as part of the broader missionary work of their respective Churches and as such shared their commitment to combating working class religious indifference. The preoccupation with only helping the respectable poor was most apparent in the work of St Luke's House but was a common concern in all the homes - although it was less rigidly adhered to at St Joseph's - and reflected the middle and upper class origins of their founders. The different denominational basis of the homes, however, set them clearly apart from each other and, as the next chapter

shows, impacted significantly on the way in which care was delivered to the patients, particularly spiritual ministrations.

CHAPTER 3

"Soul Cures": The Portrayal of Death and Perceptions of Patients' Experiences

CHAPTER 3

“Soul Cures”: The Portrayal of Death and Perceptions of Patients’ Experiences

Management of the dead had not significantly changed since the 18th century. At the Hospital of St. Luke the way in which spiritual care was delivered seems to have remained largely unchanged throughout the period. At St. Joseph's, however, in response to a change in the religious affiliation of patients admitted into the Home, its focus and format underwent a considerable shift during the early-1920s, as a predominantly Catholic population gave way to a preponderance of Church of England members. Perceptions about death and dying at St. Luke's Home also changed markedly during this period. During the early years of its history spiritual care was looked upon as the most important aspect of the work. However, the very different way in which the Home was managed, changes in personnel after 1813 and its more conscious religious basis resulted in a gradual re-prioritisation of concerns.

Pat Jelland is the only other historian who has looked in depth at attitudes towards death and dying during both the late Victorian and Edwardian eras. She argues that

The religious emphasis of the early homes for the dying played a crucial role in shaping perceptions about death and dying among those responsible for their management. The Sisters at St Joseph's and the Hostel of God and Howard Barrett at St Luke's House all gave precedence to spiritual care. Non-spiritual concerns, however, were still looked upon as important. Lay personnel, particularly the medical and nursing staff, were given responsibility for the more temporal aspects of caring for dying patients. The importance attached to physical care constituted part of the broader shift in thinking among late Victorian churches which increasingly recognised that the ability to carry out spiritual ministrations was dependent upon taking care of patients' material wants. In all three homes bodily and spiritual needs were viewed as integral so that care of the body, the mind and the soul formed an important and inter-related part of their work. The denominational basis of each home was particularly influential in shaping the attitudes of those who ran them and in formulating the model against which all patients' death and dying experiences were judged. The Catholic, Methodist and Anglo-Catholic churches each held a certain set of beliefs about the way in which death should be prepared for and met, many of which were in evidence in the work of the homes.

Management of the deathbed differed significantly in each home. At the Hostel of God the way in which spiritual care was delivered seems to have remained largely unchanged throughout the period. At St Joseph's, however, in response to a change in the religious affiliation of patients admitted into the Home, its focus and format underwent a discernible shift during the early 1920s, as a predominantly Catholic population gave way to a preponderance of Church of England inmates. Perceptions about death and dying at St Luke's House also changed markedly during this period. During the early years of its history spiritual care was looked upon as the most important aspect of the work. However, the very different way in which the Home was managed, changes in personnel after 1913 and its more tenuous religious basis, resulted in a gradual re-prioritisation of concerns.

Pat Jalland is the only other historian who has looked in depth at attitudes towards death and dying during both the late Victorian and Edwardian eras. She argues that

during the late eighteenth and first half of the nineteenth century religion was a powerful influence in shaping perceptions about death among the middle and upper classes. The Evangelical movement, which affected all denominations, revived the Protestant ideal of the good death and reawakened an emphasis upon spiritual concerns. Death was of central importance to Evangelicals because the doctrines of sin, assurance and atonement emphasised Christ's sacrificial death to save people from sin. The significance attached to the deathbed stemmed from the belief that individual judgement occurred immediately after death and that non-believers were condemned to an eternity of punishment. For the unsaved the deathbed represented the last opportunity to experience conversion, while devout believers looked upon the manner of their dying as the final proof of their salvation.¹

According to the Evangelical model, the 'good death' should take place at home, in the presence of family and friends. The dying person should be conscious and lucid until the end, resigned to God's will, able to seek forgiveness for past sins and able to demonstrate worthiness for salvation. Pain and suffering should be undergone with fortitude and looked upon as a final test of fitness for heaven and as a reparation for past sins. The most important features of the Evangelical good death were those which concerned its religious aspects; spiritual preparation was essential and it was felt that the deathbed should have a didactic value so that those who witnessed it could derive spiritual benefit from the example set by the departed.²

The issue of possible denominational variations on the 'good death' is only briefly addressed by Jalland. Her initial argument is that the Tractarian deathbed represented the only significantly different model but was still essentially a moderated form of its Evangelical counterpart. The Oxford or Tractarian movement of the 1830s and 1840s was led by a group of individuals from within the Anglican Church who wished to revive some of the elements of the High Church. Jalland argues that they reinforced the practical piety of Evangelicalism while restraining its excesses. However, as she discusses the Tractarian deathbed in more detail, she is forced to concede that there were in fact fundamental differences between the two models. The Tractarians

¹ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press, pp.19-21.

² *Ibid.*, pp.28-29.

accorded a much greater role to the clergy and attached far more importance to the sacraments, while the Evangelicals placed a much higher emphasis on the visible signs of grace, particularly conduct in the final hours.³ The Evangelical good death was thus not the only model which influenced the Victorian deathbed.

The other most clearly identifiable religious deathbed model during this period was the Catholic good death which placed great emphasis upon the importance of a final confession and the receipt of Holy Viaticum, but this is even more underplayed by Jalland, receiving only a passing mention.⁴ The nineteenth century was a time of increasing religious pluralism but she does not account for this important change, particularly the ways in which it might have impacted upon attitudes towards care of the dying. The foundation of the homes for the dying, which were all affiliated to a particular denomination, is indicative of these wider religious developments and of their importance in shaping care of the dying during this period.

During the second half of the century Evangelicalism began to decline in influence and, according to Jalland, the religious model of the good death which had emphasised spiritual piety gradually gave way to a growing preoccupation with physical distress. The “Edwardian fear of dying uncomfortably,” as she has called it, was not based on one accepted model of death. It was characterised by fear, uncertainty, uneasiness and avoidance, new features which became increasingly common between 1870 and 1914 but which did not dominate.⁵

The religious basis of the homes for the dying and their clear denominational allegiance suggest that Jalland’s evaluation of attitudes towards death and dying during the late Victorian and Edwardian eras requires some modification. Her interpretation is insufficiently nuanced because it does not allow adequately for the growing pluralism of the nineteenth century or the continued importance of spiritual issues in the care of the dying. Those who ran the homes described here were from the same social strata as Jalland’s families, yet they not only viewed death from a

³ Ibid., pp.25, 30-31.

⁴ Ibid., pp.25, 30-32.

⁵ Ibid., pp.52-54.

distinctly religious perspective but were profoundly influenced by spiritual concerns both in their view of the good death and in their perceptions of patients' experiences within the homes. Finally, Jalland fails to examine her arguments about the increasing importance of physical comfort in relation to Roy Porter's contention that the 'good death' (among the upper and middle classes) in the eighteenth century was concerned with the minimisation of bodily suffering, which suggests that late Victorian attitudes may have been part of a longer trend.⁶

The first section of this chapter looks at how physical and spiritual care were provided in the homes, particularly the relationship between the body, mind and soul and the related issues of pain and suffering. The way in which these were looked upon by staff at St Joseph's and the Hostel of God continued unchanged up until 1938. However, for reasons which will be explained later in the chapter, perceptions about death and dying at St Luke's House underwent a significant change after the second decade of the twentieth century. This section also examines how attitudes towards death in the homes were reflected in the use of particular kinds of imagery. The second section focuses upon how patients' death and dying experiences were portrayed. The material for this discussion is drawn from the patient stories contained in St Joseph's annals, St Luke's House annual reports and *St Margaret's Magazine and Half Yearly Chronicle*. The accounts suggest that within each home there was a clear sense of what constituted the 'good' and 'bad' death. At St Luke's and St Joseph's the way in which patients were portrayed changed significantly over time and occurred as part of wider changes within their respective homes. All three sets of accounts are insightful into the importance of the denominational affiliation of each home and how this impacted on the management of the deathbed.

i. Physical and spiritual care

At one level the homes aimed to tend to the physical needs of patients in the end stages of disease, many of whom were subjected to severe pain and distress. Each one, particularly in its public appeals and annual reports, emphasised the importance of

⁶ Porter, R. (1989) Death and the doctors in Georgian England, in R. Houlbrooke (ed) *Death, Ritual and Bereavement*. London: Routledge, pp.77-94.

dying in “decency”⁴ and “comfort”⁷ and the need to alleviate “bodily sufferings” as far as possible.⁸ Although only a minimum of medical assistance could be provided - the principal form of pain relief was opium and its derivatives - the relative peace, warmth and nourishment which the homes offered helped to relieve much of the discomfort experienced by the dying poor, many of whom arrived in a state of severe poverty and deprivation.

The assuagement of physical suffering was, however, only seen as the first step towards the more important goal of ministering to the patients’ spiritual needs. All three of the homes looked upon their spiritual obligations to the patients as their primary task. Howard Barrett, the Medical Superintendent at St Luke’s House, wrote: “It is much if we can render the last weeks and months less destitute of comfort, less tortured by pain. It is far more if through any instrumentality of ours some become humble followers of Christ.”⁹ Without the consolations of faith the patients had nothing to sustain them during their brief remaining time on earth. Whilst accepting that they could not offer any prospect of a bodily cure, those who ran the homes held out an alternative hope in the form of, what the Sisters at St Joseph’s called, “Soul-Cures,”¹⁰ the results of which would be effective for eternity. Barrett was clear and precise about the role of St Luke’s House in the spiritual welfare of its patients:

“We shall undoubtedly hope and endeavour to render a far more valuable service to our poor inmates in their spiritual than in their physical wants. The body we cannot cure but the Holy Spirit may use us as instruments in the cure of the soul.”¹¹

The Sisters of Charity were particularly anxious that no-one should be left in doubt that this too was the ‘real’ work of St Joseph’s Hospice. Both their public appeals and their more private reflections in the annals provide abundant testimony to this: “It is a charity this, as fragrant as the charity of the ages of faith, and courteous - it pays tribute to that light and noble thing, the Soul of man.”¹² The Sisters’ overriding

⁷ ‘St Luke’s House’, taken from 5th Annual Report of the West London Mission (hereafter WLMAR), 1892, p.19.

⁸ Hostel of God Annual Report (hereafter HOGAR) 1896, pp.5-6.

⁹ 2nd St Luke’s House Annual Report (hereafter SLHAR), taken from 8th WLMAR, 1895, p.8.

¹⁰ Newspaper advertisement: ‘The Last Appeal for the Dying’ (1913), St Joseph’s Hospice Archive.

¹¹ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p.27.

¹² ‘St Joseph’s Hospice for the Dying Christmas Appeal’, December 1923, Religious Sisters of Charity Generalate Archives (hereafter RSCG).

objective was the provision of “Soul-Cures,” defined as “hardened sinners turning back to their Saviour in their last dying moments,”¹³ whilst the Hospice itself was described as representing “the last grace from God upon which the eternal salvation of many depended.”¹⁴ Deathbed conversions were further justified and made an even greater imperative by the special endorsement given to them by Christ; “the conversion of a *dying sinner* was the last work of mercy of the Sacred Heart ere it broke upon the Cross.”¹⁵ The Hostel of God did not specifically refer to “soul-cures,” but its primarily spiritual mandate was unquestionable; the Sisters described the home as the “antechamber of Eternity,”¹⁶ the “waiting house of God”¹⁷ and wrote that “the value of the spiritual atmosphere of the Hostel to the patients is beyond words.”¹⁸

Death itself held a vital significance for each of the homes. It was described as the “last terrible struggle,”¹⁹ the “great crisis of our conscious existence”²⁰ and the “time when man’s need is greatest.”²¹ The way in which death was written about by the Sisters of Charity formed part of the broader ideology of the Catholic Church. The Sisters were especially preoccupied with sin and this had a profound influence upon the way in which they viewed death. They looked upon the deathbed as the arena in which “the conflict with the enemies of salvation” was undergone and the occasion when the “need to save the soul from Hell is greatest,”²² and defined their task as the “rescuing of sin-laden souls from the clutches of the Evil One in the last few hours.”²³ These attitudes were in keeping with the teaching of the Catholic Church which paid anxious attention to sin, viewing death as the ‘wages of sin’ and as an event followed by judgement.²⁴ It was at death that the eternal fate of the individual was decided. Hence the note of urgency in the above quotations; the death bed represented the last

¹³ Newspaper advertisement: ‘The Last Appeal for the Dying’ (1913).

¹⁴ St Joseph’s Hospice Annals (hereafter SJHA), 1922.

¹⁵ ‘Pray for the Agonising’ prayer, St Joseph’s Hospice Archive.

¹⁶ *St Margaret’s Magazine and Half-Yearly Chronicle* (1917), Vol. IV, Part 8, p.284.

¹⁷ *St Margaret’s Magazine and Half-Yearly Chronicle* (1923), Vol. VI, Part 4, p.152.

¹⁸ HOGAR, 1931, p.14.

¹⁹ ‘Prayers for the Dying’, St Joseph’s Hospice Archive.

²⁰ 5th SLHAR, 1898, pp.21-2.

²¹ HOGAR, 1896, p.9.

²² ‘Prayers for the Dying’, St Joseph’s Hospice Archive.

²³ ‘Some cases we have helped to save at St Joseph’s Hospice for the Dying’, *The Tablet*, 1 November, 1913.

²⁴ Conrad, R. (1994) *The Catholic Faith: a Dominican’s Vision*. London: Geoffrey Chapman, p.106; Heimann, (1995) *Catholic Devotion in Victorian England*. Oxford: Clarendon Press, pp.156-7.

opportunity for ensuring salvation. The more literal view of hell as a place of eternal punishment was in contrast to wider theological views, particularly among members of the Established Church, which, by the end of the nineteenth century, no longer viewed it primarily as a place of eternal punishment.²⁵ The above images of death as a time of spiritual struggle and battle lend a certain dramatic aspect to the deathbed, reminiscent of the Evangelical deathbeds of the early and mid-Victorian era.²⁶

It was only for patients who refused to accept spiritual comfort that death was felt to be such a terrifying prospect. Those who found religious consolation could look forward to death and all that it would bring. At St Joseph's Hospice death was regarded as both the culmination of earthly life, the one event to which all the rest of our time on earth was directed, and as the herald of the "real life." Father Bernard Vaughan, one of the Catholic priests closely attached to the Hospice, described death as "the grandest, most meritorious even in the life of a Catholic - the act by which life in this world was given up.....this work-a-day life was but preparatory to the real life."²⁷

The key to meeting death in the right way was spiritual preparation; all three homes emphasised its paramount importance. The Sisters at St Joseph's commended highly those patients who underwent "full and holy preparation" before death. One of the images that was used to describe the patients likened them to a "traveller" or "wayfarer" "preparing for his last journey."²⁸ The Sisters compared their work to the *ars moriendi* of the Middle Ages: "The Medievals wrote a book on the 'Craft of Dying', this craft is taught at the Hospice for the Dying."²⁹ The importance of preparation formed both part of a wider expectation of Catholics in the late nineteenth and early decades of the twentieth century and part of the theology of the Catholic Church. Mary Heimann, in an analysis of Catholic prayer books during this period, found that there was a growth in popularity of the *bona mors* or 'exercises for a happy

²⁵ Rowell, G. (1974) *Hell and the Victorians*. Oxford: Clarendon Press, pp.212-216.

²⁶ Cecil, R. (1982) Holy dying: Evangelical attitudes to death, *History Today*, Vol.32, pp.30-34 ; Jalland, *Death in the Victorian Family*, pp.17-38.

²⁷ Author unknown, 'Hackney Bazaar in aid of the Hospice for the Dying Father Bernard Vaughan on life and death', newspaper unknown, c1913, St Joseph's Hospice Archive.

²⁸ Stenson, M.D. Waiting for the last summons, a work of God's love, *The Catholic Fireside*, c1913, pp.344-45.

²⁹ 'St Joseph's Hospice for the Dying Christmas Appeal', December 1923, [RSCG].

death', for example, *A Devotional Exercise to Prepare the Soul for Death*, published in 1902. The 'art of dying happily' was also one of the popular devotional needs targeted by Catholic publishers.³⁰

The staff at St Luke's saw their task as "to prepare its guests, as far as may be, for entrance into the new life" and to ensure that "careful and diligent pains are taken to prepare him for the great and solemn change he has soon to pass through,"³¹ while at the Hostel of God every effort was made to facilitate "a religious preparation for death."³² These references to preparation clearly show that it was primarily looked upon as a spiritual activity in which patients were expected to participate as fully as possible by giving outward expression to their inner experiences.

In an article in the St Luke's House Annual Report for 1908, entitled 'A School of Pain', spiritual preparation was described as the "process of dying." The author, Irene Langridge, a regular lady visitor to the Home, wrote that the dominant impression given by St Luke's is of the "beautiful and unexpected.....process of dying."³³ The image of a 'school' highlighted the fact that the process was one of learning and development; the patients were depicted as "learning of the many lessons in the House of Death."³⁴ The main feature of this process was the identifiable change experienced by patients during their time in the 'School'. Newcomers to the Home were described as "querulous - worn out by suffering and still worrying over troubles" who found it hard "to acknowledge themselves *done*, beaten." Gradually, however, they underwent transformation; "the struggle to regain strength is given up, the recoil of the trembling human soul at the thought of death gives place to a great calm. Soon there is no fear, and only a hushed waiting, and often at the end an actual impatience for the advent of the great Deliverer."³⁵

³⁰ Heimann, *Catholic Devotion*, p.3.

³¹ 7th SLHAR, 1900, p.7 ; 5th SLHAR, 1898, p.7.

³² HOGAR, 1897, pp.10-11.

³³ 15th SLHAR, 1908, p.45.

³⁴ 19th SLHAR, 1912, p.28.

³⁵ 15th SLHAR, 1908, pp.45-46.

The gradual nature of the transformation illustrated that this was a process which occurred over a period of time and related to the patient's evolving spiritual state; patients "develop spiritually in the School of Pain."³⁶ Physical pain may have dominated the body but it never defeated the spirit. Although the effects of the process were manifested spiritually, they were also influenced by what was happening to the body and the mind; "Love, illness and religion" were all part of the "refining influence" of St Luke's.³⁷ The reports for the Hostel of God also spoke about the change experienced by patients in the Home. It was very similar to that which took place in the 'School of Pain'; ".....an atmosphere of peaceful calm pervades the place, and a frequent visitor cannot help noticing the change in the patients after a few days in the Home : they come, wearied and anxious.....and after a day or two the quiet restfulness in their faces tells its own story - they have reached a haven of peace."³⁸

Many of the images used by the homes were common to all three and help provide further insight into their perceptions of death. Much of the imagery is Biblical in origin, particularly that found in the Psalms. All three, especially St Luke's House, associated death with images of a valley or river shrouded in darkness, dread and gloom up which the patient had to journey. It was most often described, in biblical fashion, as the "valley of the shadow of death,"³⁹ but other variations included; "the gloom of the dark valley,"⁴⁰ "the ever darkening valley of the shadow of death,"⁴¹ "the dark river of Death"⁴² and "the dark silent river into whose cold waters each must go."⁴³ These images of death as a 'valley' and a 'river' characterised by darkness and gloom were used to portray the "cruel approach of death"⁴⁴ - the loneliness, fear, pain and suffering which so often overshadowed the arrival of death. Without the "companionship of the Saviour" it also became a time of "dreadful uncertainty or blank hopelessness."⁴⁵ Images of light, such as "Christ illuminates the darkness,"⁴⁶

³⁶ Ibid., p.47.

³⁷ Ibid., p51.

³⁸ HOGAR, 1896, p.9.

³⁹ 7th SLHAR, 1900, p.26.

⁴⁰ 2nd SLHAR, taken from 8th WLMAR, 1895, p.13.

⁴¹ 'St Luke's House', taken from 5th WLMAR, 1892, p.20.

⁴² 7th SLHAR, 1900, p.18.

⁴³ HOGAR, 1896, p.7.

⁴⁴ 2nd SLHAR, taken from 8th WLMAR, 1895, p.13.

⁴⁵ 7th SLHAR, 1900, p.18.

⁴⁶ 'St Luke's House', taken from 5th WLMAR, 1892, p.20

“the Light of Faith”⁴⁷ and “the light of God’s Holy Spirit”⁴⁸ were often used in conjunction with these more sombre depictions to emphasise the benefits of spiritual comfort that came from having faith in God, and enabled death to be “robbed of its terrors” and made “less lonely and terrible.”⁴⁹ St Luke’s House described its task as “lighting their path to the dark river....and irradiating the death chamber with some of the brightness of heaven.”⁵⁰ Death itself was followed by “the dawning of the day when shadows flee away,”⁵¹ whilst heaven was depicted as a place of “Refreshment, Light and Peace.”⁵² At St Joseph’s the Sisters wrote that the patients in the Hospice were “looking for the breaking of the dawn - ‘the dawn without a sunset’.”⁵³

These images of darkness and light were characteristic of the types of metaphor used by the Victorians to describe death. M.A.K. Davis in a study of death imagery in Victorian hymns has argued that the ‘night of life metaphor’ was one of the most frequently used images. Like many other metaphors, Davis found it encompassed the basic Christian paradox; Christ died that man should live and whoever gave up their life would preserve it.⁵⁴ This helps to explain the relationship between two potentially conflicting images; whenever death is referred to as darkness it is usually accompanied by a reference to light. The same paradox underpinned other images used at St Luke’s House. Death, the close of earthly life, was often seen as the “Gate of life”⁵⁵ and “entrance into new life,” which again was part of the imagery of death as a journey, while human life was considered merely the “threshold of the land of the living.”⁵⁶ In the same way, those who died were described as having “fallen asleep in Christ” before experiencing a “glorious awakening” in heaven.⁵⁷ The other most commonly recurring image used by the staff in the homes was that which described heaven as “Home” or “Eternal Home.”⁵⁸ The use of such images revealed the wider

⁴⁷ *Hackney Annals*, 1938.

⁴⁸ 5th SLHAR, 1898, p.22.

⁴⁹ HOGAR, 1896, p.9 ; 1897, p.10.

⁵⁰ ‘St Luke’s House’, taken from 5th WLMAR, 1892, p.20.

⁵¹ 20th SLHAR, 1913, p.22.

⁵² HOGAR, 1935, p.7.

⁵³ ‘St Joseph’s Hospice for the Dying Christmas Appeal’, December 1923, [RSCG].

⁵⁴ Davis, M.A.K. (1985) *Images of death in Victorian hymns, Cithara-Essays in the Judeo-Christian Tradition*, Vol. 24, No.2, pp.40-48.

⁵⁵ 16th SLHAR, 1909, p.59.

⁵⁶ 20th SLHAR, 1913, pp.21-22.

⁵⁷ 7th SLHAR, 1900, p.18 ; 9th SLHAR, 1902, p.19.

⁵⁸ For example, 6th SLHAR, 1899, p.30 ; SJHA, 1929-1934, p.10 ; 9th SLHAR, 1902, p.22.

significance of the home in Victorian middle class life and also, possibly, the growing importance attached to reunion with families in heaven.⁵⁹

Within the homes for the dying the patient was perceived as a being made up of three separate yet interrelated entities; the body, the mind and the soul. The soul was ultimately afforded precedence because it alone was immortal. Howard Barrett, at St Luke's House wrote; "at the last hour all externals, all mere clothing, fall off - there is nothing but God and the soul."⁶⁰ Patients could not physically be restored to health but their spiritual needs were the one area where a cure could be effected. The same thinking underpinned the comment by the Chaplain at the Hostel of God that the staff there were able to witness the "the triumph of the soul in spite of bodily failings."⁶¹

Although the relationship between patients' mental and bodily state and their spiritual well-being was three-way, it appears that within the homes attending to patients' bodily and mental needs was a pre-requisite for addressing their spiritual wants. Unlike earlier times when the body was given minimal recognition, Victorian working class indifference to religious efforts which centred directly on the soul had necessitated a change in the way in which spiritual care was delivered. It was increasingly felt that spiritual responses would only be evoked if they were preceded by, or accompanied with, material aid. Even religious groups with an overtly religious emphasis were forced to revise their methods.⁶² The implications of this broader shift were particularly pertinent for medical philanthropists who frequently found that physical suffering acted as a distraction from their spiritual work. The provision of care in each of the homes formed part of this change in attitudes; all three acknowledged the role played by bodily care when ministering to patients' spiritual needs. The Chaplain at the Hostel of God described the relationship in the following way:

"Good nursing, skilful treatment, and the quiet comfort of the home are not merely good for the bodily needs of the patients; but they make a

⁵⁹ Jalland, *Death in the Victorian Family*, pp.266-267.

⁶⁰ 17th SLHAR, 1910, p.24.

⁶¹ HOGAR, 1930, p.8.

⁶² Williams, C.P. (1982) Healing and evangelism: the place of medicine in later Victorian Protestant missionary thinking, in W.J. Sheils (ed) *The Church and Healing*. Oxford: Basil Blackwell, p.285.

religious preparation for death more possible. It is always hard in sickness and pain to think of anything but one's own discomfort and suffering, unless the lesson has been learnt before. It is interesting to find how the poor patients when they have experienced all the relief of being taken care of, do turn their thoughts to God, and with a simple earnestness try to make their peace with Him."⁶³

The Chaplain at St Luke's House recorded a similar observation:

"How hard, how well nigh impossible it is to speak the comfortable words of Christ when the mind both of the sufferer and the minister are taken up with the untended needs of the body.....Our teaching is maimed and undone unless the authority of the Gospel go hand in hand with the infinite compassion and helpfulness of the Saviour."⁶⁴

This relationship between body, mind and spirit was more implicit in the thinking at St Joseph's; the Sisters did not attempt to try and give it any kind of formal expression. However, the annalist for Our Lady's Hospice for the Dying in Dublin (also run by the Sisters of Charity), in describing the need to win back souls to God, was more explicit about the dynamics of the relationship:

"How can this be better effected towards the close of life than through the senses, these influence the mind and unless care is given to the body by the alleviation of its sufferings.....very difficult, and in some cases impossible, will it be to bring peace to a soul....a frame wasted by disease and racked with pain unalleviated is hardly capable of grasping the truth that God practises in love, or that there is a chance of redeeming the past."⁶⁵

Tending to patients' physical and mental needs therefore facilitated the transition to spiritual ministrations, which in turn influenced the way in which they related back to their bodily suffering. For many of the patients this was a cause of extreme discomfort and it was felt that only those who had found peace in God could bear it with patience and fortitude. One young patient at St Luke's was "perfectly helpless from nervous contraction of the limbs and her sight was virtually gone. But her life proved beautifully the power of Jesus Christ to satisfy, even under such circumstances. 'I know it is love' she said....'I cannot doubt it for a moment. I do not mean that the suffering is all easy, but He makes it up to me."⁶⁶ The Sisters at the Hostel of God wrote that many of the patients "in the midst of sufferings beyond description" were

⁶³ HOGAR, 1897, pp.10-11.

⁶⁴ 7th SLHAR, 1900, p.19.

⁶⁵ Our Lady's Hospice for the Dying Annals 1888-1894, pp.149-151.

⁶⁶ 7th SLHAR, 1900, p.29.

“filled with cheerful patience and with childlike trust in their Saviour.”⁶⁷ At St Joseph’s Hospice the reconciliation of one patient to the Catholic faith reputedly enabled him to “endure his painful illness with perfect resignation.”⁶⁸

Different types of pain and suffering associated with the body, mind and soul were also identified. Each of the homes distinguished between “physical pain,” “mental anguish” and “agony of the soul.”⁶⁹ “Physical pain” was caused by the symptoms of a patient’s disease, while “mental anguish” related to the anxiety caused by separation from families, domestic worries, the need to adjust to the reality and imminence of death and the trauma involved in letting go of life. One of the Visiting Sisters at St Luke’s in 1900 wrote; “moments of depression happen occasionally when we get a glimpse of the mental suffering involved in letting it [life] go.”⁷⁰ “Agony of the soul” was experienced by those patients who did not have the comfort and consolation which came from faith in God and the hope of eternal life. These three types of pain were felt to be intimately connected. In his report for the year 1930 the Medical Officer at the Hostel of God noted that there were a large number of cases in which “physical pain is the outstanding feature and this is largely augmented through the mental anguish suffered by the knowledge that there is no hope of human intervention to stave off a fatal termination.”⁷¹

Ultimately, pain and suffering were accepted because they were believed to be part of God’s will. The Reverend Howard May, one of the visiting ministers to St Luke’s wrote:

“We must never look upon the pain and suffering in St Luke’s *apart* from God; for however greatly we marvel at the sufferings which patients have to endure, the most wonderful thing is that Christ.....is with them in the furnace.”⁷²

He went on to observe that God, through the medical, nursing and spiritual work of St Luke’s House, shielded the patients against further calamities. Pain and discomfort

⁶⁷ *St Margaret’s Magazine and Half-Yearly Chronicle* (1902), Part II, p.54.

⁶⁸ *Hackney Annals*, 1936.

⁶⁹ 2nd SLHAR, taken from 8th WLMAR, 1895, p.18.

⁷⁰ 7th SLHAR, 1900, p.27.

⁷¹ HOGAR, 1930, p.9.

⁷² 12th SLHAR, 1905, p.32.

were made bearable because they were “encompassed” within the “Shield of God’s Salvation.”⁷³ Pain and suffering were also felt to play a crucial role in patients’ spiritual development. The Matron at St Luke’s wrote: “pain, so hard sometimes to understand, has made our patients realise as nothing else would, that they must make ‘their robes white in the blood of the Lamb and thus through pain peace has come to them in the end.’”⁷⁴ The Sisters at the Hostel of God perceived suffering as “a token of love, and the one means, often and often, of drawing souls to the Fountain of all Love.”⁷⁵ At St Joseph’s patients’ suffering was often referred to as their “cross.” Although the Sisters aimed to do their utmost to alleviate physical suffering, their higher objective was to help the patients “to accept the sufferings as the will of God and what is best for us.”⁷⁶ One patient “longed to get better....but was content with God’s will, offering up her pains in reparation for the past.”⁷⁷ These attitudes were part of the wider teaching of the Catholic Church which believed that pain was a means to redemption and holiness; it brought the sufferer closer to Jesus and could be offered up in penitence for earthly sins.⁷⁸

Until 1914 the priority given to care of the soul, the use of religious imagery to describe death, the ministration of bodily needs as a pre-requisite to spiritual care and the acceptance of pain and suffering as God’s will formed part of a philosophy which underpinned all three homes. After 1915, however, they ceased to dominate the thinking at St Luke’s House. Spiritual issues, which had been a pre-eminent feature of the early annual reports, were rarely mentioned in subsequent reports. In contrast, the work at St Joseph’s and the Hostel of God continued to be preoccupied with spiritual concerns, both publicly and privately.

⁷³ Ibid.

⁷⁴ 6th SLHAR, 1899, p.30.

⁷⁵ *St Margaret’s Magazine and Half-Yearly Chronicle* (1917), Vol. IV, Part 8, p.281.

⁷⁶ SJHA, 1915-1921.

⁷⁷ *Hackney Annals*, 1935.

⁷⁸ Heimann, *Catholic Devotion*, p.156 ; Schiefelbein, M. (1992) Little Nell, Catholicism, and Dicken’s investigation of death, *Dicken’s Quarterly*, Vol.9, No.3, p.121; Rey, R. (1995) *The History of Pain*. Cambridge, Massachusetts: Harvard University Press, p.184 ; O’Rourke, K. (1992) Pain relief: the perspective of Catholic tradition, *Journal of Pain and Symptom Management*, Vol.7, No.8, pp.486-487.

ii. Death, dying and the patients

The predominantly religious basis of these more general views of death also had a profound impact upon the way in which specific patient deaths in the homes were perceived. Most of the accounts of death and dying experiences in the homes were recorded within the context of patients' wider spiritual history which meant that death took on added meaning and significance because of the way in which it related to both this history and to their eternal destiny. These accounts of patients were primarily available for St Luke's House and St Joseph's Hospice, although some of the editions of the *St Margaret's Magazine and Half-Yearly Chronicle*, written and published by the sisterhood which ran the Hostel of God, contained a few descriptions of patients who stayed in the Home.

The annual reports for St Luke's House for the years 1893 to 1913, were considerably different from the more generic format of those issued by the other two homes which essentially served as a record of their administrative work. By contrast, those for St Luke's were fairly substantial compilations which included a lengthy report by the Medical Superintendent and contributions by other key members of personnel. The reports for these early years also devoted several pages to accounts of various inmates in the Home. The accounts of patients who stayed at St Joseph's were contained in the annals and covered a longer period; 1905 to 1938. The very different purposes of the annual reports and annals was instrumental in determining how they were written and had important implications for the way in which their contents should be interpreted historically.

The accounts for both St Joseph's and St Luke's were written by those who ran the homes and as such are significant because, by reconstructing the patients in a particular way, it is possible to glimpse how they were perceived by those responsible for their care. Given the comparatively small number of records relating to patients at the Hostel of God, this next section focuses upon St Joseph's Hospice and St Luke's House. The patient stories for both homes are sufficiently different in character, style, content, author and purpose to merit each being looked at in turn. The Hostel of God

accounts are then considered separately in section 5. It is also possible to gain a sense of the 'good death' and the 'bad death' from the three sets of stories and these are considered in the sixth and seventh sections.

iii. St Joseph's Hospice

The accounts of patients at St Joseph's Hospice are contained within the convent annals. The annals were prepared for the General Assembly which was held at the Sisters of Charity Mother House in Dublin every six years. They were written by a member of the congregation and at the end of each six year period a copy of the annals was sent to the Mother House. The Mother Superior of the Order also made regular visitations to each of the branch houses during which time she would have been shown the original set of annals kept at the convent. As such they were only intended for a limited and private audience and would not have been read outside of the sisterhood.

The principal objective of the annals was to describe the main events and happenings concerning the Convent and the Hospice during each six-year period. As well as providing a more general synopsis, they also included a section detailing some of the patients who stayed in the Hospice during that time. The records relating to St Joseph's Hospice which are kept at CARITAS, the Sisters of Charity archive in Dublin, also include a small notebook entitled 'Notes for the Annals of St Joseph's Hospice' which contains additional accounts of patients in the Hospice during the first few years after its opening. The accounts in the Annals have a distinct literary style of their own and their content altered significantly throughout the period under investigation in response to changes in the patient population.

The accounts were written very purposively. Their principal objective seems to have been to recount the spiritual history of patients, before and after admission into the Hospice, focusing in particular upon the place of their reconciliation or conversion to the Catholic Faith within this biography. The accounts fall into two broad classifications; those written between 1905 and 1920, which largely concern lapsed

Catholics who returned to the Catholic faith, and those written from 1921 through to 1938, which mainly describe non-Catholic patients who converted to Catholicism. Despite the variation in subject, the emphasis on the spiritual aspects of the patient's life history, particularly after reconciliation or conversion was achieved, was a common thread running through the stories. Of particular interest is the way in which the patients' condition, entry into the Hospice and actual death intersected with their spiritual biography. Again, this was a common feature of the accounts from both periods.

a. 1905 - 1920: death, dying and *rediscovery* of the Faith

The accounts of patients written during this period largely concern individuals who had drifted away from the Catholic Faith for one reason or another. Several were likened to "strayed" or "lost sheep."⁷⁹ A few of these patients returned to the Faith before they were admitted to the Hospice but most were reconciled after admission. In the majority of accounts the rediscovery of faith only happened after patients had found out the advanced nature of their illness. Most patients were open to the influences of the Hospice from the outset and responded readily to the opportunity to return to their faith. There are also one or two stories describing "saintly souls,"⁸⁰ those who were already strong in the Faith and who came to the Hospice to end their days in peace. The following account typifies the patient stories of this period:

"Dan O'Sullivan, a young man of 28, was brought to the Hospice from Bermondsey, he had Catholic but careless parents, made his first Communion, but afterwards drifted away from the practice of his religion. He had forgotten everything yet the bright spark of the true faith was glowing in his soul and easily rekindled into a flame. After a few weeks instruction and revival of prayer on asking Dan if he felt ready for Confession and Holy Communion he said 'Yes Sister if you think I am fit, I feel downright and thoroughly ashamed of myself and will never be neglectful again.' He received with much piety the Last Sacraments, and died after some weeks of care and comfort in the wards of the Hospice."⁸¹

⁷⁹ SJHA, 1912, 1920.

⁸⁰ SJHA, 1910.

⁸¹ SJHA, 1909.

The stories concerning Catholics who had given up the practice of their religion often used the 'spark to flame' metaphor to describe the revival of a faith which, however diminished, was never completely extinguished. The emphasis upon reconciliation of lapsed Catholics was part of the Sisters wider 'Mission' among the local parishes of Hackney, Hoxton and Shoreditch, the aim of which was to "assist and encourage these poor people [the "Catholic poor"] in the practice of the duties of our holy Religion, and to relieve them in cases of illness and want as far as they can."⁸² The emphasis on reconciliation also formed part of a wider concern of the Catholic Church as a whole during this period: the need to reconcile the lapsed poor, particularly members of the Irish immigrant population.⁸³ Many of the patients during the early years were Irish, or of Irish descent. Their lapse from the faith was often attributed to their leaving their families and homeland, and their return to Catholicism was looked upon as a particular blessing. One story described EG, originally from Cork, whose "strong Irish faith" "grew dim when exposed to the infectious air of depravity in Hoxton through the last years of her life."⁸⁴

b. 1921 - 1938: death, dying and 'conversion' to the Faith

The accounts written between 1921 and 1938 come under the title of 'Conversions'. Although the majority of these stories recounted the spiritual history of non-Catholic patients who were converted to the Catholic Faith after admission into the Hospice, this title is in fact a little misleading because the reconciliation of lapsed Catholics, which formed the basis of some of the accounts, were also described as 'conversions'. Heimann argues that, as well as being an evangelical term, 'conversion' was also used by Catholics to distinguish mere membership from a vivid and personal apprehension of the central tenets of the Faith.⁸⁵ However, the former evangelical style 'conversion' was clearly the predominant feature of the stories during this period. Many of the non-Catholic patients were referred to as Church of England, although a few were converted from other religions and there were one or two patients who were defined as

⁸² 'First Annual Report of St Joseph's Convent', 1901, p.1.

⁸³ Heimann, *Catholic Devotion*, p.163 ; Gilley, S. (1973) *Catholic faith of the Irish slums*, London 1840-70, in H.J. Dyos and M. Wolff (eds) *The Victorian City: Images and Realities*. London: Routledge and Kegan Paul, pp.837-853.

⁸⁴ 'Notes for Annals of St Joseph's Hospice', 1905-1909, p.13, [RSCG].

⁸⁵ Heimann, *Catholic Devotion*, p.144.

non-religious. Like the earlier period, several of the stories described patients who were already practising Catholics before admission. Most of these were either priests or members of religious orders. The stories are a mixture of three main types; those who did their utmost to resist the spiritual influences of the Hospice and did not convert until just before death, those who were captivated by the religious atmosphere of the home but who still held back from the actual step of conversion until death was imminent and those who, from their admission, were open and receptive to the attempts to convert them.

The accounts written before 1921 were more biographical in content. They usually began by detailing how patients came to the Hospice, their religious and family background and the condition from which they were suffering. After 1921 the stories became even more purposeful by focusing on the central issue, the patient's conversion, from the outset; several accounts began "In the conversion of....." On many occasions only the name of the person received into the Church was recorded. Some of the 1921-1938 stories were slightly more critical in tone; one female patient, for example, was described as "rather a bigoted masculine type of girl."⁸⁶

The transition in the focus of the stories from the reconciliation of lapsed Catholics to the conversion of non-Catholics seems to signify a changing emphasis in the Hospice's mission towards dying patients during the period 1908 to 1938. Although the reconciliation of lapsed Catholics to the Church continued to be important, conversion and proselytisation assumed a greater significance than they had in the earlier years. After 1921 the Sisters' chief concern appears to have been to notify the Mother House on newcomers to the Catholic faith. This change also reflected a more rigorous, and on occasion relentless, approach in the way in which the Sisters ministered spiritually to the patients. When they were largely concerning themselves with lapsed Catholics it appears that little effort was required on the part of the Sisters to secure a patient's reconciliation. In contrast, a number of the stories written after 1921 described patients who tried to resist the efforts of the Sisters and the priest. Several of the conversions in 1925 were described as "just deathbed ones, the patient

⁸⁶ SJHA, 1924, p.2.

asking for the priest at the last minute.”⁸⁷ Faced with increased resistance from some patients the Sisters were on occasion compelled to adopt more subtle measures, such as the use of subterfuge:

“Mrs O had been with us two years. Her husband who is not a Catholic was anxious for her to become reconciled to her Faith as she had not been to the Sacraments for about 40 years. Nothing seemed to affect her until in December 1927 a priest who was a Patient in the Home dropped in to see her accidentally. The ruse was successful. Father Griffin had been in Australia and was very entertaining. Mrs O invited him in and they became friends. Meantime a Novena of Masses.....were offered up. At the end of the Novena Father Griffin had attained his end. He obtained faculties and heard her Confession.”⁸⁸

The increased emphasis upon conversion during the latter half of this period could have been linked to the fact that after 1923 there was a higher proportion of Church of England patients coming into the Hospice.⁸⁹ The declining number of Irish immigrants coming to London by the early decades of the twentieth century may also have been, in part, responsible for the shift in focus in the annal accounts.⁹⁰ The changing nature of the Hospice Mission was also apparent in the Sisters’ other mission work in London. Many of the later accounts of the Hoxton Mission also recorded the conversions of non-Catholics.

From the way in which the stories in both the earlier and later period were written, it would appear that the Sisters at St Joseph’s felt that there were two crucial factors which helped to convince many patients of the need for a Catholic Faith in God and the afterlife: the imminence of death combined with their continual exposure to the Catholic religion once in the Hospice. One female patient “hesitated a long time about seeing a priest but the importance of Baptism and the uncertainty of her sentence in the hereafter compelled her to make up her mind finally and be received into the Church.”⁹¹

⁸⁷ SJHA, 1925.

⁸⁸ SJHA, 1927, p.4.

⁸⁹ See chapter 4.

⁹⁰ Gilley, S. (1969) *The Roman Catholic mission to the Irish in London, 1840 - 1860, Recusant History*, Vol.10, p.138.

⁹¹ SJHA, 1929-1934, p.3.

It is important to bear in mind that these stories recounting patients' reconciliation or conversion to the Catholic Church only accounted for a small percentage of the total number of patients within the Hospice each year. The fact that they were all written by the Sisters in the Hospice would also have influenced their style and content. However, given that they were the only specific references to patients to feature in the annals and newspaper articles, points clearly to the obvious priority which was given to the spiritual work of the Hospice and the important role it played in the management of the deathbed.

c. "Holy and Happy Deaths"

The way in which the death and dying experience of the patient was portrayed in the accounts for both periods would suggest that the Sisters had a very specific idea about the manner in which a patient should die which remained unchanged throughout the period despite the transition from lapsed Catholic to non-Catholic patients. This idea was dependent upon the patient's belief in the Catholic faith and reception into the Catholic Church. It also rested upon many of the traditional tenets of the Catholic faith, particularly the rituals and beliefs surrounding death and dying. Although "holy and happy deaths"⁹² were essentially determined by patients' spiritual condition and behaviour, the relationship of their physical and mental state to these was also important. For example, the significance of showing fortitude in the face of extreme physical suffering.

"Holy" and "happy" were the two adjectives most frequently applied to death. Others included "joyful," "beautiful," "lovely," "calm" and "peaceful."⁹³ All these descriptions were associated with certain rituals and attitudes of faith. The importance of being able to die in a Catholic atmosphere and surroundings was felt to be paramount in restoring or converting patients to the Catholic Faith and in helping them to achieve a "happy death." One female patient was even admitted into the Private Home without payment because there were no vacant beds in the Hospice and it was felt that "the salvation of the poor girl's soul depended on dying in Catholic

⁹² SJHA, 1922.

⁹³ SJHA, 1909-15

surroundings. Once under Catholic influence.....she resumed the fervent practice of her religion.”⁹⁴ Many of the stories testify to the role played by the multitude of symbols and rituals of the Catholic faith in the Hospice:

“MS, aged 18, was very interested in the Holy pictures and statues about her in the ward. When she saw the Sacred Heart on the Communion morning, she made enquiries what they were receiving. She read the life of the Little Flower and was drawn specially to her because she died of TB. She asked to be taken to the Chapel on Holy Thursday. She was instructed and received into the Church and made her 1st Holy Communion on the Feast of the Sacred Heart. That evening she passed peacefully away.”⁹⁵

Reconciliation or conversion to the Catholic faith was often an emotional experience. Displays of fervour and devotion during this time were interpreted as sign of a strong faith. One of the male patients “sobbed at the act of contrition and kissed the crucifix with intense fervour.”⁹⁶ There was considerable debate amongst Catholics during this period over the extent to which enthusiasm and devotion could be viewed as an indication of, or the means of inculcating, a more fervent love of God.⁹⁷ It would appear from these accounts that the Sisters of Charity were more of the persuasion that emotional intensity served as a measure of religious commitment. Some patients were influenced by the death or conversion experience of other inmates and this would play an important role in their decision to be reconciled or converted to the Catholic faith. A sense of feeling ‘left out’ was also instrumental in returning or leading one or two of the patients to Catholicism. The conversion of one female patient was “influenced” by her “seeing how attentive the priest was to the Catholic patients.”⁹⁸

Outward manifestations of faith were a particularly significant feature of the “holy death” and patients were expected to participate in many different forms of ritual, such as reception of the Sacraments (Baptism, Penance, Holy Communion, Confirmation, Extreme Unction), prayer, saying the rosary and aspirations, kissing a crucifix, attending Mass, and being anointed. The Sacraments were particularly important, not only for their symbolic value, but because they were also believed to impart a “soul-

⁹⁴ SJHA, May 1905 - May 1909.

⁹⁵ *Hackney Annals*, 1935-1939.

⁹⁶ SJHA, May 1905 - May 1909.

⁹⁷ Heimann, *Catholic Devotion*, pp.29-30.

⁹⁸ SJHA, 1921.

saving”⁹⁹ grace to recipients and to help fortify them for death. The Blessed Sacrament holds a singular significance for Catholics who believe that Jesus is actually reincarnated in the bread and the wine.¹⁰⁰ The reception of Holy Communion as near as possible to the time of death was therefore felt to confer a special blessing. Baptism is crucial because through it one becomes a member of the Church and to refuse it is to reject God’s offer of salvation.¹⁰¹ The sacrament of penance is the principal Catholic mechanism for dealing with sin and religious doubt;¹⁰² it is only through Confession that God’s forgiveness can be received and a ‘state of grace’ be achieved. The Sisters of Charity also emphasised the importance of dying in a “good disposition” which was dependent upon being in a “state of grace.”¹⁰³ It was particularly important to administer Extreme Unction to the dying because it fortified the recipient for the final struggle before entering God’s house.¹⁰⁴

The patient stories for St Joseph’s Hospice also suggest that dying was viewed as an active process into which patients were required to fully enter in order to be prepared for when they eventually met death. One of the annalists described it as the inmate’s “career as a Hospice patient.”¹⁰⁵ The process was longer for lapsed or non-Catholic patients because they had first to be made aware of the need to die a practising Catholic. Lapsed Catholics were then expected to make a Confession before they could be reconciled to the Faith, whilst non-Catholics had to first be instructed in the Catholic Faith before being formally received into the Church and going on to receive Confirmation. These initial steps were followed by further rituals in which all Catholics, as far as they were able, were expected to participate - attending Mass, saying prayers, reciting the rosary, being anointed and receiving Holy Communion and Extreme Unction as close to death as possible.

⁹⁹ Wilberforce, W. ‘St Joseph’s Hospice, Mare Street, Hackney, *The Catholic Weekly*, date unknown, p.2.

¹⁰⁰ Tays, A. (1985) Context and meaning: Roman Catholic devotion to the Blessed Sacrament in mid-nineteenth century America, *Church History*, Vol.54, No.4, p.486.

¹⁰¹ Strange, R. (1986) *The Catholic Faith*. Oxford University Press, p.87 ; Conrad, ‘*The Catholic Faith*’, p.164.

¹⁰² Heimann, *Catholic Devotion*, p.150.

¹⁰³ SJHA, May 1905 - May 1909.

¹⁰⁴ Conrad, ‘*The Catholic Faith*’, p.181.

¹⁰⁵ SJHA, 1929-1934, p.2.

“Holy and happy deaths” were also characterised by a belief in the miraculous and the intercession of saints, both of which were interpreted as a sign of genuine faith. Many of the stories recount instances of patients or nuns who invoked the help of particular saints. Another patient’s conversion was “looked on....as due to the doctoring of the Communion of Saints”; two other patients (“holy souls”) had died in the same week and had promised to intercede on the patient’s behalf.¹⁰⁶ Several of the patients also made visits to Lourdes. The Sisters were particularly vigilant in persuading patients who came from a mixed marriage to renew their vows in a Catholic marriage ceremony. Once patients were found to be actually ‘dying’ they ceased to have any specific active participation because many became unconscious. Various prayers and the Rosary were said by the Sisters; for example, the ‘Prayers for the Dying’, ‘Prayers for the Departing Soul’ and ‘Prayers for the Agonising’. The final moments of one patient’s life were described in the following manner:

“On Wednesday the change came. She got unconscious about 9 o’clock in the morning. Sister L and Sister R began the prayers for the dying and between times when the little aspiration ‘O Immaculate Mother of God I am thy own true child intercede for me’ she would open her eyes as if she understood. The rosary was said and the Sisters just begun the Prayers Recommending the Departing Soul when she simply stopped breathing and gave her soul up to God. It was a lovely death, calm and peaceful. Certainly she did go joyfully to the Sacred Heart.”¹⁰⁷

The importance attached to “happy and holy deaths” was part of a wider tradition both within the Sisters of Charity and the Catholic Church as a whole. St Joseph was a highly venerated saint whose death was believed to have been a particularly happy one. The corresponding annals for St Patrick’s Hospital for Incurables in Cork and Our Lady’s Hospice for the Dying in Dublin, both run by the Sisters of Charity, contain stories of patients, many of which describe “holy” and/or “happy” deaths. These deaths were associated with the same characteristics as those at St Joseph’s Hospice. The author of an article printed in the *Irish Monthly* in 1880 wrote that the ‘happy death’ was the special preserve of Irish Catholics:

“Unquestionably all die a good death who depart in the grace of God. However, when our people speak of a happy death they mean something over and above. They mean that their hope is to have time to prepare for appearing in the Divine Presence; to retain their senses to the end; and to

¹⁰⁶ SJHA, 1900-1905.

¹⁰⁷ SJHA, May 1909 - May 1915.

have someone in their last hour to speak strengthening and consoling words to them. When death is imminent, they consider it no kindness on the part of a friend to gloss over the matter and to cajole them into the belief they may recover.”¹⁰⁸

Within the Catholic Church in the late Victorian period there was a growing emphasis on the need to achieve a “happy death.” This was part of the ‘new piety’ and zeal which characterised Catholic devotional life from 1850 onwards and was manifested in newly popular devotions such as the making of novenas, recitation of the rosary, Stations of the Cross and pilgrimages to shrines. A special confraternity, the *Bona Mors Confraternity* was founded which aimed at promoting devotions ‘for a happy death’.¹⁰⁹

Many of the rituals associated with “holy and happy deaths” were also rooted in the doctrine of the Catholic Church. For most Catholics the Catechism was the principal authoritative source of Church doctrine. The edition published in the 1880s stated that the Sacraments were the “chief means of our Salvation” and that neglecting to hear Mass was a “mortal sin.” It also said that honour should be given to relics, crucifixes and holy pictures and that the Catholic Church forbade mixed marriages except under very exceptional conditions.¹¹⁰

The Congregational *Rules and Constitution* for the Sisters of Charity, which set out the founding philosophy of the order and its specific aims and objectives, provide a point of reference for the above discussion of the ‘holy and happy death’ by contextualising the Sisters’ work in the Hospice within their broader mandate. The Rules stated that the Sisters “must endeavour to excite those they treat to good works, especially to Confession and Communion” and assist in “bringing back to mutual peace and concord those who are at variance.” The primacy given to conversion was also reflected throughout the Rules, for example one rule stipulated that although the

¹⁰⁸ S.A. (1880) ‘Hospice for the Dying, 1880’, reprinted from the *Irish Monthly*, p.2.

¹⁰⁹ Heimann, *Catholic Devotion*, pp.35-6, 126-7.

¹¹⁰ ‘190th Thousand. The Explanatory Catechism of Christian Doctrine’. London (1884), in Heimann, *Catholic Devotion*, pp.114-117.

Sisters were prohibited from entering the hospitals or houses of ‘Heretics’, this did not apply “if there be any hope of their conversion.”¹¹¹

The *Rules and Constitution* also contained a section entitled “Of the assistance given to those who die in this Congregation, and of the suffrages made for them after death” which particularly illuminates the ultimate importance attached to death. This section set out the ideal manner in which death should be met by the nuns and the help which was to be given to them in order that they might come as close as possible to achieving it.

“As it is to be the main effort and care of all during life that our Lord may be glorified in them, His holy will executed, and all edified; so in a like manner, and even much more, they must strive to attain the same object at their death, by the example of patience and fortitude they exhibit, joined to a lively faith, and hope and love of the eternal goods, which Christ our Lord by the truly admirable trials of his mortal life, and his sufferings in death, merited and acquired for them.”¹¹²

The fortifying power of the sacraments was emphasised and the importance of administering these before the dying Sister was deprived of her senses. The Sister was also to be aided by prayers throughout. Special persons were to be assigned for the particular tasks of consoling and assisting her at the approach of death, helping to raise her confidence by suggesting considerations and offering every aid which was fitting for the moment.¹¹³ The significance attached to death and the manner in which it was to be met by the Sisters themselves, which is so clearly evidenced in the *Rules*, helps to explain their concerted efforts to secure a “holy and happy” death for the patients in the Hospice.

The specifically Catholic emphasis of these accounts of patients’ deaths at St Joseph’s and the Sisters diligent efforts to engineer a particular manner of death can also be viewed as part of a growing attempt by the Catholic Church, from the 1880s onwards, to assert and protect its denominational exclusiveness. The preoccupation with “holy and happy deaths” was part of more subtle doctrinal changes which were designed to

¹¹¹ *Rules and Constitution of the Congregation of the Sisters of Charity* (1912), pp. 133-34, 139.

¹¹² *Ibid.*, p.127.

¹¹³ *Ibid.*, pp.127-128.

reinforce a sense of separateness. Successive editions of the Catechism increasingly stressed the exclusivity of the Catholic faith. Mary Heimann observed that the tone of the revised catechism of the 1880s was far more prescriptive than the 1859 edition; it forbade mixed marriages, stated that relics, crucifixes and holy pictures should be given honour and placed special emphasis upon attending Mass and receiving the Sacraments. She went on to argue:

“The cumulative effect of these apparently minor changes in the revised edition was to present the emphasis of an English Catholic’s self-definition in a manner which was far more assertively Catholic and to alter significantly the tone and slant of this official presentation of the fundamentals of the Catholic faith as practised and understood in England.”¹¹⁴

This shift towards greater denominational distinctiveness was therefore part of a more general trend towards denominational assertiveness in England which gathered increased momentum after 1880 because of heightened concerns about ‘leakage’ and dechristianisation.¹¹⁵ However, it was particularly pronounced within the English Catholic Church because of its position as a minority Faith.

iv. St Luke’s House

The accounts of patients at St Luke’s House are contained in the annual reports, the majority of which can be found in those written for the years 1894 to 1913. After 1914 no further stories were included until the 1933, 1935 and 1937 reports. These accounts are considerably more varied in style and content than those written at St Joseph’s. They were also written by various different types of author; the Medical Superintendent, the Visiting Sisters, the Matron, the Sister, Visitors and the Chaplain. The fact that the stories were published in the annual reports meant that they were intended for a very different audience to the annals of the Sisters of Charity. While the latter were aimed at an internal, private readership, the annual reports were written for a much wider audience - current and potential subscribers - and their principal purpose was to demonstrate to them the various needs which were met by the Home and to appeal for support, particularly the ongoing need for financial aid. Although it is not

¹¹⁴ Heimann, *Catholic Devotion*, pp.115-117.

¹¹⁵ *Ibid.*, pp.115-124.

known how accurate a representation these accounts are of the patients and their experiences within the Home, the way in which the patients are portrayed and the place of death within their stories provides an insight into how both of these were perceived by those who cared for them. Despite different authorship, the stories written between 1894 and 1913 share a number of common themes which both illuminate and, constitute part of, the overall philosophy of the Home during this period. The absence of any stories between 1914 and 1932 and the distinct change in style and content of the later accounts are also particularly revealing of the changing preoccupations of the Home.

a. 1894 - 1913

The majority of the stories during this period were written by either Howard Barrett, the Medical Superintendent of the Home, or the Visiting Sisters. The Chaplain occasionally included a story or two in his report. The Matron and Sister also contributed several accounts to the 1899 report and the Matron did so again in 1913. The 1908 report included a few patient stories written by Irene Langridge, one of the regular lady visitors to the home.

The accounts of patients by Howard Barrett were written primarily with a view to rousing public interest in the Home. They were, for the main part, designed to draw the attention of the reader to the various plights of the patients and the great need which existed for a home such as St Luke's. The stories contained a mixture of different elements; moral, spiritual, humorous, social and pathological. Many were examples of the patience, fortitude, courage and cheer shown in the face of deep physical suffering. A few were simple caricatures of the patients whilst others highlighted their destitution and loneliness and the various hardships which they had endured.

Barrett was particularly concerned about the moral behaviour of patients within the Home and could sometimes adopt a fairly critical tone. One young man was described as a "very unsatisfactory case altogether" because, despite being married, he had "got

into liaison” with another girl. He was unable to decide between them and this made him behave badly towards the Matron and nurses.¹¹⁶ Another patient was described as being “as dismal as a Georgian chant” with “rather a severe manner which discourages conversation.”¹¹⁷ In the same way, Barrett did not stint in his praise for patients he felt showed exemplary moral character. He referred to one of the female patients as “a superior woman, of good education, and the manners and refinement of a lady, and this being fully recognised in the ward she is always respectfully addressed as *Miss L.*” He lamented that they did not receive more of this type.¹¹⁸

Despite the broad-base appeal of his stories it is very apparent that Barrett wanted the public to be aware that he considered the spiritual work of the Home to be the principal justification for its existence:

“Unless we can insure that the period of their stay with us can be used by all our dying brothers and sisters as one for spiritual reflection and education, and such preparation as at the end of this life is possible for entrance into the mystery of the unknown, we are only accomplishing half our mission.”¹¹⁹

He often referred to the “great change” which occurred in many patients after they found peace in Christ.¹²⁰ The following is a typical example of the type of story written by Barrett. It describes PJ, a 38 year old railway guard admitted with consumption:

“He had been ill for more or less three years, but worked until last September in spite of it. Then he had to give in and was admitted to Victoria Park Hospital where they kept him for a time, but, finding him past cure, sent him home again. He had been with us three months and is, as I write, I grieve to say, dying. We shall all mourn his loss for never have we had a more charming patient. Notwithstanding the prostrating nature of his disease, and his frequent suffering, he has always been optimistic and cheerful, has made the best of himself (better than the best indeed), and has rarely complained and then with an air of apology, as of one so richly endowed with comforts that to complain was unmanly. He is a brave and manly fellow, of which character consideration of and gratitude to the nurses has been a conspicuous part. A day or two ago he seemed to be dying, and was drawing his breath in gasps with great difficulty, but even

¹¹⁶ 12th SLHAR, 1905, p.14.

¹¹⁷ 11th SLHAR, 1904, p.15.

¹¹⁸ *Ibid.*, p.17.

¹¹⁹ 13th SLHAR, 1906, p.16.

¹²⁰ 4th SLHAR, taken from 10th WLMAR, 1897, p.7.

then, as he could interjectionally find utterance it was ‘Thank you, Matron’ - ‘Thank you Nurse’ - ‘You have been good to me.’ - ‘God bless you for it.’ And to me said ‘I’m in the best Hands, doctor,” to which I replied, ‘Yes God’s hands can always be entirely trusted,’ and he gave me a satisfied smile of assent.”¹²¹

In contrast to Barrett’s more wide-ranging accounts, the stories written by the Visiting Sisters and the Chaplain dealt primarily with the spiritual aspects of patients’ lives and were often used to illustrate particular points they wished to make. Other accounts were more biographical in nature; recounting the patients’ lives before their disease, the onset of disease and their life after coming to St Luke’s House. The object of most of these stories was to emphasise the place of faith within the patients’ biographies and the way in which their conversion influenced their attitude towards both their physical condition and the approach of death. In this sense they bore a closer resemblance to the stories in the Sisters of Charity Annals, although they were not always solely preoccupied with the patient’s spiritual history. The stories by the Visiting Sisters also included references to the social aspects of patients’ lives, for example their domestic and family worries, which reflected the dual character of the Sisters’ role within the homes.

These biographical accounts can be divided into two main types; firstly patients who refused to have anything to do with religion, who wanted to hold on to life and resented their suffering, but who were converted to the Christian faith once they came to St Luke’s, and secondly, patients who had found God before they were admitted and as a result saw the Home as very much provided by Him. The first type of narrative occurred more frequently. There were also a few stories, during the latter part of this period concerning patients who refused to find any comfort in religious beliefs or seek a spiritual dimension to their suffering. Like the accounts at St Joseph’s, the stories emphasised the instrumental role of the Home itself in helping patients to turn their thoughts towards God: “A beautiful feature of the Home is the opportunity it gives of rest and quietness of the soul” which “makes it possible for their minds to dwell upon things that are eternal.”¹²²

¹²¹ 11th SLHAR, 1904, p.15.

¹²² 2nd SLHAR, taken from 8th WLMAR, 1895, p.18.

The importance attached to conversion was rooted deep within the thinking of the Methodist Church. Victorian and Edwardian Methodism placed a strong emphasis on the need for a 'personal conversion experience'. S.J.D. Green has argued that Edwardian Methodism was characterised by a transition from a religion of 'mass appeal' to one based on 'individual persuasion'. By the late-Victorian and Edwardian era mission hall evangelism, which had characterised early and mid-Victorian Methodism, was perceived as ineffective because of the state of indifference and worldliness that prevailed. The shift to 'individual persuasion' was based on a new way of looking at the religious capabilities of the individual soul and culminated in the formation of the idea of the "susceptible individual." The new evangelism emphasised the importance of a personal approach rooted in an individual understanding, and was based, not on emotion, but a quiet surrender to God. It became known among Methodist circles as the theory of 'spiritual science'.¹²³

An individualist approach underlay much of the thinking at St Luke's. Howard Barrett wrote in his report for 1909:

"We do not think or speak of our inmates as 'cases'. We realise each one is a human microcosm, with its own characteristics, its own aggregates of joys and sorrows, hopes and fears, its own life history, intensely interesting to itself and some small surrounding circle. Very often it is confided to some of us."¹²⁴

Such thinking may relate, in part, to changes in wider medical opinion during the early twentieth century; this period saw the development of a resistance strand within mainstream medicine led by individuals and groups who feared that a growing dependence upon laboratory science and an over reliance upon technology would result in the dehumanisation and depersonalisation of medicine.¹²⁵ However, the importance attached to personal conversion at St Luke's meant that broader changes in Methodist thinking might also have exerted an influence upon staff interaction with

¹²³ Green, S.J.D. (1992) 'Spiritual Science' and conversion experience in Edwardian Methodism: the example of West Yorkshire, *Journal of Ecclesiastical History*, Vol. 43, No. 3, pp.428-446.

¹²⁴ 16th SLHAR, 1909, p.36.

¹²⁵ Lawrence, C. (1998) Still incommunicable: clinical holists and medical knowledge in interwar Britain, in C. Lawrence and G. Weisz (eds) *Greater than the Parts: Holism in Biomedicine*. Oxford University Press, pp.94-111.

patients. Thus, whilst individualism within a medical context was considered important, it encompassed a far more significant element: spiritual individualism. The Visiting Sisters' perceptions of their work, in particular, incorporated an individualistic approach towards patients spiritual needs:

"It is the duty of the Visiting Sisters....to try and reach that which makes the man *himself*, and does not belong to another." "We have to try and go beneath the surface to reach the essentials."¹²⁶

Barrett envisaged a similar role for them:

"It is theirs to gently invite the confidence of those they converse with on both their temporal and spiritual difficulties and troubles, to advise them, to lead them, if they will come, to the feet of Christ, to befriend them in all possible ways, and often to become the medium of material assistance to their struggling families outside."¹²⁷

Given that the Sisters were primarily concerned with patient's spiritual welfare and did not play a part in the medical or nursing care of the Home, their attitudes are more likely to have been shaped by the shift in wider Methodist thinking.

The Sisters also made a strong link between the spiritual condition of patients and their sense of individuality; "everyone must give an account of *himself* to God."¹²⁸ Life in the Home was described by Sister Lily as "the absolute reality of the individual on the last step of the earthly journey with the hand on the latch of the door into the Holy City."¹²⁹ In 1904, when a large number of patients sought spiritual solace, Sister Lily could happily pronounce that many of the patients "retain their individuality,"¹³⁰ but in 1913 Sister Gertrude, in a commentary on the diminishing number of patients turning to Christ, had cause to remark "there have been fewer patients of marked individuality and fewer who have been capable of any perceptible depth of feeling."¹³¹ Thus it could be argued that the individualistic evangelical techniques at St Luke's were part of the broader ideological and methodological shift within Methodism identified by Green.

¹²⁶ 13th SLHAR, 1906, pp.32, 34.

¹²⁷ 16th SLHAR, 1909, p.32.

¹²⁸ 11th SLHAR, 1904, p.25.

¹²⁹ 12th SLHAR, 1905, p.36.

¹³⁰ 11th SLHAR, 1904, p.24.

¹³¹ 20th SLHAR, 1913, p.16.

Some of the reports of the Visiting Sisters highlighted their perceptions of changes in the types of patients that were admitted to the Home over the years. Their observations were based primarily upon their apprehension of the patients' spiritual status, and on occasion were followed by specific patient examples. In 1897 Sister Lily stated that many patients had shown resentment of their suffering and had given no thought to spiritual matters, not from deliberate rebellion but from forgetfulness; God had no room in their lives. However, she went on to record that eventually "from each has come the same result, 'Not my will, but Thine be done.'" ¹³²

In 1904 her perceptions had altered very little; although a large number of the patients had said on admission that they had no religion and did not want any, she could confidently declare "we have never yet met with a wilful rejection of Jesus."¹³³ However, by 1906 some of her former optimism had disappeared; she noted that "some of the patients are determined to 'cheat the doctors' and get well,"¹³⁴ and by 1913 there was a clear note of despondency in Sister Gertrude's lament:

"It has seemed to me that during the past year.....I have sat by many and felt they were just stoically enduring.....It was not that they had no beliefs, but they did not in the least realise God as their loving Father, or Christ as their Saviour, and missed all the peace and hope and joy which that knowledge would have brought."¹³⁵

In his reports Howard Barrett made similar observations. In 1899 he wrote "there are very few who pass away amongst us who have not been the subjects of some gracious change of heart, or who have not with more or less completeness submitted themselves to Christ."¹³⁶ In 1907 a request by the patients for a Sunday morning service was interpreted as further evidence of this.¹³⁷ By 1912, however, he too was commenting that "most people are very reticent on matters we feel most deeply. Some patients talk freely with the Visiting Sisters but many keep silence."¹³⁸ Thus at St Luke's House the way in which patients faced death was felt to be dependent upon their spiritual condition. Most of the stories written by the Matron and the Sister also

¹³² 4th SLHAR, taken from 10th WLMAR, 1897, pp.15-16.

¹³³ 11th SLHAR, 1904, p. 24.

¹³⁴ 13th SLHAR, 1906, p.33.

¹³⁵ 20th SLHAR, 1913, p.16.

¹³⁶ 6th SLHAR, 1899, p.22.

¹³⁷ 14th SLHAR, 1907, p.35.

¹³⁸ 19th SLHAR, 1912, p.28.

emphasised the difference that faith in God could make to the dying patients remaining time in the Home. The decline in the number of patients seeking spiritual comfort was also reflected in the patient stories in the annual reports. After 1906 a number of accounts described patients who refused any spiritual solace.

b. 1933 - 1938

A few accounts of patients were included in the 1933, 1935 and 1937 annual reports. These were considerably briefer than many of the earlier stories. In some ways they were slightly reminiscent of those written by Howard Barrett and were included because the Committee thought it might be in the “interest of the Governors” to read them.¹³⁹ They primarily concerned patients whose stories the Committee felt had stood out. For example, the report for 1933 described the case of a woman whose house had been bombed in the First World War, the shock of which she had never recovered from, and whom the Queen took a particular interest in and sent gifts to.¹⁴⁰ Although these accounts did mention the condition from which the patient suffered, no reference was made to the suffering or physical distress which it caused. It was only noted that the patient passed “peacefully” away. These stories did not contain any reference to spiritual matters either except for one patient who wished to be confirmed before her death. Thus it would appear that by 1933 patients’ deaths had not only become increasingly detached from their spiritual status but the Committee itself was far less concerned about emphasising this aspect of the Home’s work.

The disappearance of patient stories from the annual reports after 1913 and the diminishing number of references to the spiritual work of the Home over the following years suggests that, although it continued to be an important aspect of the work of the Home, and remained part of its founding philosophy, it no longer assumed the precedence it once had. Instead it became one equal part of a three-fold mission to provide “physical, mental and spiritual comfort.”¹⁴¹ The absence of any accounts of

¹³⁹ 40th SLHAR, 1933, p.5.

¹⁴⁰ Ibid., p.6.

¹⁴¹ 30th SLHAR, 1923, p.8.

patients after 1914 was partly due to, but also a reflection of, the changing nature of the Home.

The separation of St Luke's from the West London Mission in 1912 and the retirement of Howard Barrett as Medical Superintendent in 1913 were in some measure responsible for this alteration in the Home's overall mission. Although Barrett continued to be involved indirectly in the work of the Home, he no longer exerted his former power and influence. The Sisters of the People also continued to attend the Home but in 1926, despite an increase in the number of beds, the Constitution, which had formerly stipulated the attendance of a minimum of three Visiting Sisters, was amended so that only two Sisters were required to visit. The accounts of patients in the reports may also provide a clue to the diminishing importance of spiritual issues. If the observations by Howard Barrett and the Visiting Sisters about the declining interest among the patients in spiritual matters were true, then it may, in part, account for the gradual re-orienting of the Home's work.

M. Edwards has also identified a shift within wider Methodist thinking during the late nineteenth and early twentieth century which may have impacted upon the philosophy of the Home. His analysis of Methodist hymn-books, one of the principal indicators of changing Methodist thought, published between 1850 and 1932, revealed that within this period there was a clearly discernible movement away from a preoccupation with life after death to a concern for 'this-worldliness'. He also observed the same trend in Methodist theology. This changing emphasis was particularly evident in a very marked reduction in the number of hymns on death, judgement and heaven.¹⁴² At St Luke's such a shift in thinking would have been reflected in the increasing preoccupation with easing the end of patients' temporal life rather than an overwhelming concern for their eternal destiny.

The declining importance of spiritual issues in the Home may also have been influenced by wider changes in social attitudes towards death and dying during this period. Historians, particularly Jalland and David Cannadine, argue that the First

¹⁴² Edwards, M. (1943) *Methodism and England: a Study of Methodism in its Social and Political Aspects During the Period 1850-1932*. London: The Epworth Press, pp.74-85.

World War had a profound impact upon British society and fundamentally altered popular attitudes towards death.¹⁴³ One of its most important effects was to transform the meaning of life and death and give renewed impetus to the process of religious decline. Before 1914 religion had served as the principal coping mechanism for Victorians confronting their own mortality, but the war largely undermined the ability of Christianity to provide meaning and solace because it was unable to provide an adequate explanation for the unprecedented grief and mortality that had ensued.¹⁴⁴ Other historians, however, most notably Jay Winter, have argued that many traditional beliefs and practices persisted into the inter-war period: the War's "immediate repercussion was to deepen and not transform older languages of loss and consolation."¹⁴⁵ One particular example of this was the rapid growth of spiritualism after 1914, which until the War had attracted only limited interest. The apparent inadequacy of traditional religion when confronted with so much death and bereavement, led many people to seek meaning through communion with the dead. As Jay argues, spiritualism was "as remote as could be from the mental environment of fundamentalist Christianity," because "observation, not Scripture, was the source of wisdom," but some people did manage to combine spiritualism with a watered down form of Christianity.¹⁴⁶

The work of both Winter and Cannadine, also challenges the arguments of those such as Phillippe Ariès and Geoffrey Gorer who argue that the First World War led to the twentieth century denial of death.¹⁴⁷ Winter's argument that the use of Victorian motifs (such as spiritualism) after the War helped people to come to terms with their grief and loss and Cannadine's contention that after 1914 there was a mass preoccupation with all forms of death associated with the War (as shown by the proliferation of war memorials and the creation of Armistice Day),¹⁴⁸ suggest that

¹⁴³ Jalland, *Death in the Victorian Family*, p.380 ; Cannadine, D. (1981) War, death, grief and mourning in modern Britain, in J. Whaley (ed) *Mirrors of Mortality: Studies in the Social History of Death*. London: Europa Publications Limited, pp.217, 231.

¹⁴⁴ Jalland, *Death in the Victorian Family*, pp.6, 380 ; Cannadine, 'War, death, grief and mourning', p.218.

¹⁴⁵ Winter, J. (1995) *Sites of Memory, Sites of Mourning*. Cambridge University Press, p.76.

¹⁴⁶ *Ibid.*, pp.5, 56, 76.

¹⁴⁷ Gorer, G. (1965) *Death, Grief, and Mourning in Contemporary Britain*. London: Cresset ; Ariès, P. (1981) *The Hour of Our Death*. London: Allen Lane.

¹⁴⁸ Cannadine, 'War, death and grief', p.232.

people wanted to remember the decease of loved ones and were willing to confront their death on a scale not previously seen. Thus rather than death being driven into secrecy and denial by the War, the use of older, traditional beliefs and practices helped those affected by it to find other ways of articulating their loss.

It can be argued that before the First World War Victorian practices such as spiritualism were essentially confined to a minority of individuals and largely overshadowed by more traditional forms of Christian belief. However, after 1914, the failure of Christianity to provide adequate explanation for the sudden mass slaughter of millions of young men, meant that they assumed a widespread and compelling significance. Thus it could be said that attitudes towards death after 1914, whilst not undergoing a radical, fundamental alteration, were beginning to change in the sense that people were seeking alternative means and contexts in which to understand mortality. Although a death-denying culture was not yet apparent, there is evidence to suggest, as chapter five shows, that within certain contexts, death was becoming a subject for avoidance and concealment. There is also scope to argue that the declining significance of traditional Christianity may have impacted upon the diminishing importance of spiritual care at St Luke's, especially given that the Home's tenuous financial basis meant that the staff were more sensitive to popular opinion.

It also appears that St Luke's underwent a gradual process of 'medicalisation' over the years, especially after 1917, when it changed its name to 'St Luke's Hospital for Advanced Cases' and began to be looked upon, both by its own staff and the wider medical community, as a small, special voluntary hospital.¹⁴⁹ In 1916 the annual report referred to it as "first and foremost a Medical Charity"¹⁵⁰ and by 1925 it was declared to be "a modern and fully equipped Hospital."¹⁵¹ This growing preoccupation with the more medical aspects of the Home formed part of a change in attitudes towards death among the staff which were themselves a response to a perceived shift in attitudes among the wider public. The decision to alter the name in 1917 originated, in part, from a concern among members of the medical staff that the public at large

¹⁴⁹ 24th SLHAR, 1917, p.4.

¹⁵⁰ 23rd SLHAR, 1916, p.14.

¹⁵¹ 32nd SLHAR, 1925, p.12.

were not comfortable with the term 'Home for the Dying': "It has become increasingly evident for some time that patients and friends shrink from the words 'home for the dying'." The new title 'Hospital for Advanced Cases' was chosen because it "conveys substantially the same meaning to the medical world but to the lay mind not the same feeling of shock and hopelessness."¹⁵² As other chapters show, this sense of an aversion to the title 'home for the dying' among the public was, in fact, an ongoing concern in the Home's history and had been evident from its very foundation. As early as 1892 Howard Barrett had commented on the unwillingness of landlords to let out a house once they knew its purpose because they feared it would devalue the property.¹⁵³

c. The 'Respectable Christian Death'

In 1897 Howard Barrett described suffering as "the one thing which declares the true humanity in everyone of our race, and brings all men together on a level." He went on to observe that "so long as all goes well, men and women see but the outside part of each other.....We recognise those we meet with, either in business or society, by their several grades, profession or style. But beneath all this, is there not the simple manhood or womanhood, which we all share alike as God made us?" As death approaches "no longer do you see in the rigid or suffering form that lies there, the common labourer, the mechanic, the poor tradesman, but the *man*, the same as yourself, come to the same pass you will yourself come to one day."¹⁵⁴ However, at St Luke's House, there was a clear discrepancy between the acceptance of this maxim at a theoretical level and its practical application within the Home. Appeals to man's common humanity, such as the one above, were a rhetorical device used by Barrett as a way to drum up support for the Home. Both the annual reports and the advertisements placed in newspapers were far more concerned to emphasise that only certain groups - the 'respectable' or 'deserving' poor - were eligible for admission. The 1893 report even provided a definition of the type of patient to whom this referred:

¹⁵² 24th SLHAR, 1917, p.4.

¹⁵³ 'St Luke's House', taken from 5th WLMAR, 1892, p.18.

¹⁵⁴ 4th SLHAR, taken from 10th WLMAR, 1897, pp.13-14.

“a decent, self-respectful and hardworking member....of the London working-class, probably an honest, sober man or woman, but not specially clever (the large majority of us are not), or he would, in the long run, have raised himself to a higher position.....at any rate he has never needed to apply for parish relief of any kind and to do so would be felt as a crushing humiliation.”¹⁵⁵

Death at St Luke’s House therefore had a specific moral condition attached to it. In 1895 Barrett wrote: “A notable and most healthy and wise disposition is coming into the public mind to distinguish in dealing with the poor, between the two great subdivisions of the class - the worthy and the unworthy.....They must not only be estimated at very different values, but must be treated and provided for differently.” He went on to add that at St Luke’s House this “conviction has been the leading principle.”¹⁵⁶ This preoccupation with respected and self-respecting members of the poor formed part of prevailing attitudes within the Methodist Church specifically and among the upper and middle classes as a whole. Death at St Luke’s House embodied the paradox which several historians have argued characterised death during the nineteenth century; it was both the great leveller and the ultimate upholder and reinforcer of religion and class boundaries.¹⁵⁷

The ‘respectable death’ was only one aspect of death at St Luke’s House. The spiritual condition of the patients was also believed to have a profound effect upon the way in which it was met. Within the home having faith in Jesus Christ as one’s personal Lord and Saviour was felt to be essential. The denominational route through which patients came to acquire this faith was largely irrelevant. Barrett wrote:

“Dying men and women here have got past nice distinctions between churches; the simplest personal realities of religion are what their tremulous souls can firmly grasp. If they can be brought while here to realise the loving Fatherhood of God, the full atonement of Christ, and with a whole-hearted faith to appropriate to themselves, we are quite content.”¹⁵⁸

¹⁵⁵ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, pp.24-25.

¹⁵⁶ 2nd SLHAR, taken from 8th WLMAR, 1895, p.4.

¹⁵⁷ Barnard, S. (1990) *To Prove I’m Not Forgotten: Living and Dying in a Victorian City*. Manchester University Press, p.x ; Richardson, R. (1987) *Death, Dissection and the Destitute*. London: Routledge and Kegan Paul Ltd, p.99.

¹⁵⁸ 13th SLHAR, 1906, pp.21-22.

“A dying man doesn’t want an ‘ism’ he wants Christ, broadly and simply presented, as He lived and died and rose again, in the Gospels, and as He dwells in Heaven today.”¹⁵⁹

Patients who found faith in Jesus were described under the broader heading of ‘Christians’ rather than being identified with a specific denomination. This concern to emphasise the non-sectarian basis of the Home was itself a distinct characteristic of Methodism and thus it can be argued that patients in the Home were expected to conform to a specifically Methodist way of thinking. At St Luke’s House far less credence was given to outward forms of faith; what mattered was being “able to rejoice in the assurance of sins forgiven.”¹⁶⁰ One of the Visiting Sisters neatly captured the dual nature of the ‘Respectable Christian death’ in her description of one of the female patients in the home in 1907:

“When it dawned on her she had a mortal illness and it was not just sufficient to have led a respectable life she gave herself to prayer and turned the face of her soul towards God.”¹⁶¹

Many of the patient stories in the annual reports were examples of the “process of dying” identified by Irene Langridge. As well as describing the patient’s transition from a state of restlessness and anxiety to one of peace and acceptance, they were more explicit about the fundamental role played by religion, especially in the shift from confronting the reality of suffering to accepting the reality of Christ. For one patient the gradual realisation that she would “never enjoy life” was a period of “cruel darkness” until the “bitterness grew less” and the “love of God became more real.”¹⁶²

Finally, these stories can be seen as forming part of the wider Methodist tradition of publishing conversion and death bed stories. The purpose of these was to demonstrate that even in the most trying circumstances it was religion that had been the sustaining force.¹⁶³ These published accounts, usually in the form of obituaries, reveal that the most important time in life was the moment of conversion. Even the moment of death

¹⁵⁹ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p.27.

¹⁶⁰ 5th SLHAR, 1898, pp.21-22.

¹⁶¹ 14th SLHAR, 1907, p.43.

¹⁶² 6th SLHAR, 1899, p.25.

¹⁶³ Schneider, A.G. (1987) The ritual of happy dying among early American Methodists, *Church History*, Vol. 56, No. 3, p.360.

did not hold the same degree of significance. Within these accounts death and dying were very much viewed in relation to the experience of conversion; finding faith in God was what mattered ultimately. The effects of this would be felt up to and including the time of death and would have a profound bearing upon the way in which the latter was met. Many of the obituaries which featured in Methodist publications were written in a similar style to those published in the St Luke's House annual reports, as the following extract shows:

“At the commencement of his last illness he prayed for submission to the Divine will; and during the month following his faith was implicit, his joy rapturous, his victory complete, and his sick room became the gate of heaven. On his last Sunday night, with radiant face, tender tone, and impressive gesture, he quoted copiously from the Bible and Hymn book passages expressive of his experience. Later, he sang the verse, ‘All Hail the Power of Jesu’s Name’ etc. and just before his death the two words ‘Crown Him’. He passed into the fellowship of the Church triumphant on October 16.”¹⁶⁴

v. The Hostel of God: perceptions of death and dying

The Hostel of God records contain markedly fewer descriptions of patients but it is still possible to gain some insight into the perceptions of those who worked there and the way in which they viewed the deathbed. One or two of the early annual reports and a few of the Sisters' reports in *St Margaret's Magazine and Half-Yearly Chronicle* include accounts of patients who stayed in the Home. Unlike the annual reports, the entries in the *Magazine* were written solely by the Sisters. Although the latter was published by the sisterhood, it was intended for a more specialised readership, principally the Mother House and other Anglo-Catholic religious organisations. By contrast, the annual reports were aimed at a wider audience, particularly current and potential subscribers.

The accounts in the annual reports were primarily concerned to justify the work of the Hostel as a home for the dying respectable poor (see chapter 5 for a more extended discussion of these). However, the purpose of stories in the *Magazine* was to emphasise the spiritual work of the Home. Again, the influence of the denominational

¹⁶⁴ *Wesleyan Methodist Church Minutes of Conference* (1892) London: Wesleyan Methodist Book Room.

basis of the Home in shaping the Sisters' attitudes was very apparent. Faith in God, described as claiming "the Power of the Saving Name of Jesus"¹⁶⁵ was regarded as the fundamental factor in ensuring death was "faced happily,"¹⁶⁶ but at the same time patients were expected to participate in certain rituals. One patient, although difficult to manage, was well-liked because "his real fervour in the ward prayers, his fervent 'Hail Mary's' and the 'Divine Praises' were a joy to hear; his religion really meant much to him."¹⁶⁷

The Sacraments of Baptism, Confirmation and Holy Communion were all considered an important part of preparation because they were believed to impart special "Grace"¹⁶⁸ to the recipient. The Sisters wrote that many patients were "brought for the first time to the use of the Sacraments and none have gone forth on their last journey without the help of prayers and the offering of the Holy Sacrifice on their behalf."¹⁶⁹ In each annual report the Chaplain stated how many patients had been baptised and confirmed and how many had received Communion. The importance attached to the sacraments, particularly Holy Communion, formed part of their wider significance within the doctrine of the Anglo-Catholic Church. Like the Catholic Church, Anglo-Catholics believed that God provided His Church and its sacraments as a means of grace for all mankind and that to reject them meant to reject salvation.¹⁷⁰ The Blessed Sacrament also held a particularly special place in the work of the Sisters of East Grinstead. Their Constitutions stated:

"And as Jesus represented by His poor is to be the object of their active work, Jesus, yet more lowly, as present in the Blessed Sacrament, shall be the central Light of their devotion. They shall offer their work to His Glory in the Blessed Sacrament."¹⁷¹

The report in the 1922 issue of the *Magazine* provided a brief account of a "day's experience" of one of the Sisters in which she recounted the stories of two patients whose deathbed she had witnessed that day. The first concerned a patient who had

¹⁶⁵ HOGAR, 1933, p.7.

¹⁶⁶ HOGAR, 1923, p.7.

¹⁶⁷ *St Margaret's Magazine and Half-Yearly Chronicle* (1917), Vol. IV, Part 8, p.285.

¹⁶⁸ HOGAR, 1925, p.6.

¹⁶⁹ *St Margaret's Magazine and Half-Yearly Chronicle* (1931), Vol. III, Part 3, p.88.

¹⁷⁰ Booth, C. (1902) *Life and Labour in London*. London: Macmillan and Co. Ltd, 3rd series, pp.49-50.

¹⁷¹ Hutton, R.E. (1959) *St Margaret's Convent East Grinstead: An Account of the Community and its Work*, revised edition, p.11.

been a Christian before admission and simply stated that in the early morning she, the Sister, had kneeled at the bedside of one of God's Saints who had passed away. The second account which told the story of a non-religious patient was much more detailed in content. As such it provided the reader with a more vivid illustration of the Sisters' work and, more importantly, it served as a justification for the Home's existence. It described a patient who had lived a hard life with little chance for religion because the claims made by her family, the need to earn a living and the daily jostling with a noisy, busy world had left no room for God. Her admission into the Home, however, had provided the opportunity for religion to be made known to her:

“But in this quiet ward her chance had been given her, and she received it with such a simple faith and such humble childlike trust, that I felt in a short time she had fulfilled a long time, and had now gone to the eternal enjoyment of all she had missed in earth.”¹⁷²

Unlike St Luke's House, the spiritual work of the Home continued to receive precedence over the years. The Chaplains' reports remained one of the main features of the annual reports and throughout the 1930s they recounted the ongoing success of his ministrations: “many untouched heretofore, many long dead to the things of God, respond to the things of the Spirit” ; “Frequent turnings to God point quite clearly to the need of the soul for help and support in the midst of bodily pain and suffering.”¹⁷³

vi. The ‘good death’

Reading through the patient stories for the three homes there is a growing sense of what might be termed the ‘ideal’ or ‘good’ death. Some of its characteristics were common to all three homes. The importance of showing “fortitude” and “patience” in the face of severe suffering and “resignation to God's will” was emphasised by the staff at each institution. Patients were also expected to have “no fear”; be “conscious”; “peaceful”; “happy”; “calm”; and “full of faith and confidence.”¹⁷⁴

¹⁷² *St Margaret's Magazine and Half-Yearly Chronicle* (1922), Vol. VI, Part 2, pp.65-67.

¹⁷³ HOGAR, 1935, p.8.

¹⁷⁴ SJHA, 1905-1909 ; 1909-1915 ; 3rd SLHAR, taken from 9th WLMAR, 1896, p.18 ; SLHAR 1899, pp.25, 27 ; 1909, p.42 ; 1912, p.24 ; *St Margaret's Magazine and Half-Yearly Chronicle* (1900), Vol. VI, p.54.

Other elements of the 'good death', especially at St Joseph's, were rooted within the theology of their particular denomination. At St Luke's House resignation to death was felt to be particularly important. It not only required acceptance of the fatality of one's illness and a willingness to let go of life but also relied upon a firm faith in Christ. The latter, in accordance with both Methodist and general Nonconformist doctrine, did not have to be expressed through any particular denominational medium. One of the Visiting Sisters told the story of a young man with cancer of the face who had to write on a slate because his speech was affected by the nature of his disease:

"One day he gave me the slate to read; 'Sister will you ask God to give me His Holy Spirit, to make me sorry for my sins?' I looked back at him....his sad disfigured face and felt he was not far from the Kingdom of God. When his chief concern was not his suffering might be removed, not that his life might be prolonged, but that he should be sorry for his sins, surely he was one to whom the gift of repentance would be readily given? And so it was....In spite of increased suffering and much anxiety of mind he never lost the happy consciousness of God's favour."¹⁷⁵

The 'good death' at St Joseph's Hospice was contingent upon reception into the Catholic Church and the administration of all five sacraments (Baptism, Penance, Holy Communion, Confirmation and Extreme Unction). Reconciliation to any estranged family members was also important. The 'good death' should be edifying to others, especially non-Catholic family and friends, who should themselves go on to find consolation in the Catholic faith. The annalist noted how the relatives of a patient who was restored to the Catholic faith were "greatly edified" by his death and "promised to return to their religion also."¹⁷⁶ The following account describes a patient who was converted to the Catholic Faith after admission. It contains many of the elements of the 'good death': conversion to the Catholic faith, an awareness of sin, Confession, attending Mass, receiving Holy Communion and resignation to God's will. This account also illustrates the relationship between death and religion; the patient's death and spiritual development were always seen in relation to the all important event of her conversion ("Reception") to the Catholic faith.

"After ten days in the Hospice she called the Sister one night and pleaded piteously that she be saved from Hell, as her past had been a very sinful one....she wished to join the Catholic Church. She was given an explanation of Confession etc. She asked to be received, the Priest was

¹⁷⁵ 4th SLHAR, taken from 10th WLMAR, 1897, p.16.

¹⁷⁶ SJHA, 1925, p.2.

sent for and received her. Peace filled her soul. She tasted for the first time real happiness. After receiving Holy Viaticum, she revived and lingered on. Religion now meant everything to her, she realised how good God was to have brought her to the Hospice. She went to Midnight Mass at Christmas and on her return to the Ward, the same joy flooded her soul during Mass, as it did on the day of her Reception into the Church. She longed to get better.....but was content with God's will. She longed for heaven and the final call came on March 11th, five months after her receipt into the Church."¹⁷⁷

Despite the small number of accounts of patients at the Hostel of God, there was still very much a sense of what constituted the good death. The following account describes a 44 year old woman who had turned away from all forms of religious consolation until she had come to the Home. Her death bore a similar resemblance to the "holy and happy death" at St Joseph's in that it was largely dependent upon participation in certain rituals and Sacraments, but as they accorded with Anglo-Catholic teaching rather than Roman Catholic beliefs.

"She combines an independent outlook with a deeply receptive attitude of mind. After some time she asked the Chaplain to hear her confession saying that listening to the Ward Services carefully and thinking it out 'independently', she knew he could give her God's forgiveness....One night when the pain was acute she asked what she could do about it and was told she might 'offer' it on behalf of another in great need....She receives Holy Communion (having lapsed since girlhood) with almost heart broken delight."¹⁷⁸

How likely was it in reality that patients in the homes could even come close to achieving a death such as the one described above? Certain factors, particularly the physical nature of their illness and the length of time spent by the patient in the home before their death, would have precipitated against many of its requirements. Evidence of this can be found in some of the stories. Several patients at St Joseph's were prevented from receiving all five of the sacraments because the sudden onset of death did not allow sufficient time for it. One young man was given Conditional Baptism and Extreme Unction but the annalist noted "it was too late to think of First Communion as he was now in his agony."¹⁷⁹ Another patient did not have time to receive any of the Sacraments because she died before the priest could get to the

¹⁷⁷ *Hackney Annals*, 1936.

¹⁷⁸ *St Margaret's Magazine and Half-Yearly Chronicle* (1938), Vol. X, Part 1, pp.12-13.

¹⁷⁹ 'Notes for Annals of St Joseph's Hospice', 1905-1909, p.4, [RSCG].

Hospice,¹⁸⁰ while “incessant vomiting” meant that one of the other female patients was denied the consolation of receiving Holy Viaticum even once during her stay.¹⁸¹

At St Luke’s one of the Visiting Sisters, in an attempt to explain the declining spiritual response from patients, remarked that “many cases have been of such acute suffering that it was almost impossible for them to think of anything but their pain.”¹⁸² Barrett too commented frequently on the “agonising”¹⁸³ sufferings of some patients. One account concerned a female patient with cancer of the stomach and throat. She could only breathe through a tube inserted into her windpipe and was fed through another leading into the stomach. As a result she constantly struggled for breath.¹⁸⁴ Another described a female patient with cancer of the liver which was irreducible by surgical aid and meant that she:

“suffered abominably and waxed larger and larger.....until she was such a helpless and enormous mass that only with a severe effort could four nurses move her. For weeks before she passed away she was compelled to keep to the sitting position. Her actual pain we could and did relieve, but the distress and weariness caused by her terrible condition were so intense, so impossible to remove, and so painful to witness that when I entered one day and found the place empty where that pathetic and uncouth travesty of the human form had sat and endured so much for such long weeks, I was profoundly grateful.”¹⁸⁵

However, desirous as the ‘good death’ was, the deprivations caused by the patients’ bodily sufferings could still be looked upon as beneficial. Extreme physical discomfort enabled patients to demonstrate more forcibly certain other elements of the ‘good death’, especially ‘courage’ and ‘fortitude’. One patient at St Luke’s, despite excruciating pain, retained his strong religious convictions, and it was noted “how his faith triumphantly sustained him through such a really appalling trial.”¹⁸⁶ In the same way another patient suffering from tuberculosis was in “such intense pain” that he could “seldom apply his mind to anything beyond the mere struggle to endure,” but “now and then, however, in short intervals of abatement, it became evident that the

¹⁸⁰ Ibid., pp.21-22.

¹⁸¹ Ibid., pp.15-16.

¹⁸² 20th SLHAR, 1913, p.16.

¹⁸³ 11th SLHAR, 1904, p.15.

¹⁸⁴ 16th SLHAR, 1909, p.39.

¹⁸⁵ 14th SLHAR, 1907, p.23.

¹⁸⁶ Ibid., p.22.

eye of his spirit had turned to Christ.....He could not often talk, but through all the repulsiveness and horror of his disease there shone a gentleness of spirit and the light of a faith in things eternal.¹⁸⁷ The annalist at St Joseph's recorded how one of the female patients, although conscious, was unable to receive Holy Communion because she could not swallow. However, she was still able to achieve a "happy death" because the priest brought the Blessed Sacrament into her room so that she could "make her Act of Adoration and get our Divine Lord's blessing."¹⁸⁸

vii. The 'bad death'

The accounts of patients also contain a definite sense of what might be termed the 'bad death'. It is very apparent that a refusal to be resigned to one's fate and dying without the comfort and consolations provided by faith was not seen as a good way to die. Again, these perceptions were largely shaped by the denominational underpinning of the homes. One male patient at St Luke's House, dying from cancer, was unable to swallow when he was admitted:

"...but he is patient and sternly sets himself to bear whatever may betide him, not in any spirit of saintly resignation but because he will not be beaten.....[he] stoically goes through each day....waiting to see what will happen to his throat. He is doubly unfortunate, for he seems quite inaccessible to religious influences, there is no 'Faith' in him at all, as far as can be gathered, to bring him a ray of comfort or light in the darkness."¹⁸⁹

Occasionally, the annual reports for St Luke's would juxtapose an account of a 'good death' with one in which death was not being met in the required manner. One pretty bright woman in the prime of life who had scarcely known a day of illness "loved life passionately and could not bear to believe she was dying. She suffered from a most cruel form of cancer but preferred to persuade herself it was neuralgia." Another patient, an elderly woman, "suffered very excruciating torture but was a model of patient fortitude, never murmuring and in the midst of her suffering it seemed as if the eye of her soul already saw the King in His beauty."¹⁹⁰ The contrast between these two

¹⁸⁷ 13th SLHAR, 1913, p.17.

¹⁸⁸ SJHA May 1915 - May 1921.

¹⁸⁹ 20th SLHAR, 1913, p.23.

¹⁹⁰ 9th SLHAR, 1902, p.24.

patients, both of whom were described as experiencing immense bodily pain, was designed to reinforce the difference that resignation to suffering and death and having trust in God could make to one's death.

At the Hostel of God the 'bad death' is associated with an account in the *Magazine* which described the deathbed of a patient who refused to accept the spiritual ministrations of the Sisters.

“a poor sin stained hardened heart, one who had turned away from God - refusing all the ministrations of religion - dying alone, at enmity with her people, hugging pride and resentment in her heart.”¹⁹¹

However, even in cases such as this, the Sisters wanted to provide reassurance to those who read this account that “God's mercies fail not” and that their prayers, “an 'all-pervading sacrifice' offered morning by morning in the quiet little Chapel,” would yet help to secure her redemption.¹⁹²

The annals at St Joseph's did not contain any accounts of 'bad' deaths but the 'Notes for the Annals' included an example of a patient whose departure did not accord with the Sisters' expectations. One of these was an Irish woman, a lapsed Catholic, who was described by the annalist as “not a very consoling case.” She was admitted to the Hospice on New Year's Eve and did not appear to be at all well.

“However, she could not be induced to go to Confession on the appointed day. She got suddenly bad one morning and hastily sending for the priest made preparations for anointing and in a state of fearful anxiety fearing he would be too late endeavoured to help her and dispose her soul for the reception of the Sacraments without much apparent effect. She was quite conscious but paid little heed to what the priest said and did. She couldn't get Holy Communion and he could only pray to the end that the Lord's mercy would be felt in that poor soul.”¹⁹³

Another example of a 'bad death' concerned a young Indian man who worked in the India Office and was described as “quite an educated man.” The Sister went on to record; “It was sad that we could give him no spiritual help in his last moments. He was most respectful to the nuns and to everything regarding religion and believed in

¹⁹¹ *St Margaret's Magazine and Half-Yearly Chronicle* (1922), Vol. VI, Part 2, pp.65-67.

¹⁹² *Ibid.*, p.67.

¹⁹³ 'Notes for Annals of St Joseph's Hospice', 1905-1909, pp.29-30, [RSCG].

God as shown in his works of Nature.”¹⁹⁴ The omission of these accounts from the official annals is in itself very telling, suggesting that either the Sisters did not want them to be known to the Mother House or that their inclusion would in some way compromise the purpose of the annals. Although patients of all denominations and none were admitted into the Hospice, the Sisters ultimately hoped that as many as possible would embrace the Catholic faith. The purpose of the annals was to celebrate their successes in this, not draw attention to their failures.

viii. Conclusion

The particular way in which death and dying were portrayed within the early ‘hospices’ was deeply entrenched in both their denominational underpinnings and the broader evangelistic mission of their respective Churches. Each patient’s death and dying experience was viewed principally from a spiritual perspective and priority was given to the salvation of souls. As such the work of the homes played an important role in the Churches’ wider attempts during this period to counter perceived working class religious indifference. The specific denominational character of each home had a particularly strong influence upon perceptions of the ‘good death’ and the way in which spiritual care was delivered to the patients. The “soul-cure”, although manifested in a different way in each of the homes, played a central role in the management of the deathbed. In the same way that bodily and mental needs were used as a vehicle to address the patients’ spiritual needs, death itself was subtly manipulated to help further the more pressing and ultimate goal of salvation which underlay virtually all religious-based institutional work during this period.

The patient stories for the three homes reveal that they each had a particular way of thinking about death and dying which patients were expected to conform to as closely as possible. The reconstruction of patients’ death and dying experiences at the Hostel of God, the “holy and happy death” at St Joseph’s and the “respectable Christian death” at St Luke’s were firmly rooted within the specific denominational thinking of

¹⁹⁴ This account was part of 2 pages of hand-written notes, included among the records at CARITAS, which described some of the early patients in the Hospice.

the homes. The stories also give an insight into the expectations placed on incoming patients by the staff in the homes.

Although St Luke's advocated a particular manner of death which formed part of the wider thinking of the Methodist Church, the way in which death was met was not ultimately dependent upon membership of a specific religious denomination. In contrast, every aspect of death and dying at St Joseph's was deeply entrenched within the Catholic religion. Dying well was dependent on either being reconciled or converted to the Catholic faith and death itself could only be approached through participation in the rituals of the Catholic Church. In the same way, the stories recounting patients' dying experiences at the Hostel of God were grounded in the teaching of the Anglo-Catholic Church; the good death required the patient to follow its particular rituals and practices.

Perceptions of death and dying at the Hostel of God remained unchanged throughout the period 1890 to 1938 but those in the other two homes, particularly St Luke's, underwent certain changes. The Sisters at St Joseph's remained committed to ensuring a "holy and happy death" for as many patients as possible, but the type of patient at which it was aimed changed during the early 1920s from lapsed Catholics to non-Catholics, thereby necessitating a slight alteration in the way in which spiritual ministrations were carried out; a higher proportion of patients admitted after 1921 had first to be made aware of the need to die a Catholic. In contrast, the 'respectable Christian death' was only looked upon as the most important aspect of the work at St Luke's in the early years of its history. After 1914 spiritual concerns assumed less and less significance in the Home.

The Sisters at St Joseph's and the Hostel of God viewed virtually every aspect of their work from a spiritual perspective, a way of thinking which remained unaltered over the years. This was largely due to the fact that they were responsible for both the running of the Hospice and a large proportion of the nursing work throughout the period. In contrast, spiritual concerns only dominated the work of St Luke's House during the early years. After 1914 it became increasingly vulnerable to secular

influences which gradually infiltrated and altered its philosophy. The greater involvement of lay personnel in both the running of the home and the nursing, the resignation of its spiritually motivated founder, Howard Barrett in 1913, the declining role of the Visiting Sisters and its separation from the West London Mission in 1912, would have partly contributed to this. The often tenuous financial position of the Home may also have been partly responsible for its growing susceptibility to wider changes. Whilst the patient stories at St Joseph's and the Hostel of God continued to be preoccupied with cases in which their spiritual ministrations were successful, those written between 1908 and 1913 at St Luke's became more open about the spiritual difficulties that were encountered and the growing tendency for patients to resist religious ministrations.

The above discussion has clear implications for Pat Jalland's argument that from the 1870's onwards concern for spiritual welfare among the upper social tiers was gradually superseded by an anxiety over physical suffering.¹⁹⁵ In the homes for the dying the relationship between bodily and spiritual care was looked upon by those who ran them in a very different way. Although the alleviation of bodily suffering was an important part of their work, priority was given to spiritual care. Physical pain was ultimately accepted because it was felt to play a key role in the patients' spiritual development. In light of Jalland's findings the continued emphasis on, and re-iteration of, this aspect of their work by the homes could be seen as representing an attempt on their part to reassert the spiritual aspects of care of the dying. As such it represented a desire to return to some of the more traditional features of caring for the dying which were characteristic of earlier periods and which were increasingly being subsumed within more temporal and secular concerns. The progressive medicalisation and secularisation of St Luke's House after 1914 suggests that resistance to wider changes in attitudes did become more difficult, but the continued emphasis upon spiritual care at the Hostel of God and St Joseph's serves only to underline the strength of their achievement.

¹⁹⁵ Jalland, *Death in the Victorian Family*, pp.51-52.

Thus even this study has focused upon the biological underpinnings of the three homes, viewed entirely from the perspective of those responsible for such arrangements. In this chapter the emphasis moves away from theoretical considerations to an exploration of the practical workings of the homes and the types of patient who were admitted into them. An examination of the homes from a more patient-orientated perspective will help to give greater balance to the overall discussion. The principal objective of this chapter is to build up a demographic understanding of the inmates and to examine the various patterns of admission, epidemiology, length of stay, mobility and discharge through an empirical analysis of the patient data for each of the homes. Although the information does not provide direct insight into the patients' experiences, it is possible to look at them as a group and to explore changing trends over the years.

CHAPTER 4

Reconstructing Patient Profiles

There has been a growing awareness of the importance of patient records to historians of medicine wishing to reconstruct medical experiences and perceptions of the past. These records exist in a variety of forms from simple admission registers, general medical notes, laboratory tests, technologically assisted examinations, anaesthesia records and resuscitative status. As Quentin B. Riser and John Harley Warner have argued:

... Patient records are surviving artifacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expedients, and the reality of power relationships are expressed.¹

Patient records not only serve to establish the population basis of an institution and create patient profiles but also help to place patterns of disease within the context of contemporary epidemiology and to provide an insight into the social, administrative and economic factors which influenced admission and discharge policies.²

This chapter is based primarily upon a quantitative analysis of statistical information relating to patients in the three homes. Most of the data is drawn from admission

¹ Riser, Quentin B. and Harley Warner, J. (1992) Reconstructing medical activities: patient records in medical history. *Journal of the History of Medicine*, Vol. 3, No. 2, p. 189.

² *Ibid.*, pp. 181-205.

Until now this study has focused upon the ideological underpinnings of the three homes viewed entirely from the perspective of those responsible for their management. In this chapter the emphasis moves away from theoretical considerations to an exploration of the practical workings of the homes and the types of patient who were admitted into them. An examination of the homes from a more patient-orientated perspective will help to give greater balance to the overall discussion. The principal objective of this chapter is to build up a demographic understanding of the inmates and to examine the various patterns of admission, epidemiology, length of stay, mortality and discharge through an empirical analysis of the patient data for each of the homes. Although the information does not provide direct insight into the patients' experiences, it is possible to look at them as a group and to explore changing trends over the years.

There has been a growing interest in recent years in the importance of patient records to historians of medicine wishing to reconstruct medical experiences and perceptions of the past. These records exist in a variety of forms from simple admission registers, providing basic demographic information, to clinical charts including information on laboratory and pathology tests, technologically assisted examinations, anaesthesia records and postoperative status. As Guenter B. Risse and John Harley Warner have argued:

“Patient records are surviving artefacts of the interaction between physicians and their patients in which individual personality, cultural assumptions, social status, bureaucratic expediency, and the reality of power relationships are expressed.”¹

Patient records not only serve to establish the population basis of an institution and create patient profiles but also help to place patterns of disease within the context of contemporary epidemiology and to provide an insight into the social, administrative and economic factors which determined admission and discharge policies.²

This chapter is based primarily upon a quantitative analysis of statistical information relating to patients in the three homes. Most of the data is drawn from admission

¹ Risse, Guenter B. and Harley Warner, J. (1992) Reconstructing clinical activities: patient records in medical history, *Social History of Medicine*, Vol. 5, No. 2, p. 189.

² *Ibid.*, pp.183 - 205.

registers. Unfortunately, these do not include individual case histories for the patients which means that most of the information is of a quantitative rather than qualitative nature. However, even though it is only possible to work with statistical data, it provides a spring board for a more qualitative analysis by allowing the exploration of questions relating to issues such as policy making, professional behaviour and financial contexts. It also generates questions as to *why* and *by whom* particular facts were recorded and what they reveal about life in the homes. For example, did a high discharge rate undermine their status as homes for the *dying*? Or did the length of stay in the home influence a patient's outcome (death or discharge)? Finally, an analysis of patient data provides insight into the broader conditions of social life, such as contemporary local epidemiology and social attitudes, and how these might have impacted upon the patient populations. Findings are further explained, supported and contested by reference to other primary material and to the secondary literature. Part of the objective is to explore the relationship between ideas and practice, by looking at how closely the principles set out in each home's mandate were borne out in practice and how what happened in practice may have shaped ideology.

Analysis is complicated by the fact that the data is not consistent for all three institutions. St Joseph's Hospice and St Luke's House have the most comprehensive information; both homes still have their patient registers. Those for St Joseph's are retained at the Hospice and run from its opening in 1905 right through until the 1990s, while the registers for St Luke's have been deposited at St Mary's Hospital and are virtually a complete set; only the first three years are missing. The first register dates from September 1896 and they continue up until 1967. The statistical information contained in the two sets of registers was virtually identical and included the following: patient number, name, age, address, occupation, religion, ailment, date of admission, and date left / died.

The registers for St Joseph's also have a column recording the name of the person/s or institution recommending the patient. At St Luke's the same information is listed under the section headed 'By Whom Introduced' which also gives details on the doctor who signed Form I of the application form and the signatories to Form III

(filled in by the patient's friends or relatives). Although there are no individual case histories for the patients, some of the early registers for St Luke's contain brief notations on the social and family background of patients and their pathological history, which help provide further insight into the perceptions and opinions of those who ran the Home. Occasionally these include a comment on the patient's physical condition or moral character.

The patient data for the Hostel of God is less consistent. The institutional records for the Home have been deposited in a public archive - Lambeth Archives - which is part of the Minet Library in Lambeth. Patient registers only exist for the years 1927 to 1938. Before this the only data available on patients is contained in the annual reports. However, even this is incomplete because a considerable number of the reports before 1920 are missing (1899-1901, 1903-1905, 1907, 1909-1910, 1913, 1915-1916 and 1918-1919) which means that, until 1927, it was not possible to actually work with the raw data. The major implication of this is that another level of bias has to be taken into account; the interpretation of the original data by the Medical Officer. There is no way of knowing how accurately the information in the registers was represented. The statistical information in both the annual reports and the patient registers is far less comprehensive than that for St Joseph's or St Luke's; data was only provided on the following: gender, age, disease, length of stay (days, weeks or months), and outcome (death or discharge).

Although the patient registers for all three homes are hand-written, it is still not possible to know by which member of staff they were filled in; the medical staff, the nuns or other members of personnel. Another drawback is that it is not possible to ascertain at what stage of a patient's stay each section was filled in.

The data from the registers and reports was inputted directly onto a database and a simple statistical analysis was conducted using Excel. A statistical comparison of the data for all three homes was not viable because the information is too varied and inconsistent, particularly for the Hostel of God. The patient registers for St Luke's House and St Joseph's Hospice were more consistent and offered a slightly more

reliable comparison. Analysis of the data did reveal certain patterns and differences which, even if they could not be statistically tested, could be used as a basis for making some suggestions, especially when they were noted as significant by those involved in the homes.

Given the length of the period encompassed by this study a decision was made to analyse the data on a ten-yearly basis. The years 1895, 1905, 1915, 1925 and 1935 were chosen because they cover the longest time span. The missing Hostel of God records meant that in several instances it was not possible to use the annual report for these particular years. Instead the closest available report was used; 1896 or 1897 for 1895, 1906 for 1905 and 1914 for 1915. Likewise, the absence of any patient data at St Luke's House for 1895 meant that 1897, the first year with a complete set of data, was used instead. Where relevant the data for the total population of the homes was also broken down into male and female figures. As well as comparing the three homes each institution was examined separately, where applicable, in order to understand those trends and patterns which were peculiar to each.

The discussion follows the patient's career through the home, beginning with admission. Particular attention is given to the admission policies of each institution. This helps to provide a theoretical framework for the work of the homes which can then be contrasted with what happened in practice. It then moves on to a consideration of the social, economic and religious background of patients by examining their age, occupation and religious affiliation. This section also looks at *how* patients entered the homes. Epidemiological patterns in the homes are then explored. The focus of this section is on the incidence of two specific diseases - phthisis and cancer - because these were the principal ailments suffered by inmates. The changing occurrence of these two conditions was also responsible for a discernible epidemiological shift within each of the homes. The length of stay is an important consideration because it was felt by contemporaries to serve as an indication of the homes' effectiveness as institutions for the *dying*. The last part of the discussion analyses patterns of mortality and discharge, also seen as a way to gauge the overall performance of the homes, before trying to draw the findings together in a conclusion.

i. Admissions

Patients entering the homes were expected to meet a number of criteria, some of which were common to each, and others which were peculiar to an individual institution. These regulations were set out in the annual reports for each of the homes. All three stipulated two fundamental qualifications for admission: patients had to be poor and certified by a registered medical practitioner as dying.³ Both requirements were, however, further qualified by the attachment of extra conditions. For example, at St Luke's House entry was made conditional upon a specific time limit. In December 1895, in an attempt to minimise the problem of having to care for inmates who were not in a dying condition, the Committee of Management agreed that patients must not be expected to live over four months. Any patient who was an inmate for over six months would be brought before the Committee to review their suitability.⁴ At both the Hostel of God and St Luke's the decision of eligibility rested ultimately with the head of the medical personnel; the Medical Officer and the Medical Superintendent respectively, but at St Joseph's the Mother Rectress appears to have had supreme authority. Eligible cases at St Luke's were admitted, as far as possible, in order of application but the Medical Superintendent had the power to grant priority to "especially suitable or deserving cases."⁵

The staff at all three homes were also concerned about the expense of removing deceased or discharged patients. Relatives and friends of inmates at St Luke's House were expected to sign an application form agreeing to remove the patient, at their own expense, either within twelve hours after notification of death by the Medical Superintendent or thirty-six hours after notification of discharge.⁶ In 1896, after complaints by the Matron about the frequent dilatoriness of friends and relatives in removing the deceased, a five shilling deposit was required on admission which

³ 'The Report of St Luke's House', taken from 6th West London Mission Annual Report (hereafter WLMAR), 1893, p.27 ; 'Application Form for Admission to St Joseph's Hospice for the Dying', Religious Sisters of Charity Generalate Archives (hereafter RSCG) ; Hostel of God Annual Report (hereafter HOGAR), 1896, p.6.

⁴ Minute Book of St Luke's House Committee of Management 15 Nov. 1895 - 19 July 1905: 06/12/1895.

⁵ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24 ; HOGAR, 1896, p.6 ; (hereafter SJHA), May 1915 to May 1921.

⁶ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24.

would then be confiscated if the deceased was not removed within the fixed number of hours.⁷ In 1911 it was obviously still felt necessary to impose a fine and payment was increased to nine shillings for all patients except those in extreme poverty, where the decision to charge the extra four shillings would be left to the discretion of the Medical Superintendent and the Matron.⁸ At the Hostel of God and St Joseph's the issue of expenses was not the same pressing concern it was at St Luke's. The annual reports for the Hostel of God simply stated that family and friends of patients were expected to give a guarantee to provide for the funeral expenses upon the patient's death,⁹ while the application form for St Joseph's was even less prescriptive; it merely said that patients found unsuitable after admission had to be removed at the expense of their friends.¹⁰

The homes were not only limited to a particular social class of patients, the poor, but were also confined to a specific section within that class. Only members of the 'respectable' poor, those whose poverty was due to circumstances beyond their control, were eligible for admission. Howard Barrett, the Medical Superintendent at St Luke's House, was particularly emphatic about this: "great care is taken to select the most respectable and deserving"¹¹ and he often elaborated on the types of patients who would fulfil these criteria:

"There are none to be so deeply pitied as these last people [the "working classes and middle classes who have fallen on their fortunes"], who have seen much better days, who are well educated, have worked hard and lived in comfort, and then perhaps, from no fault of their own, great losses take place or employment fails, and health and capability are gone. There are none who we welcome so cordially."¹²

Thus as well as the working classes the 'respectable poor' also included members of the middle classes who had "fallen on their fortunes."¹³ In cases where the character of the candidate might be in any way questionable Barrett felt testimonials as to their character and manners should be acquired. This particularly applied to labourers,

⁷ Minute Book of St Luke's House Committee of Management 15 Nov. 1895 - 19 July 1905: 27/03/1896.

⁸ Ibid: 17/10/1911.

⁹ HOGAR, 1896, p.6.

¹⁰ 'Application Form for Admission to St Joseph's Hospice for the Dying', [RSCG].

¹¹ 8th St Luke's House Annual Report (hereafter SLHAR), 1901, p.7.

¹² 6th SLHAR, 1899, p.11.

¹³ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, pp.6-8.

charwomen and laundresses, “amongst whom there were some very rough characters.”¹⁴ A further indication of the importance of moral considerations at St Luke’s can be found in the occasional remark in the Register on a particular patient’s ‘respectability’ or moral unsuitability. For example, a female patient in the home in 1900 was referred to as a “quiet sensible woman of the better class” who was “very bright and happy,” while another patient in 1910 was described as “an Infirmary class patient - as is so often the case with such patients he was dissatisfied with St Luke’s House.”¹⁵

The annual reports published by the Hostel of God also drew attention to the fact that their accommodation was confined specifically to members of the respectable poor:

“Sorry as we were to have to shut our doors upon the lowest class, still in view of the excellent accommodation provided for them in the infirmary, we felt that no real harm was done to them by confining ourselves to patients of a somewhat higher social standing, to whom the privacy of the Hostel has proved a great boon.”¹⁶

Similarly, the rescuing of the respectable poor from the prospect of dying in the workhouse formed an important part of the mandate at St Joseph’s. The list of rules attached to the application form stated that preference would be given to those who were “least suitable for the workhouse infirmary.”¹⁷

Those for whom provision was made under the Poor Law were not deemed suitable candidates for admission. Howard Barrett wrote: “We do not intend, however, to take in what we may call the regular pauper, even though dying. There are unfortunately an immense number for whom.....the parish infirmary *is* the proper place.”¹⁸ One of the questions on the second application form at St Luke’s specifically asked whether the patient had ever been in receipt of parish relief or an inmate of a parish infirmary.¹⁹ In the same way, those who could afford to secure the comforts and care provided by the

¹⁴ 15th SLHAR, 1908, p.21.

¹⁵ St Luke’s House Patient Case Books 25 September 1896 - 8 September 1904, No.179 ; 7 January 1909 - 16 October 1911, No.200.

¹⁶ HOGAR, 1895, p.3.

¹⁷ ‘Application Form for Admission to St Joseph’s Hospice for the Dying’, [RSCG].

¹⁸ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p.27.

¹⁹ Ibid., pp.6-8.

Home through their own means were inadmissible.²⁰ At St Joseph's Hospice the Sisters were less dogmatic about the issue of pauperism; there was no specific question on the application form asking if the patient had ever received Poor Law relief.

Applicants to the homes were not expected to procure a letter of admission, an often lengthy and difficult task which dogged many hospital applicants, the frequent failure of which would usually result in their inability to gain admission. However, inmates at all three homes were still expected to produce a reliable form of recommendation, which also served as means of confirming their respectability.²¹ At St Luke's and St Joseph's admission was a somewhat bureaucratic procedure. Applicants to St Luke's had to submit three application forms, the first of which was completed by a medical man and the third by the patients' friends or relatives. The second form contained questions about the patients' respectability and required the signature of the person recommending them.²² In order to receive an application form to St Joseph's Hospice, potential applicants had to first fill in a smaller form giving a few items of personal information and a brief indication as to the nature and prognosis of their disease. This form also had to be signed by the patient's doctor. The application form sent to successful candidates was divided into two sections; the first required personal information on the candidate and the name and address of their recommender. The second section contained questions about the patients' medical status and had to be filled in by their medical attendant. At the Hostel of God candidates had to send an application form to the Sister-in-Charge, together with a medical certificate confirming they were in a dying state. The patient was only admitted if the medical attendant was satisfied with the certificate.²³

The issue of eligibility was an ongoing concern at St Luke's House. At a meeting of the Committee of Management in November 1906 Howard Barrett drew attention to

²⁰ 24th SLHAR, 1912, p.36.

²¹ 7th SLHAR, 1899, pp.6-8 ; Farish, E. 'Report on the Hostel of God', 30 March 1894. Charity Organisation Society (hereafter COS) correspondence and papers, London Metropolitan Archives (hereafter LMA) ; HOGAR, 1897, p.3.

²² 7th SLHAR, 1899, pp.6-8 ; HOGAR, 1897, p.4.

²³ 'Application Form for Admission to St Joseph's Hospice for the Dying', [RSCG] ; *St Margaret's Magazine and Half-Yearly Chronicle*, (1899) Vol. V, No.8, pp.456-457.

the all too frequent need to investigate applicants because of the tendency of some relatives and friends to shirk all responsibilities and contributions. The admission of patients who Barrett felt were far more suited to the infirmary also gave cause for concern. In order to try and counter these problems the Charity Organisation Society agreed to undertake, free of charge, the task of investigating applicants to the Home.²⁴ In 1909 the problem of ineligible patients again came to the forefront when Miss Cook, a former West London Mission Sister and district nurse, described as being particularly knowledgeable about the London poor, agreed to visit applicants personally and to report back confidentially to the Medical Superintendent.²⁵

Over the years the number of admissions to the homes increased gradually (figure 1a). These generally corresponded to the various enlargements in accommodation that occurred as the homes changed premises or added extensions. Although St Luke's House had the smallest number of admissions when it first opened, by 1938, despite being the smallest of the three homes, it had twice as many admissions as the Hostel of God and over 25% more than St Joseph's. The high number of admissions was largely the result of the Home's policy of only accepting patients with less than four months to live. Likewise, the smaller number of admissions at St Joseph's in 1938, despite a greater number of beds, was due to the Sisters' willingness to accept more long-term patients. The sudden rise in admissions at St Luke's in 1925 (from 138 in 1920 to 275 in 1925) was partly due to the high number of deaths that occurred during that year (222), but also the increase in accommodation from 32 beds to 48 in 1924.²⁶ Similarly, the sudden increase in patients admitted to St Joseph's in 1925 was occasioned by the building of a large extension which enabled up to 75 patients to be accommodated.²⁷

²⁴ Minute Book of St Luke's House Committee of Management 11 October 1905 - 21 May 1912: 14/11/1906, pp.57-58.

²⁵ 17th SLHAR, 1910, p.18.

²⁶ 32nd SLHAR, 1925, p.4.

²⁷ SJHA, 1925.

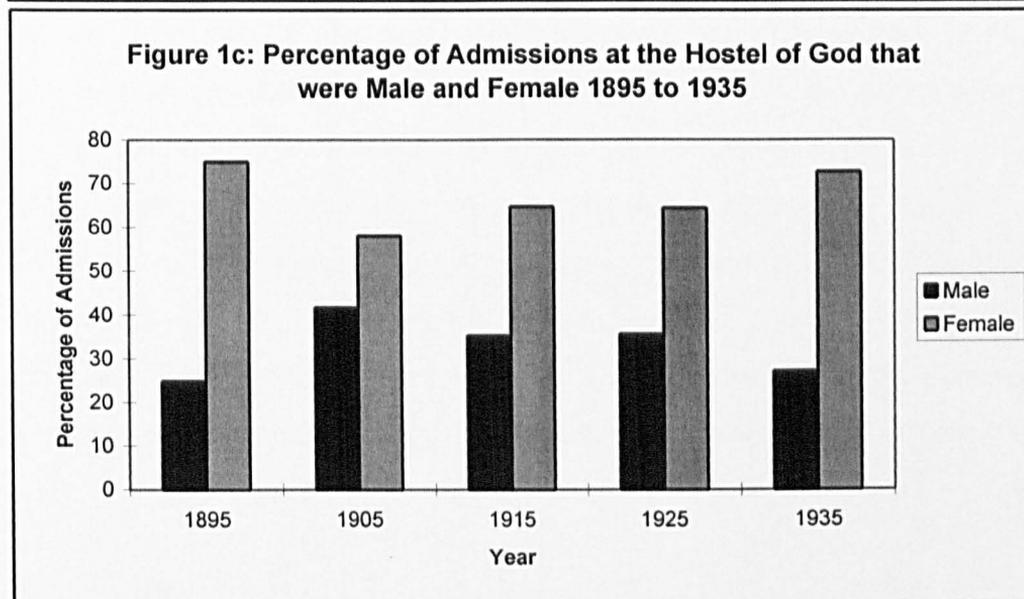
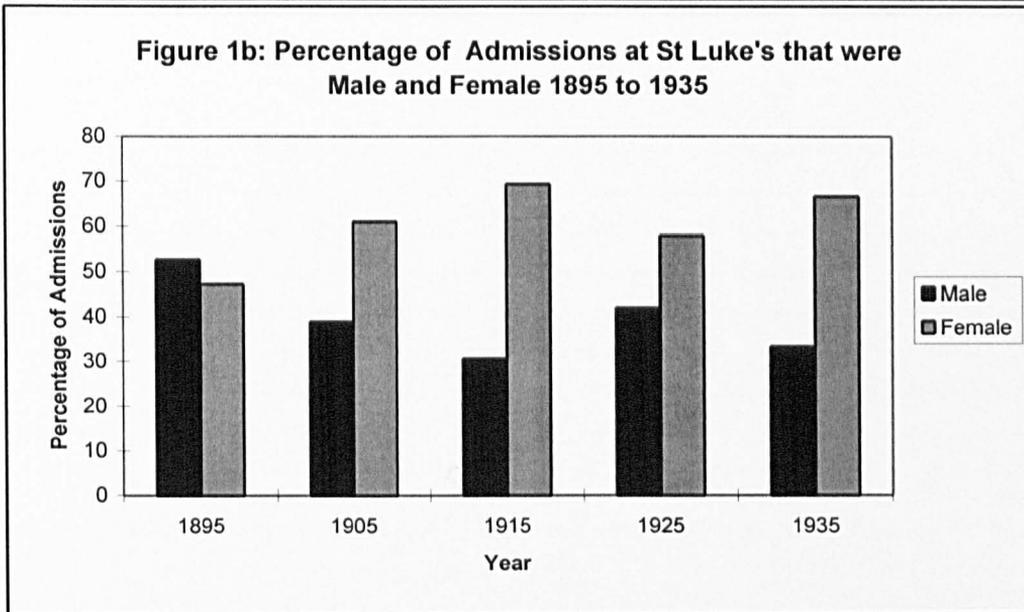
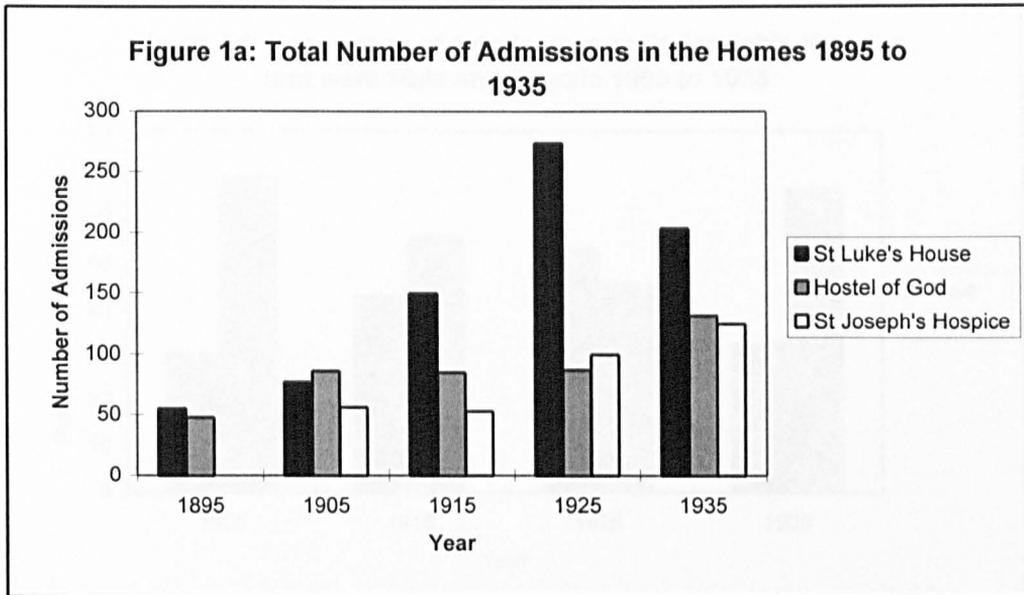
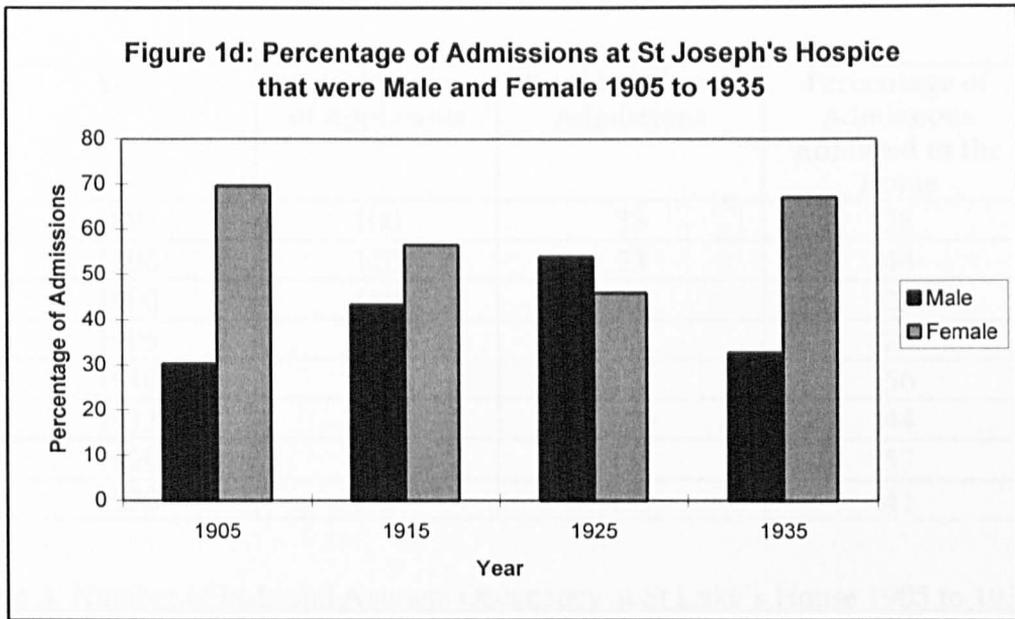


Figure 1d: Admissions



| Year | Total Number of Beds | Average Number of Beds Occupied |
|------|----------------------|---------------------------------|
| 1910 | 37 | 16 |
| 1915 | 37 | 30 |
| 1920 | 37 | 21 |
| 1925 | 38 | 28 |
| 1930 | 43 | 41 |
| 1935 | 44 | 23 |
| 1938 | 43 | 23 |

The average bed occupancy for 1910 was not given as there appears to have been the 1910 annual report.

St Luke's House was the only source that kept any records of the number of persons waiting windows, although the inability of the other two houses to accept all applicants was often cited as grounds for expanding their accommodation. Until 1972, the annual reports for St Luke's provided the number of applicants to the Home each year (Table 1). These figures suggest that very often less than half succeeded in gaining admission. The annual reports also indicated the average number of beds occupied after 1915. From Table 1 it can be seen that despite the high number of applicants each year beds were often left empty. The reason given in the report was

Table 2: Number of Admissions and Applicants to St Luke's House 1893 to 1922

| Year | Total Number of Applicants | Total Number of Admissions | Percentage of Admissions Admitted to the Home |
|------|----------------------------|----------------------------|---|
| 1893 | 100 | 38 | 38 |
| 1896 | 120 | 53 | 44 |
| 1900 | 159 | 37 | 23 |
| 1905 | 272 | 77 | 28 |
| 1910 | 307 | 171 | 56 |
| 1915 | 339 | 150 | 44 |
| 1920 | 243 | 138 | 57 |
| 1922 | 343 | 139 | 41 |

Table 3: Number of beds and Average Occupancy at St Luke's House 1905 to 1938

| Year | Total Number of Beds | Average Number of Beds Occupied |
|------|----------------------|---------------------------------|
| 1905 | 33 | 18 |
| 1910 | 36* | 30* |
| 1915 | 35 | 27.7 |
| 1920 | 30 | 28.4 |
| 1925 | 48 | 42.8 |
| 1930 | 48 | 44.1 |
| 1935 | 48 | 42.5 |
| 1938 | 48 | 39.3 |

* The average bed occupancy for 1910 was not given so these figures are taken from the 1911 annual report.

St Luke's House was the only home that left any records of the number of persons seeking admission, although the inability of the other two homes to accept all applicants was often cited as grounds for expanding their accommodation. Until 1922 the annual reports for St Luke's provided the number of applicants to the Home each year (Table 1). These figures suggest that very often less than half succeeded in gaining admission. The annual reports also included the average number of beds occupied after 1905. From Table 2 it can be seen that despite the high number of applicants each year beds were often left empty. The reason given in the reports was

that many potential patients were felt to be ineligible for admission, both socially and medically.²⁸

In all three homes women constituted a considerably higher proportion of admissions (figures 1b to 1d). This was primarily due to the fact that a larger number of beds were allocated to female patients. For example, in the 1900s sixteen of the twenty-five beds at the Hostel of God were set aside for female patients.²⁹ Likewise, nine out of the sixteen beds at St Luke's during the early years were for women.³⁰ The higher number of female patients suggests that many of these women would not have had anyone at home to care for them, whereas men could be nursed more easily by their wives. Howard Barrett also attributed the higher number of female patients at St Luke's House to their "greater liability to various forms of cancer."³¹ This belief in women's greater susceptibility to cancer reflected wider thinking among late nineteenth century physicians. Herbert Snow, a leading cancer expert, delivered a lecture at the Cancer Hospital in Brompton in February 1891 in which he discussed the proclivity of women to certain cancerous diseases and benign tumours, particularly cancers of the breast and uterus. He ascribed this tendency partly to women's more neurotic, emotional characters and the more stressful nature of their lives, and partly to the fact that these organs were rich in cells which were very sensitive to any form of irregularity or imbalance.³²

ii. The origins of patients

This section explores the social, economic and geographic background of the patients and their route of entry into the homes by posing three questions: [1] How did the patients come to be in the homes? ; [2] where did they come from? and [3] what was their social, religious and economic status? Information on patient origins was derived from a variety of sources. The patient registers at St Joseph's provided details on each

²⁸ 12th SLHAR, 1905, p.8.

²⁹ H. Kelly, 'Report of Visit to the Hostel of God (Free Home for the Dying) Clapham Common', 27 October 1908, p.1, [LMA].

³⁰ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24.

³¹ 15th SLHAR, 1908, p.14.

³² Snow, H. (1891) *The Proclivity of Women to Cancerous Diseases and Certain Benign Tumours*. London: J and A Churchill.

patient's religion and occupation. The column entitled "Recommenders" listed the person, institution or organisation responsible for sending them to the Hospice. At St Luke's information was available in both the patient registers and the annual reports. Each patient entry in the registers included a section under the heading "By Whom introduced" which largely corresponded to the information on patient "sources" contained in the reports, although the latter was divided up into specific categories (such as hospitals, charitable institutions), rather than the individual/s, institution or organisation provided in the registers. The latter also listed each patient's religion and occupation. Occasionally, the annual reports contained details of the former occupations of inmates and between 1896 and 1909 they provided statistical information on patients' religion. Information on the origins of patients at the Hostel of God was obtained from three sources: firstly, from occasional references in the annual reports to where the patients came from and their social, economic and geographical background; secondly, from the column in the patient registers detailing by whom the patient was recommended; and, thirdly, from observations made in the reports written by local secretaries of the Charity Organisation Society after visiting the Home.

The route through which patients entered the homes was closely linked to the principle of recommendation. It was not sufficient just to be diagnosed as dying; as well as procuring a medical certificate, patients had to provide evidence of moral suitability. The fact that all patients had to be recommended stemmed largely from concerns about issues of respectability and moral character. Sometimes the two requirements could be provided by one person, for example a doctor, but for the most part a separate recommender was needed to confirm moral suitability.

Patients at St Joseph's Hospice came from a variety of sources. The principal recommenders altered significantly over the years. The first half of the period was characterised by a high intake of patients from local religious groups. During the first few years after the Hospice opened the majority of patients were recommended by the "Sisters on Mission." These were Sisters who went out into the local communities of Hackney and Hoxton to seek out and minister to lapsed or careless members of the

Catholic poor.³³ The other most frequent recommenders during this period were ministers and priests, the great majority of whom were Catholic. Over the years the number of patients recommended by the Sisters on Mission and priests and ministers declined gradually.

After 1918 there was a gradual shift away from primarily religious sources to more secular ones. Between 1918 and 1920 a considerable number of male patients were sponsored by the Insurance Committee for the County of London, set up when the National Insurance Act came into force in 1911 to provide free medical treatment for insured workers. Most of these patients at St Joseph's were ex-servicemen who had contracted pulmonary tuberculosis.³⁴ This receipt of financial contributions from the public authorities represented the beginnings of a continuing relationship with the State. In 1921 National Insurance Act taxation ended and the county councils took over responsibility for treatment costs.³⁵ After 1923 the county councils of London and Essex became the principal recommenders of patients. As the years progressed they were responsible for an increasing number of admissions. The other major county councils recommending patients were Surrey, Buckingham, and Middlesex and, after 1927, local Borough Councils, particularly Hackney and East Ham, also sent a few advanced cases.

The early years at St Joseph's Hospice were also characterised by a higher percentage of patients sponsored by 'friends' or persons of a recognised social standing who could vouch for their character. Occasionally persons of very high social ranking were responsible for recommending a patient. Several were subscribers to the Hospice and the Sisters would have been obliged to accept those cases which they put forward for admission provided they fulfilled all the relevant criteria. In the majority of such instances the relationship between recommender and patient was probably one of employer and employee (or had been in the past) because many inmates from this source were recorded as having some form of domestic occupation. For example, in 1916, the Duchess of Bedford recommended a female servant.³⁶ Very few patients

³³ SJHA, 1905 ; *Hoxton Mission*, 1929 - 1935, p.2.

³⁴ SJHA, 1919.

³⁵ Smith, F.B. (1988) *The Retreat of Tuberculosis 1850-1950*. London: Croom Helm, pp.107-8.

³⁶ St Joseph's Hospice for the Dying Female Patient Register, January 1905 to May 1939.

were recorded as recommended by relatives, possibly due to the fact that in many instances the patient did not have any family or if there were any family members their social standing did not qualify them to apply for admission.

A relatively small number of patients were recommended directly by doctors, particularly during the early years when members of the medical profession were only listed as sponsoring one or two inmates. Although the proportion of patients recommended by doctors did increase very slowly, it was not until the 1930s that any significant change was evident. Between 1930 and 1938 doctors accounted for a comparatively higher proportion of patients than in earlier decades. For example, in 1907 only 2% of patients were recommended by doctors compared to 11% in 1938. The most frequently cited doctors were Dr James Harold, one of the honorary medical staff, Dr James Ross, the Catholic doctor attached to the Hospice until 1923 and Dr Arthur Ambrose, his successor.³⁷ Occasionally consumptive patients were recommended by a Medical Officer of Health. It is likely that these cases had been referred to their local Medical Officer as part of the process of compulsory notification of consumption which came into effect in the first decade of the twentieth century³⁸ and the Medical Officer would then have applied to the homes on their behalf.

Likewise, relatively few patients were admitted through the recommendation of hospitals but of those which did apply the majority were London based. During the early years they were only responsible for a minority of admissions but over the years this gradually altered so that by the 1930s they accounted for a higher percentage of patient recommenders. Between 1905 and 1910 only 7 of the patients admitted to the Hospice came through hospital recommendation, compared to 14% in 1935. The fact that very few of the doctors attached to the Hospice also worked at a voluntary hospital may help to explain why significantly fewer patients were recommended through this source than at the other two homes.

³⁷ SJHA, May 1915 to May 1921 ; 1923 ; 1924.

³⁸ Smith, *The Retreat of Tuberculosis*, p.69.

Several patients during the early years were admitted to St Joseph's from local Poor Law infirmaries. These were predominantly cases that the Sisters encountered during their mission visits to the local workhouses and infirmaries. The annals record various accounts of patients found dying in the Bethnal Green Infirmary and other similar institutions, who were subsequently removed to the Hospice.³⁹ These patients would have been admitted at the request of the Sisters rather than the infirmary and it is highly probable that some of the patients listed under the recommendation of the "Sisters on Mission" also came from this source. Many of these patients were cases that the Sisters felt would benefit from the spiritual atmosphere in the Hospice. Other institutions and organisations which recommended the occasional patient were the Charity Organisation Society, various nursing homes, tuberculosis dispensaries, and tuberculosis officers. A few patients were sponsored directly by local Boards of Guardians. However, as this thesis has shown, it is likely that a higher percentage of inmates than were actually recorded came from this source.

Although the official rhetoric of the Sisters of Charity emphasised that the Hospice was intended for the respectable poor, in practice they were prepared to adopt a more flexible admissions policy; both prostitutes, convicted criminals and others from the lower end of the social scale were admitted. This attitude formed part of the broader Catholic preoccupation with 'Holy Poverty', which rested upon a new tolerance of the poor and stemmed from the belief that the poor were Christ.⁴⁰ The Annals described two occasions when women imprisoned for murder were received as patients. Neither came through the recommendation of the prison authorities themselves; one patient was recommended by the Duchess of Bedford and the other by the chaplain of the prison.⁴¹

At St Luke's House, with the exception of the years 1898 to 1903, by far the largest proportion of patients came from the various London hospitals. Howard Barrett attributed this to the fact that the type of cases admitted to the Home occurred in a much higher percentage in hospitals than elsewhere.

³⁹ SJHA, 1900 - 1905 ; May 1905 - May 1909 ; May 1909 - May 1915.

⁴⁰ Gilley, S. (1971) Heretic London, holy poverty and the Irish poor, 1830 - 1870, *Downside Review*, Vol. 89, pp.64-65.

⁴¹ SJHA, May 1915 to May 1921.

“It is comparatively easy to keep a limited number of hospitals or their ward Sisters acquainted with our work, and our readiness to take their suitable cases; but a very slow and gradual manner to bring what we have to give to the knowledge of the community at large, especially that part of our community from which our patients are mostly drawn.”⁴²

From Table 3 it appears that the number of patients from the London hospitals gradually increased over the years. Although overall the greatest proportion of patients came from the general hospitals, the Brompton Hospital, the principal specialist hospital for tubercular cases, was, until the early 1920s, very often the largest individual contributor. However, as the number of tuberculosis patients in the Home declined, an increasingly smaller number of patients were received from this Hospital, so that by the 1930s it only sent a tiny minority of cases. All of the honorary consulting medical staff at the Home, and several of the Honorary Visiting Physicians, were attached to one or more of the major teaching and voluntary hospitals in the city which helps to explain why so many patients would have come through their recommendation.

Before 1903 the most frequent means by which patients were admitted to the Home was through “private application,” which included applications made by “friends interested in them,” district visitors or ministers of religion.⁴³ After 1903 these were listed in the annual reports as separate categories. In 1910 Howard Barrett defined “friends” as “those in a higher position who have interested themselves in the case,” but they also included family members.⁴⁴ In contrast to the percentage of inmates from hospitals, the proportion of patients recommended through ‘friends’ over the years declined gradually. Private doctors did not feature as a separate category until 1905. Although the proportion of patients derived from this source gradually increased before 1920, by 1925 it had fallen sharply and continued to do.

⁴² 4th SLHAR, taken from 10th WLMAR, 1897, p.7.

⁴³ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p.24 ;

⁴⁴ 19th SLHAR, 1910, p.12 ; 18th SLHAR, 1909, p.11.

Table 4: Patient Sources at St Luke's House 1895 to 1935

| SOURCE | 1895 | 1900 | 1905 | 1910 | 1915 | 1920 | 1925 | 1930 | 1935 |
|------------------------------------|------|------|------|------|------|------|------|------|------|
| London Hospitals | 44 | 10 | 34 | 42 | 58 | 49 | 58 | 61 | 64 |
| Private application | 30 | 38 | | | | | | | |
| Friends | | | 24 | 28 | 22 | 16 | 14 | 13 | 10 |
| Insurance Committee for London | | | | | 2 | 7 | | | |
| County Councils | | | | | | | 7 | 12 | 5 |
| Public Health Departments | | | | | | | 5 | 2 | |
| Private Doctors | | | 6 | 7 | 8 | 11 | 2 | | 1 |
| Ministers of Religion | | | 12 | 9 | 3 | 1 | | | |
| West London Mission | | | 7 | 1 | 1 | 1 | 1 | 1 | 1 |
| Missions and similar organisations | 8 | 23 | | | | | | | |
| Charity Organisation Society | | | 4 | 5 | 3 | | 2 | | |

Like St Joseph's Hospice, the period 1895 to 1935 saw a shift in the percentage of patients at St Luke's from religious-based sources. During the very early years ministers of religion, the West London Mission and other mission organisations were collectively responsible for recommending a relatively large number of patients. However, after 1905 they accounted for an ever smaller percentage of patients. In the annual report for 1909 Howard Barrett commented on the tiny minority of patients

sponsored by the clergy. He attributed the low numbers to the increasing demands upon their time and a corresponding decline in pastoral visitation.⁴⁵

As the number of admissions increased over the years so did the variety of sources from which the patients came. Other sources included nursing homes, relief committees, district nursing associations and dispensaries. However, most of these only accounted for a small number of patients, usually two or three each year. On occasion the Jewish Board of Guardians applied for admission, for example, in 1905 it recommended six patients.⁴⁶ Between 1914 and 1918 two organisations related to the War effort were responsible for sending several patients to the Home: the War Refuge Committee and the War Pensions Committee. A few patients also came through the recommendation of the 'Military Authorities'.⁴⁷ The War Pensions Committee continued to send cases for a few years after the war was over.

Patients recommended by the Insurance Committee of London were admitted several years earlier at St Luke's House than those who were sent to St Joseph's; the first patients to the House were admitted in 1913.⁴⁸ Initially the Committee of Management for the Home had decided that tuberculosis cases which came under the National Insurance Act would not be eligible for admission, despite repeated requests from the Commissioners to accept insured cases. However, in June of 1913, amidst concern about the recent fall in patient numbers, it was agreed that, on occasion, cases of advanced tuberculosis would be accepted provided they fell within the category of those patients for which the Home was founded. No payment was to be accepted because it was felt it would compromise their reputation as a 'pure charity' and undermine the basis of their appeal to the public for support.⁴⁹ The following month it was also agreed that patients with letters of recommendation from the Hospital Saturday Fund would be accepted provided that they qualified on medical grounds.⁵⁰

⁴⁵ 19th SLHAR, 1910, p.13.

⁴⁶ 15th SLHAR, 1906, p.20.

⁴⁷ 23rd SLHAR, 1914, p.17 ; 24th SLHAR, 1915, p.13 ; 25th SLHAR, 1917, p.11 ; 26th SLHAR, 1918, p.11.

⁴⁸ 21st SLHAR, 1914, p.16.

⁴⁹ Minute Book of St Luke's House Committee of Management 18 June 1912 - 27 May 1918: 22/04/1913 pp.44-45; 17/06/1913, p.63 ; 21st SLHAR, 1914, p.16..

⁵⁰ Minute Book of St Luke's House Committee of Management 18 June 1912 - 27 May 1918: 15/07/1913, pp.69-70.

The Home also accepted soldiers and sailors discharged from the Army and Navy because they had contracted tuberculosis during their service. Edmund Barrett, in his report for 1919, commented upon the difficult task which the local authorities faced in finding institutional provision for these men.⁵¹

The first patients recommended by county councils were admitted in 1921, the majority of which were tuberculosis cases.⁵² After 1920 patients were also recommended by the local public health departments.⁵³ Although by the late 1920s county councils and other public health departments accounted for the third largest source of patients after hospitals and private applications, the number of *tuberculosis* patients sent by public authorities had declined considerably. The Medical Superintendent attributed this to the fact that such authorities now provided an increasing amount of their own accommodation for advanced cases.⁵⁴ During the 1920s and 1930s there was a rise in the number of patients admitted to the Home suffering from cancer. Several of these were sent by recently founded cancer organisations in London; the Radium Institute, the Marie Curie Hospital, a voluntary cancer hospital for women, and the National Society for Cancer Relief.⁵⁵ The early 1920s also saw a small number of patients being sent by local businesses; presumably they were, or at one time had been, employees of these companies.

Although the Hostel of God Registers are available from 1927 onwards, they do not include information on where the patients came from until 1931. There are also many gaps in the records which make any statistical calculations impossible, particularly after 1935 when the person or institution recommending the case is left unfilled. However, it is still possible to draw a few conclusions on the basis of the information that is provided. The large majority of patients were recorded as being sent by the various London hospitals and it is reasonable to assume that they would also have been responsible for recommending a high proportion of those admitted before 1927.

⁵¹ 26th SLHAR, 1919, p.10.

⁵² 29th SLHAR, 1922, p.10.

⁵³ 28th SLHAR, 1921, p.9.

⁵⁴ Minute Book of St Luke's Hospital for Advanced Cases Committee of Management, 30 April 1925-26 February 1931: 06/12/1927, p.164.

⁵⁵ 43rd SLHAR, 1936, p.10 ; 34th SLHAR, 1926, p.9.

Like St Luke's House, many of the consultant medical staff worked at the major voluntary and teaching hospitals and would have been responsible for making the work of the Home known to them. The other most frequently mentioned sources were ministers, doctors and private applications by individuals on behalf of the patients. Unlike the other two homes, virtually no patients appear to have been recommended by the local authorities, suggesting that it was more successful in retaining a voluntary basis. The balance sheets in the annual reports confirm this; the large majority of income was received from subscriptions and donations, legacies and dividends from invested property.

The annual report for 1895 also gave a list of some of the sources from which the patients came and as such provides an insight into how inmates came to be in the Home during the early years. Those included were the Charity Organisation Society, local infirmaries, ministers of religion, various local mission organisations and relief committees, the North London Nursing Association, Chatham and Dover Railway Works and several of the London hospitals.⁵⁶

Over the years a few patients came through the recommendation of the Hospital Saturday Fund, various Poor Law Guardians, tuberculosis dispensaries, the Mother House at East Grinstead and other mission and convent organisations.⁵⁷ The 1934 annual report referred to patients who were sent by the London Cancer Clinics which are possibly the same as those mentioned above for St Luke's.⁵⁸ One patient was even admitted through royal recommendation. The 1917 issue of *St Margaret's Magazine and Half-Yearly Chronicle* recorded that a Guardsman, in whom Queen Alexandra was "deeply interested," had been admitted at her direct request. Another patient, in 1933, was recommended by HM Prison, Holloway but it is unclear whether he was an inmate or an employee of the prison because the registers do not contain any information on occupations.⁵⁹

⁵⁶ HOGAR, 1895, p.5.

⁵⁷ Letter from the Sister-In-Charge, 10 June 1896, COS correspondence and papers, [LMA].

⁵⁸ HOGAR, 1933, p.10.

⁵⁹ Hostel of God Patient Register January 1927 to June 1942.

A few patient exchanges occurred between the three homes themselves as well as with the other two homes for the dying in London, the Friedenheim in Hampstead and the Home of the Compassion of Jesus in Thames Ditton. Two of the patients admitted to St Joseph's were recommended by the Matron at St Luke's House, one in 1908 and the other in 1923, while in 1927 a chronic female patient was discharged from the Hostel of God and sent to the Home of Compassion.⁶⁰ The relationship between St Luke's House and the Friedenheim was more closely developed because of their closer proximity. Over the years they each sent and received a number of patients. For example, in 1911 four of the patients admitted to St Luke's came from the Friedenheim.⁶¹

It would appear then that the homes for the dying began life as small local community-based institutions, largely reliant upon local ministers and mission-based organisations as a source of patient recommendation. Over the years, as they gradually became established, they were assimilated into the wider networks of medical provision in London. St Luke's House and the Hostel of God appear to have become integrated into the London hospital system, while St Joseph's was incorporated into local government networks of provision. Hospital referrals of dying patients to the homes would have enabled them to free up beds for acute cases. The annual report of St Luke's House for 1915 described the Home as a "supplement" to the hospitals.⁶² The 1920s and 1930s was also a time of increasing financial crisis for the voluntary hospitals which may further help to explain why two of the homes received so many hospital referrals.

At St Joseph's Hospice a much higher proportion of patients came through public authority recommendation; in 1935 the latter contributed £649 towards the cost of these patients. The Hospice also received money from the Hospital Savings Association, a contributory scheme, but it accounted for a considerably smaller sum (£240 in 1935).⁶³ St Luke's too was reliant upon funding from public authorities but

⁶⁰ St Joseph's Hospice for the Dying Female Patient Register, January 1905 to May 1939 ; Hostel of God Patient Register January 1927 to June 1942.

⁶¹ 21st SLHAR, 1912, p.13.

⁶² 23rd SLHAR, 1916, pp.9, 11.

⁶³ 'Report for St Joseph's Hospice for the Dying 1935', pp.14-15.

to a lesser extent than St Joseph's. Unlike the Hospice, it was far more dependent upon patient payments, particularly in the form of contributory schemes. In 1938 a total of £1,855 came from patient payments, £765 in the form of direct payments and £1,090 from various contributory schemes.⁶⁴ The changing philanthropic basis of these two homes was part of wider changes that were taking place, many of which were shaped by developments in the voluntary hospitals. During the early twentieth century, as a result of overcrowding, inefficiency and abuse, the voluntary basis of many hospitals became more and more tenuous and they found themselves in a position of having to rely upon contributory schemes (such as the Hospital Savings Association and Hospital Saturday Fund) and public authority funding.⁶⁵ However, given that St Joseph's was by far the wealthiest of the three homes and had little difficulty in generating income, its willingness to accept state funding suggests a deliberate choice on its part to incorporate itself into public authority networks of medical provision, perhaps as way to heighten its status. By contrast, St Luke's dependence upon patient payments and contributory schemes was a response to the growing financial difficulties it experienced in the early decades of the twentieth century, and was thus more characteristic of developments within the voluntary hospitals. The Hostel of God appears to have been less interested in cultivating links with the public authorities, concentrating instead on developing a close relationship with the London hospitals and the retention of its voluntary basis.

a. Geographical distribution

At both St Joseph's Hospice and the Hostel of God admission was open to patients of all nationalities and from all geographical areas. Although the majority of inmates came from London and its environs, patients from more distant parts of England were also received. Several foreign patients or patients of foreign origin applied for admission over the years. The annual reports for the Hostel of God made reference to patients from Denmark, Germany and Poland.⁶⁶ St Joseph's also accepted patients

⁶⁴ 46th SLHAR, 1939, pp.24-25.

⁶⁵ Cherry, S. (1996) Accountability, entitlement, and control issues and voluntary hospital funding c1860-1939, *Social History of Medicine*, Vol.9, No.2, pp.218-219. See chapter one for a more detailed discussion of this.

⁶⁶ HOGAR 1897, p.10 ; 1920, p.4.

from as far afield as Australia and America and during the War a number of Belgian refugees were inmates.⁶⁷

The Sisters of Charity appear to have made a special point of reaching out to displaced persons, especially immigrants. Many of the patients at the Hospice, particularly during the early years, were of Irish descent. The high proportion of Irish names in the Registers for this period reflected the Sisters of Charity special "Mission" to the Irish Catholic poor, many of whom, it was felt, had drifted away from their faith. The annual report for 1907 recorded that over half of the patients admitted that year came from Hackney and the neighbouring district of Shoreditch.⁶⁸ Many of these patients would have been impoverished immigrants who had come to London after the famine and subsequently congregated in the slums of the East End. By the 1930s the patient catchment area for the Hospice had substantially altered. Most patients still came from London but the number of inmates from each district showed a more even distribution.⁶⁹ The changing geographical basis of the Hospice may have been due, in part, to the declining number of Irish immigrants coming to London by the beginning of the twentieth century.⁷⁰ It also reflected the growing number of patients being sent there by the local authorities.

In contrast, the patient catchment area at St Luke's House was more formally delineated. The admissions policy stated that only the poor of London and its immediate environs would be accepted, hence the large number of admissions from London hospitals and London, Surrey and Essex County Councils. The reasoning behind this, according to Howard Barrett, was three-fold: firstly, the practical difficulties of conveying seriously ill persons over long distances and the possibility of having to restore them to their homes rendered it necessary that patients live within driving distance; secondly, the condition of the London poor was felt to be more urgent and distressing and thirdly, the number of eligible cases was far higher than

⁶⁷ SJHA, May 1915 to May 1921 ; 1926, p.3.

⁶⁸ 'St Joseph's Hospice for the Dying Poor Report 1907', p.7.

⁶⁹ 'Report for Joseph's Hospice for the Dying 1935', p.4.

⁷⁰ Gilley, S. (1969) *The Roman Catholic mission to the Irish in London, 1840 - 1860, Recusant History*, Vol.10, p.138.

those in the country.⁷¹ In his report for 1913 Edmund Barrett wrote that most of the patients came from the East End and the poorer suburbs.⁷² Occasionally this policy was relaxed, for example, during the war two Belgian women and a few Russians and Romanians were inmates of the Home.⁷³

b. Occupations

The patient registers for St Joseph's and St Luke's both recorded the patient's occupation. An examination of this information suggests that virtually all of the patients at St Joseph's came from the lower middle or working classes. Most of the occupations given were those that could be clearly linked to a particular trade (see Table 4). Several male patients were simply recorded as 'labourers'; denoting unskilled, seasonal or casual workers. Likewise, the frequent use of the term 'domestic' to describe the occupations of some of the female patients would have been used to cover a number of different forms of domestic service.

The list of occupations for patients at St Luke's House in 1905 was very similar in content to those recorded in patient registers for St Joseph's, suggesting that the patients came largely from the same social and economic background. Many of the patients who were inmates at the two homes during the years when tuberculosis was the principal cause of death were employed in occupations which were notably high risk; tailors, seamstresses, clerks, printers, drapers, bookbinders, masons, shoemakers and bakers.⁷⁴ The occupation of patients at St Luke's was also recorded in the annual reports for the early years. Howard Barrett wrote that the reason for including this information was to demonstrate more clearly the class from which inmates came.⁷⁵ As such it represented a further way of reinforcing the ideology of the Home.

⁷¹ 6th SLHAR, 1899, p.11-12.

⁷² 21st SLHAR, 1914, p.13.

⁷³ 24th SLHAR, 1915, p.4.

⁷⁴ Hardy, A. (1993) *The Epidemic Streets*. Oxford: Clarendon Press, pp.246-249 ; Dormandy, T. (1999) *The White Death: A History of Tuberculosis*. London: The Hambledon Press, p.82.

⁷⁵ 4th SLHAR, taken from 10th WLMAR, 1897, p.7.

Table 5: List of Occupations of Male and Female Patients at St Joseph's Hospice and St Luke's House, 1905

| ST JOSEPH'S HOSPICE | | ST LUKE'S HOUSE | |
|---------------------|-----------------------|-------------------------|---------------|
| MALE | FEMALE | MALE | FEMALE |
| 4 clerks | 4 servants | 3 clerks | 5 servants |
| tram driver | 3 industrial children | 2 storekeepers | 4 nurses |
| mechanical engineer | 3 labourers' wives | cab driver | 3 teachers |
| labourer | 2 tailoresses | manservant | 2 tailoresses |
| worker in bamboo | 2 housekeepers | Midland Railway checker | 2 machinists |
| porter | seamstress | foreman | laundryworker |
| tailor | needleworker | driver | lacemaker |
| smith | charwoman | finisher | maid |
| designer | lady's maid | shop assistant | cook |
| horsehair dresser | news agent | electrician | housekeeper |
| engineer | carman's wife | caretaker & clerk | greengrocer |
| polisher | distressed lady | errands boy | 13 not given |
| 2 not given | widow | painter | |
| | teacher | estate agent | |
| | hairdresser | Fusilier | |
| | various | sweep | |
| | coster | house decorator | |
| | governess | waiter | |
| | boot-fitter | timekeeper | |
| | painter's wife | printer | |
| | rope makers wife | compositor | |
| | nurse | 3 not given | |
| | no employment | | |
| | 2 not given | | |

The Hostel of God registers do not provide information on the former occupation of inmates; the only information was contained in the annual reports. Each year several masons, soldiers and sailors were patients in the home. The 'Waterloo Bed' and the 'Nelson Bed' were set aside for members of the army and navy, while a special bed, known as the 'Clarence Bed' was reserved for members of Masonic lodges and their families.⁷⁶ During the War a substantially higher number of soldiers than normal were

⁷⁶ HOGAR, 1897, pp.12-13.

patients in the Home. For example, in 1917 the Home admitted 15 soldiers, as compared to 3 in 1912.⁷⁷ The annual report for 1895 provided a list of some of the occupations of inmates. Those mentioned were all forms of employment associated with the middle and lower middle classes, for example, nurses, musical composer, artist, policeman. It may have been that the Hostel of God, whilst still accepting the 'respectable' working class, gave priority to members of the middle classes who had fallen on hard times.⁷⁸

iii. Religious affiliation of inmates

All three homes advertised themselves as open to patients of any or no denomination.⁷⁹ However, each institution showed its own denominational bias. Statistical information on religion is contained in the patient registers for St Luke's House and St Joseph's Hospice but it has two principal limitations; firstly, it is not possible to know, at what stage of the patient's stay it was recorded, although presumably it corresponds to what patients filled in on their application forms, and secondly, it does not reveal whether the patient was a practising or nominal member of that religion.

Figure 2 shows that by far the largest proportion of patients admitted to St Joseph's Hospice were recorded as being Catholic. This trend was particularly accentuated before 1925 and was largely due to the Sisters of Charity's mission work among the local Catholic population and the priority given to Catholic patients.⁸⁰ Between 1905 and 1915 the percentage of Catholic admissions remained consistently high but after 1920 the numbers began to drop. There was a slight increase between 1925 and 1930 after which they levelled off before starting to decline again. In contrast the proportion of Anglican patients was very small before 1920 (between 1% and 9%). However, by 1925 it had begun to increase. The particularly marked rise between 1920 and 1925 was, in part, caused by the substantial increase in accommodation created by the new

⁷⁷ HOGAR, 1912, p.4 ; 1917, p.4.

⁷⁸ HOGAR, 1895, p.5.

⁷⁹ 6th WLMAR, 1893, p.24 ; 24th SLHAR, 1912, p.36 ; Author and title unknown, *Daily Graphic*, 11 October 1913.

⁸⁰ 'A London Gate to Heaven', reprinted c1919 from the *Ave Maria*, p.8, [RSCG].

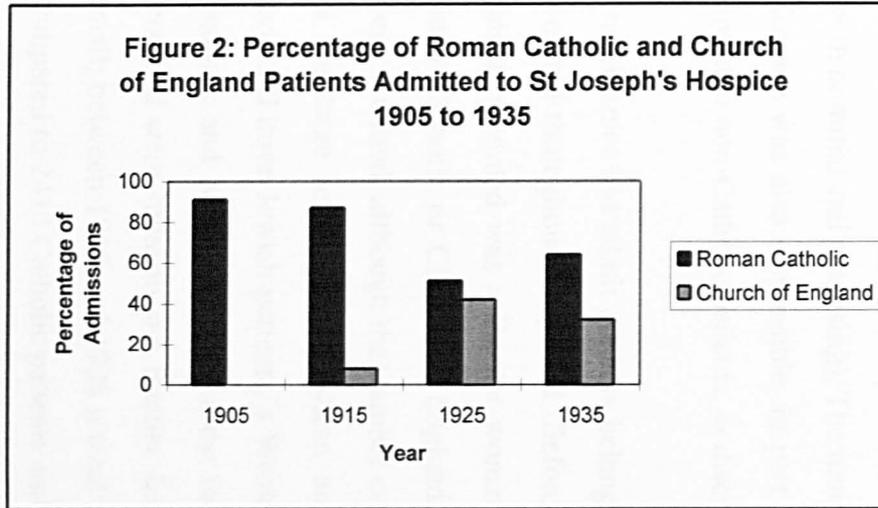


Table 4: Percentage of Patients Admitted to St Luke's House Belonging to Each Religion 1895 to 1938

| YEAR | TOTAL NO. PATIENTS | CHURCH OF ENGLAND | ROMAN CATHOLIC | WESLYAN/METHODIST | JEWISH | BAPTIST | CONGREGATIONALISTS | PRESBYTERIANS | OTHER FREE CHURCHES |
|------|--------------------|-------------------|----------------|-------------------|--------|---------|--------------------|---------------|---------------------|
| 1895 | 55 | 69 | 10 | 4 | 2 | 4 | 4 | 0 | |
| 1900 | 39 | 72 | 8 | 5 | 3 | 0 | 3 | 3 | 1 |
| 1905 | 77 | 71 | 4 | 13 | 0 | 4 | 5 | 8 | |
| 1910 | 171 | 75 | 6 | 3 | 2 | 3 | 2 | 0 | |
| 1915 | 150 | 78 | 7 | 0 | 4 | 2 | 0 | 0 | |
| 1920 | 137 | 77 | 11 | 6 | 1 | 0 | 0 | 1 | |
| 1925 | 274 | 76 | 7 | 3 | 3 | 1 | 1 | 1 | 1 |
| 1930 | 186 | 77 | 8 | 3 | 1 | 1 | 1 | 2 | |
| 1935 | 204 | 81 | 5 | 2 | 1 | 2 | 0 | 1 | 3 |
| 1938 | 215 | 71 | 6 | 1 | 2 | 2 | 1 | 0 | 2 |

extension, but it might also relate to the declining number of Irish immigrants (most of whom were lapsed Catholics) coming in to London by the early decades of the twentieth century⁸¹ and the changing means by which the patients came to the Hospice. By the early 1920s the number of patients recommended by the Sisters on Mission and Catholic priests had begun to drop. These two groups, in their mission work among the local Catholic population, would have come across large numbers of potential patients. After 1920, however, the gradual increase in the number of patients sent by the local authorities meant that there would have been a higher intake of patients whose selection would not necessarily have been based upon their religious affiliation and would inevitably have included a larger percentage of Anglican patients (both nominal and practising). The transition from Catholic to Anglican patients in the Hospice was also responsible, in part, for the shift in the focus of the annals from lapsed to non-Catholic patients, as discussed in the previous chapter.

The Hospice did admit patients belonging to other denominations but numbers were minimal throughout the period. Before 1914 the only non-Catholic or non-Anglican patient recorded was a Baptist woman in 1906. Until 1919 all male patients were either Catholic or Church of England. After 1920 a growing diversity of religions were admitted, although the number continued to remain small. By 1930, in addition to the large number of Anglican and Catholic patients, the admissions register recorded three Jewish patients, a Wesleyan, a Baptist and a Presbyterian. Aside from Catholic and Anglican patients, the two religions or denominations most frequently recorded were Judaism and Baptist, but the numbers of adherents was still relatively small; between 1905 and 1938 a total of only 16 Jews and 15 Baptists was admitted compared to 2413 Catholic patients and 920 Anglican.

Information on the religion of patients at St Luke's House is contained in the patient registers and the annual reports. The information in the reports was only provided for the years 1897 to 1910, but the data in the registers was consistent throughout the period. Table 6 gives the number of patients belonging to each religion as a percentage of the total patient population in the Home each year. It can be seen that

⁸¹ Gilley, 'The Roman Catholic mission', p.138.

the large majority of patients was described as Church of England. The greater diversity of denominations from early on in the history of the Home reflected its non-sectarian basis. Howard Barrett wrote that the reason for the high numbers of Anglican patients was that many who were not especially devoted to any doctrine or form of worship said they belonged to the Church of England in order to be able to place themselves somewhere.⁸² “When asked to which Church they belong, sooner than acknowledge irreligion or indifference they naturally affiliate themselves to the Church of England.”⁸³ He went on to add that the Church of England had a much higher percentage of “really poor” members than the Free Churches which were predominantly composed of the middle classes.⁸⁴ Barrett’s observations reflected the wider attitudes of many of his contemporaries. Charles Booth in his study of London also noted that the Nonconformist churches were primarily made up of the middle classes.⁸⁵

The annual reports for the Hostel of God also seem to indicate a preponderance of Church of England patients, particularly among the women. Some of the reports by the Chaplain provide statistical information on the number of communicants, Baptisms and Confirmations each year. According to his data the proportion of female Anglican patients was particularly high, especially during the later years. For example, he noted that 16 of the 33 male patients in the Home in 1917 had been Communicants and 38 of the 64 female inmates.⁸⁶ In 1926 he reported that 84 communions took place in the male wards and 290 in the female wards.⁸⁷

iv. Patient ages

The data on patient ages was divided up into age ranges in order to determine any evidence of changing patterns over the years. Unfortunately, the Hostel of God records only contain information on the ages of patients up until 1914, so it was only possible

⁸² 4th SLHAR, taken from 10th WLMAR, 1897, p.7.

⁸³ 13th SLHAR, 1906, p.22.

⁸⁴ Ibid.

⁸⁵ Booth, C. (1904) *Life and Labour of the People in London*. London: Macmillan and Co. Ltd, 3rd series, p.396.

⁸⁶ HOGAR, 1917, pp.5-6.

⁸⁷ HOGAR, 1926, p.5.

to carry out a three-way comparison of the homes until this year. The patient registers for St Joseph's and St Luke's provide information on patients' ages throughout the period so some tentative suggestions have been made for the remaining years on the basis of my analysis of these.

The age ranges for the total patient population in each of the homes are shown in figures 3a to 3e. There appears to have been an identifiable change over the years in the ages of patients. Figure 3a suggests that in 1895 the majority of patients admitted to the Hostel of God were under 50 years of age. However, between 1906 and 1914 this began slowly to alter as a growing number of older patients entered the Home. By 1914 a slightly larger percentage of patients than in the earlier years was over 50 years old. Figures 3a to 3e suggest that a similar transition occurred at St Luke's House; by 1915 the percentage of patients over the age of 50 showed a discernible increase. The figures for St Joseph's (3b to 3e) also depict a change in the ages of inmates but suggest that the shift from younger to older patients occurred at a slightly later date. From 1905 to 1925 most patients were under 50 years of age (over 60%). After 1925 the percentage of patients over 50 years old slowly began to increase while the percentage of younger patients began to fall so that by 1935 69% of patients were aged 51 and above. It is thus reasonable to conjecture that the transition to a larger intake of older patients at the Hostel of God would have continued throughout the rest of the period.

A comparison of the ages of male and female admissions to the three homes (figures 3f to 3q) suggests that during the early years there was generally a higher percentage of male patients under the age of 50, particularly at St Luke's House. The transition from younger to older patients at St Joseph's, both male and female, became apparent after 1925. However, the shift in the age of patients at St Luke's House showed a discernible difference for the male and female populations. The percentage of women over the age of 50 began to increase after 1905, while that for men only began to rise noticeably after 1925. By 1935 the percentage of men and women over 50 years of age, particularly the former, at both St Joseph's and St Luke's, contrasted significantly with the very early years of their history.

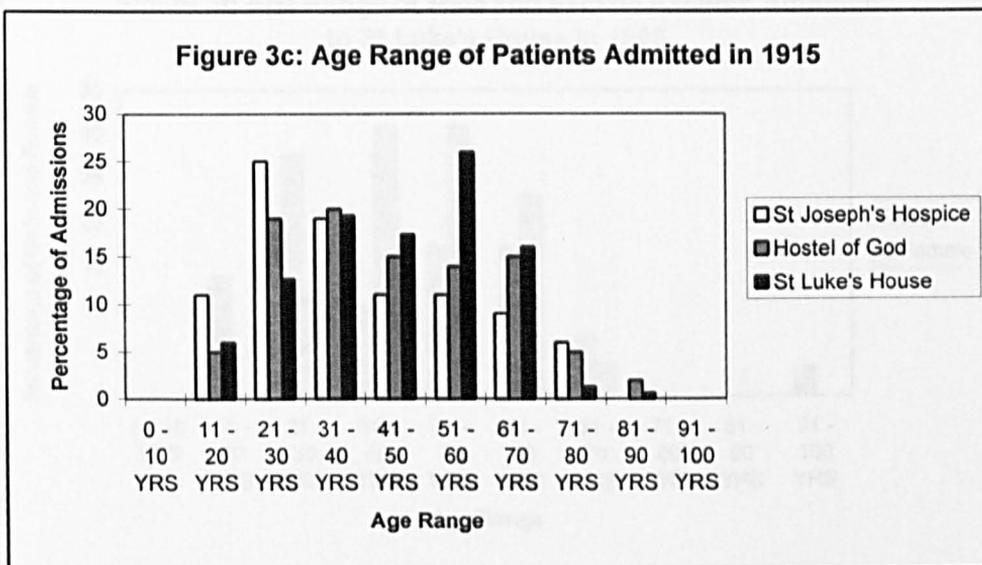
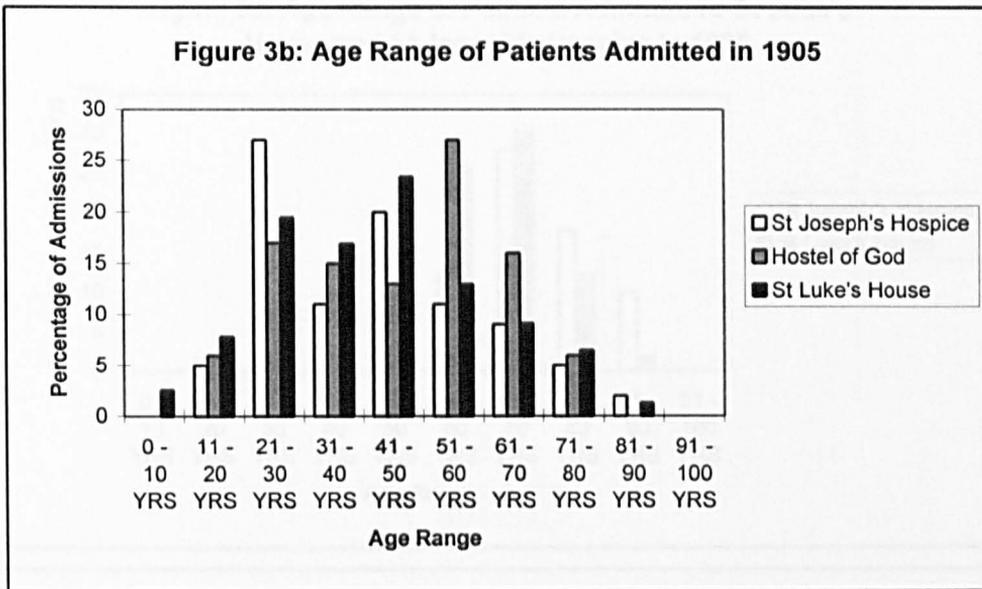
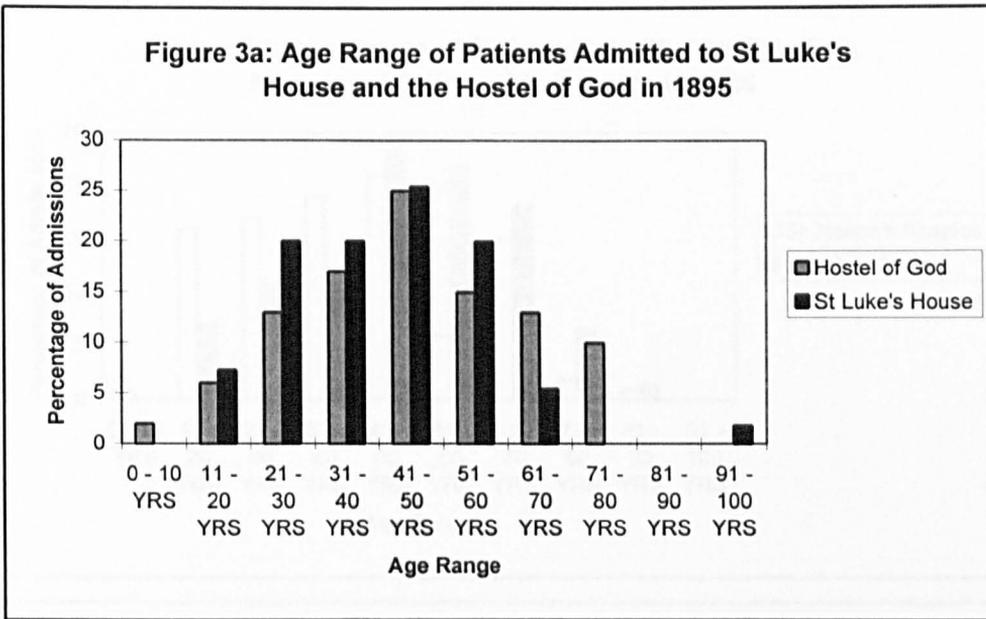


Figure 3d: Age Range of Patients Admitted to St Luke's House and St Joseph's Hospice in 1925

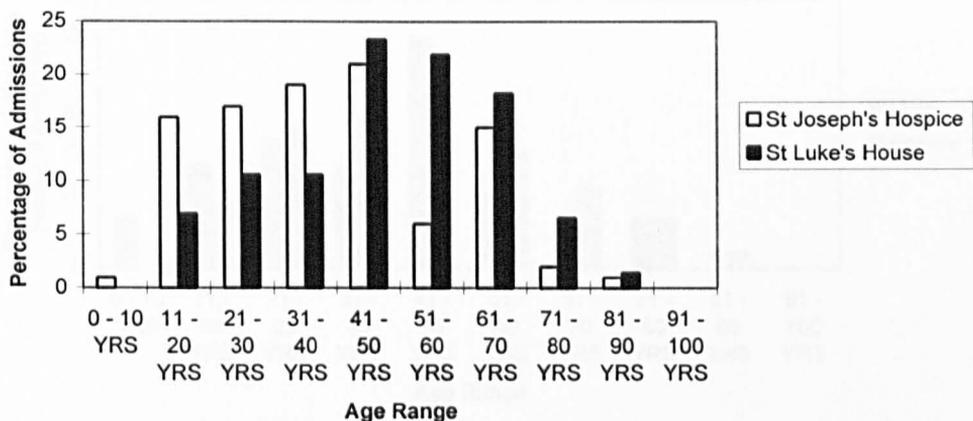


Figure 3e: Age Range of Patients Admitted to St Luke's House and St Joseph's Hospice in 1935

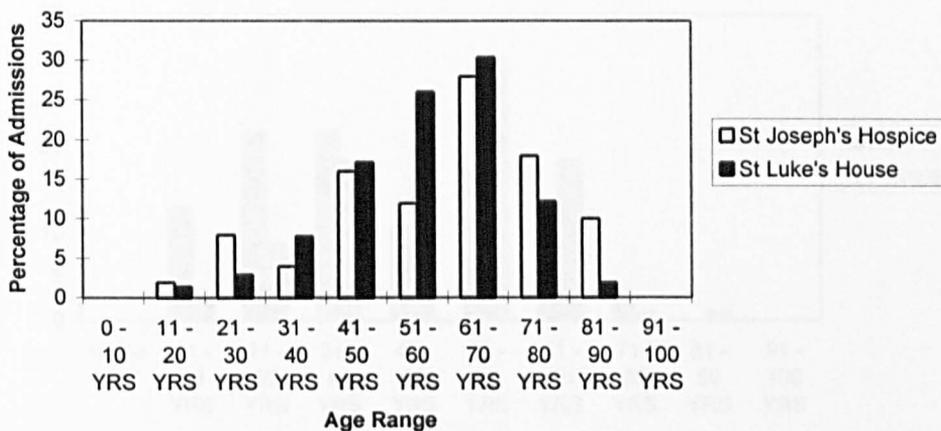
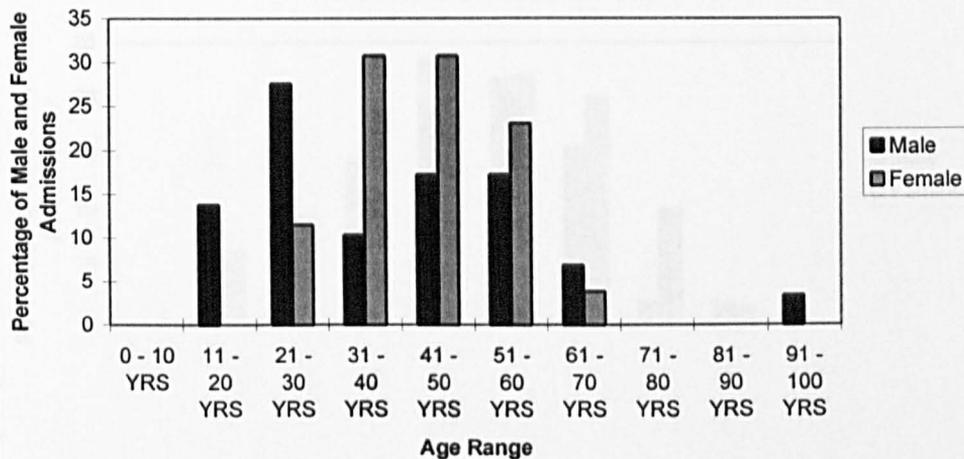
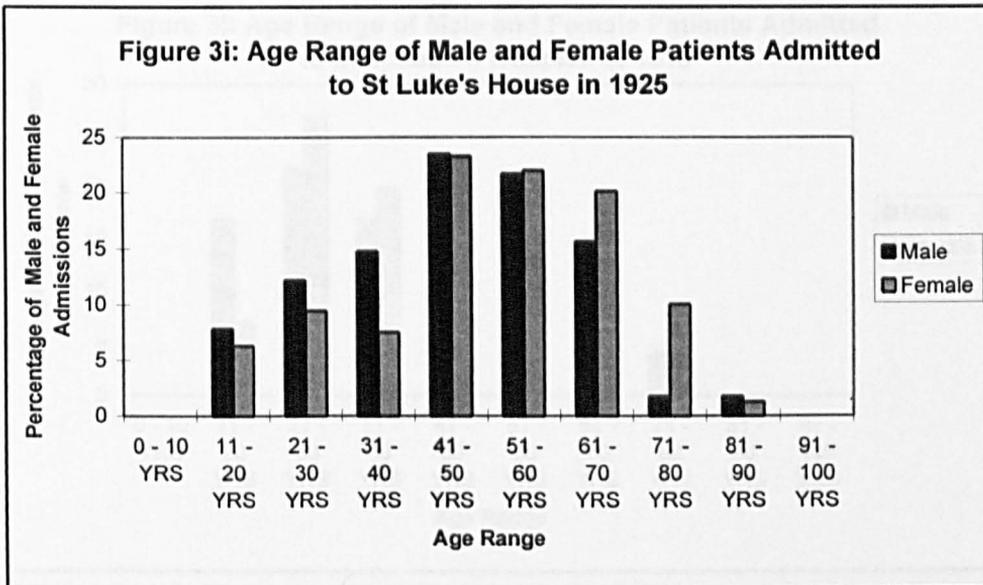
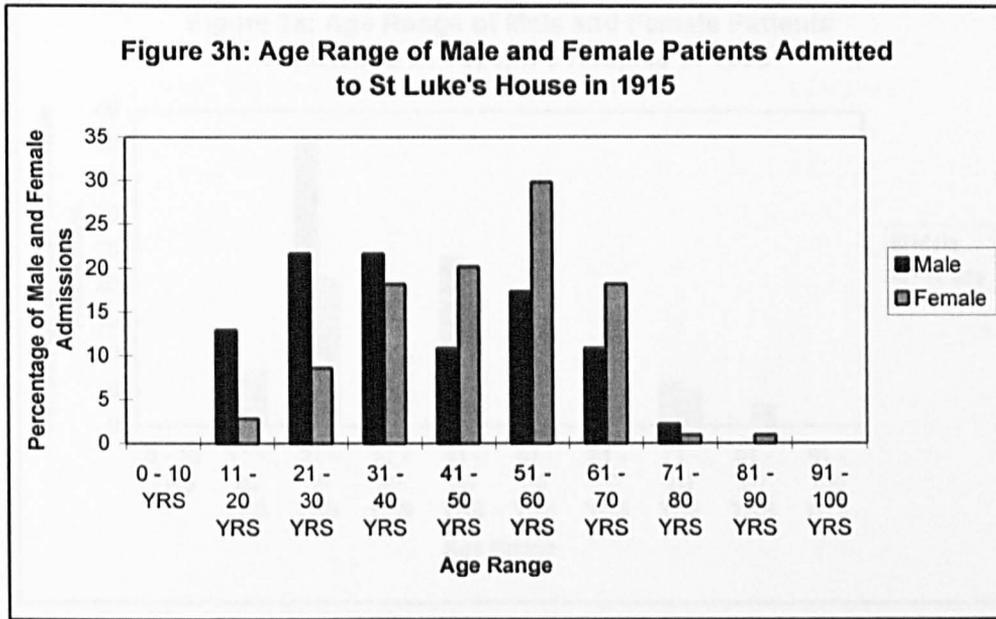
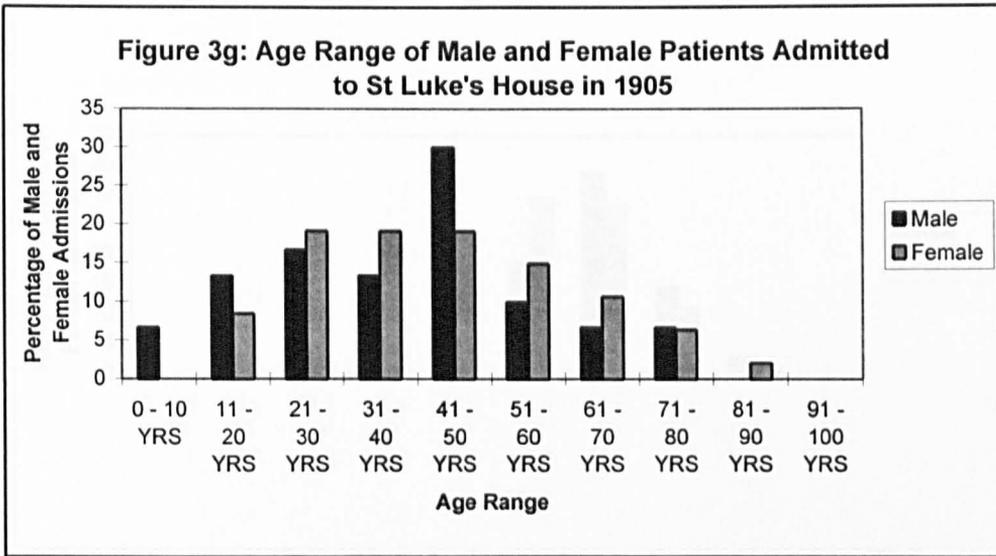


Figure 3f: Age Range of Male and Female Patients Admitted to St Luke's House in 1895





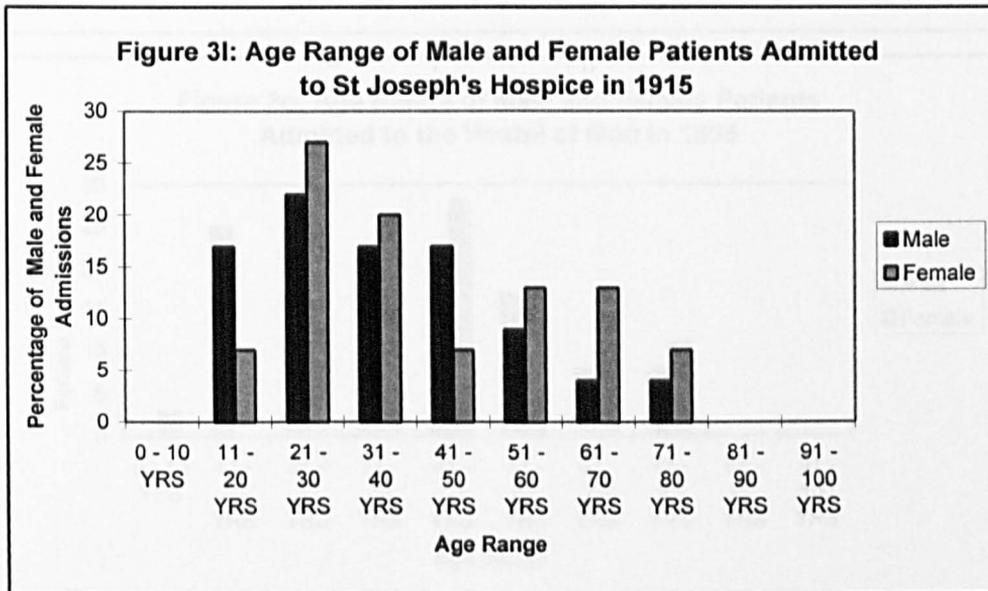
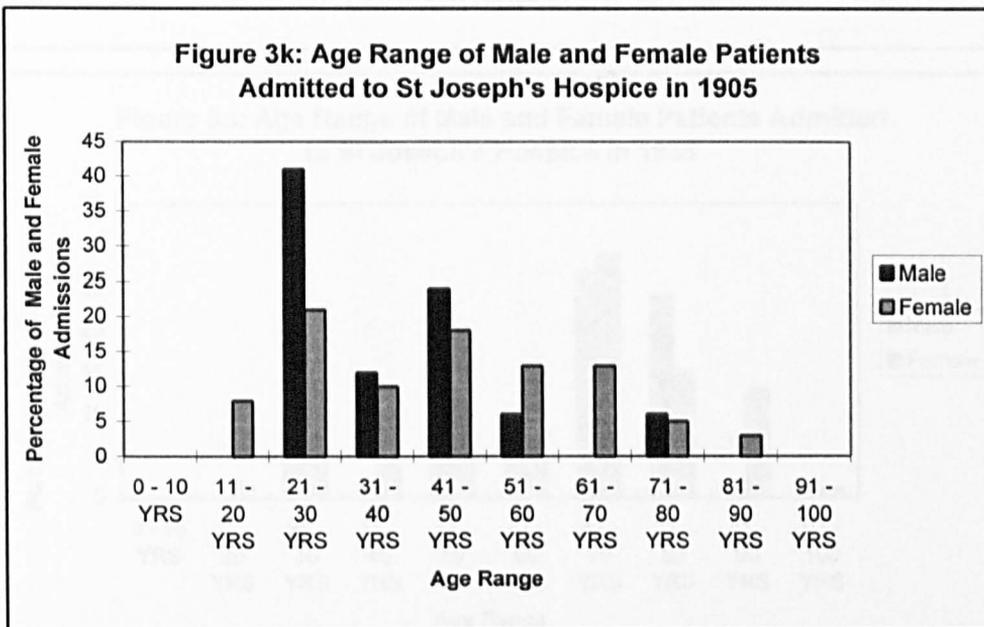
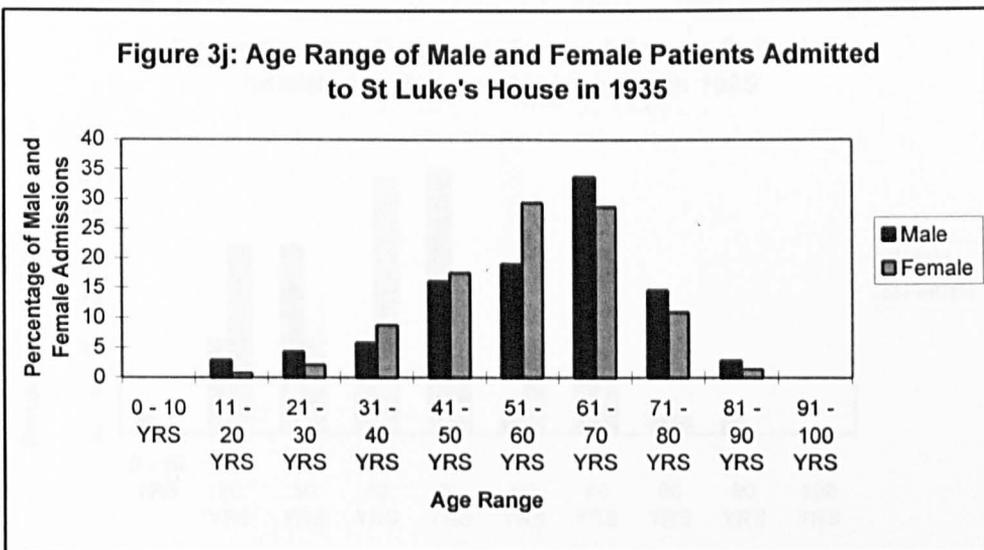


Figure 3m: Age Range of Male and Female Patients Admitted to St Joseph's Hospice in 1925

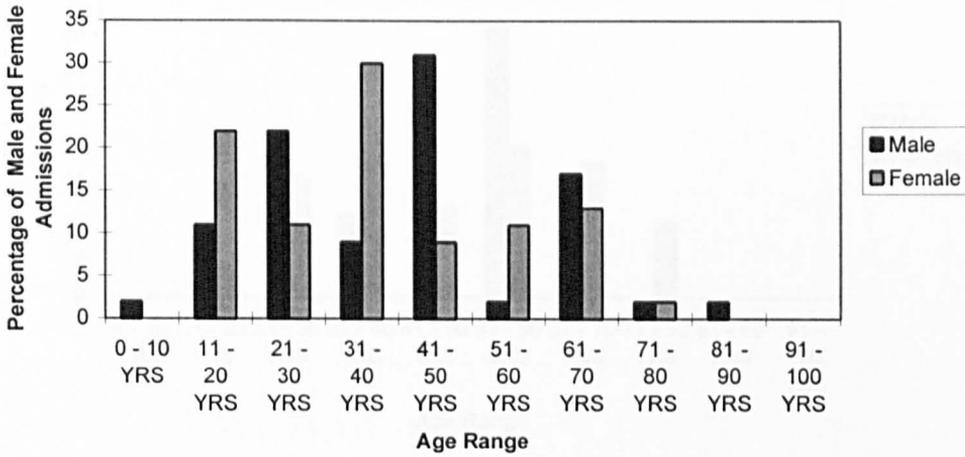


Figure 3n: Age Range of Male and Female Patients Admitted to St Joseph's Hospice in 1935

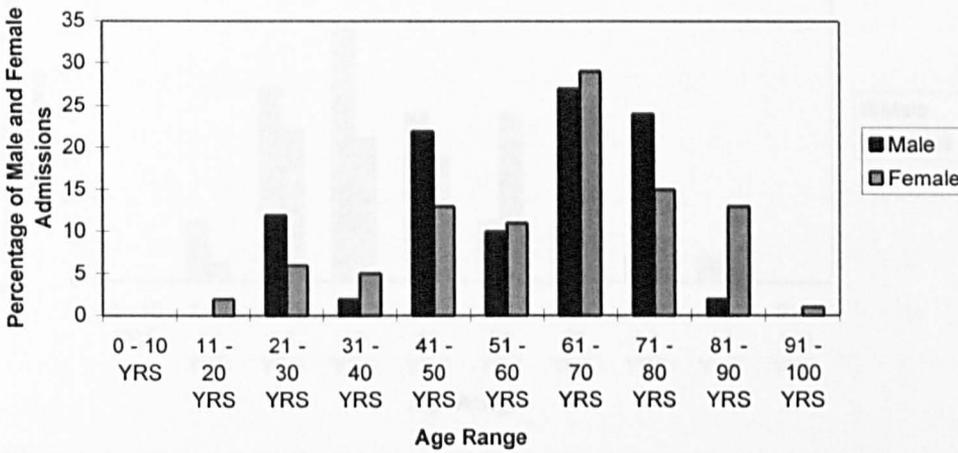


Figure 3o: Age Range of Male and Female Patients Admitted to the Hostel of God in 1895

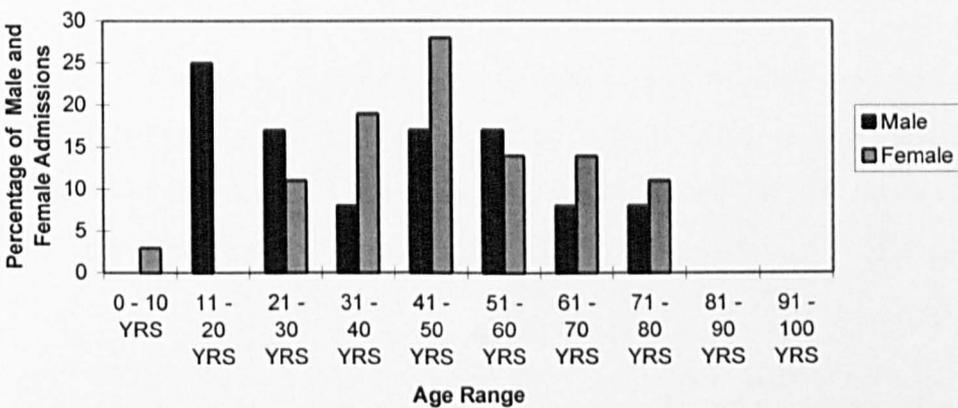


Figure 3p: Age Range of Male and Female Patients Admitted to the Hostel of God in 1905

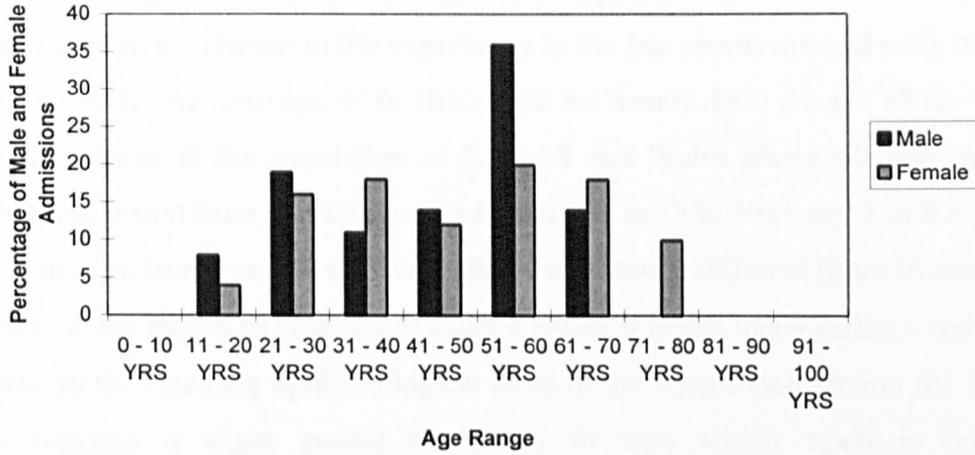
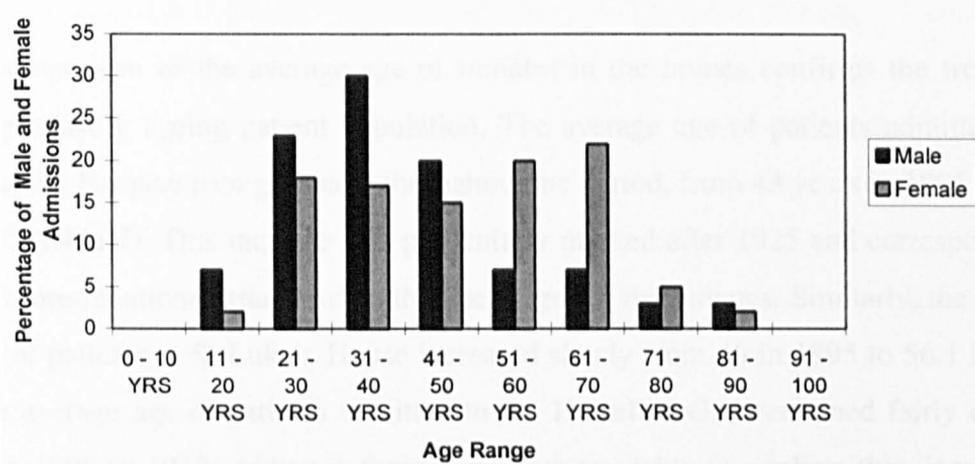


Figure 3q: Age Range of Male and Female Patients Admitted to the Hostel of God in 1915



An analysis of patient age-ranges therefore suggests that in the period between 1895 and 1935 all three homes experienced a gradual shift in the ages of inmates, so that by the end of the period the patient population was perceptibly older. This increase may have related to the change in life expectancy in the late nineteenth and early twentieth century which rose from age 40 in 1850 to 52 for men in 1911-12 and 55 for women. The proportion of the population in England and Wales above 60 also increased during this period from 1 in 15 people in 1826 to 1 in 13 in 1911 and 1 in 8 in 1931.⁸⁸ The transition from younger to older patients occurred at different times in each of the homes - at the Hostel of God and St Luke's House it began much earlier - and relates, in part, to the changing epidemiological basis of the homes (see section 6). The data also suggests a slight gender distinction in ages which again is linked to epidemiological trends. Women tended to form a higher percentage of older patients, particularly at St Joseph's and St Luke's.

A comparison of the average age of inmates in the homes confirms the trend of a progressively ageing patient population. The average age of patients admitted to St Joseph's Hospice rose gradually throughout the period, from 43 years in 1905 to 60 in 1935 (table 7). This increase was particularly marked after 1925 and corresponded to the afore-mentioned transition in the age ranges of the inmates. Similarly, the average age of patients at St Luke's House increased slowly from 46 in 1895 to 56.1 in 1938. The average age of patients admitted to the Hostel of God remained fairly constant from 1895 to 1915. Although there is no data available to confirm this, it would be fairly logical to assume that it too would have risen gradually throughout the period.

a. Children

At both St Luke's House and the Hostel of God priority of admission was given to adults over sixteen years of age.⁸⁹ By 1895, the Hostel of God, had virtually given up admitting children because of the heavy demand placed on the Home by adult patients.⁹⁰ Howard Barrett gave three reasons for according priority to adult patients at

⁸⁸ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press, pp.143-144.

⁸⁹ HOGAR, 1894-1895, p.3 ; 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24.

⁹⁰ HOGAR, 1894-1895, p.3.

Table 7: Average Age of Patients Admitted to St Joseph's Hospice, St Luke's House and the Hostel of God 1895 to 1938

| YEAR | ST JOSEPH'S HOSPICE | ST LUKE'S HOUSE | HOSTEL OF GOD |
|------|---------------------|-----------------|---------------|
| 1895 | | 41.7 | 46 |
| 1900 | | 43.2 | 40 |
| 1905 | 43 | 42.4 | 46 |
| 1910 | 42.5 | 44.7 | 45 |
| 1915 | 39 | 45.9 | 46 |
| 1920 | 41 | 46.3 | |
| 1925 | 39.5 | 48.9 | |
| 1930 | 52 | 51.5 | |
| 1935 | 60 | 57 | |
| 1938 | 49 | 56.1 | |

St Luke's; firstly, that children were far more easily nursed at home, secondly, their families were more reluctant to part with them and thirdly, their diseases were comparatively rapid.⁹¹ In practice, however, children were occasionally accepted because they were felt to increase the morale of both patients and staff. Barrett wrote that they had an "excellent effect on the others in the wards, especially the mens' wards" and it gave the nurses "a special pleasure to have one or two 'kids' to look after and play with."⁹²

In contrast, St Joseph's Hospice accepted a number of patients under the age of sixteen, although they only formed a very small proportion of the total patient population each year. The period 1905 to 1938 also saw a gradual change in the ages of child admissions which reflected the general trend towards older patients. After 1925 no patients under 10 years of age were inmates of the Home. Prior to this several very young children had been admitted, the youngest of these was a three year old girl received into the Hospice with abdominal cancer in 1914.⁹³

⁹¹ 13th SLHAR, 1906, p.15.

⁹² Ibid.

⁹³ St Joseph's Hospice for the Dying Female Patient Register, January 1905 to May 1939.

vi. Patient ailments

This section examines the types of conditions suffered by patients in the homes. Again these were listed individually for each patient both in the registers and the annual reports. Before proceeding with an analysis of the data it is important to point out its limitations and the implications this has for its reliability. Firstly, the need to be aware of the temptation to employ retrospective diagnosis; the superimposing of modern classifications of disease upon late nineteenth and early twentieth century nosology. This is largely avoided by staying as close to the original classifications as possible. Secondly, it is not known by whom or at what stage of the patient's illness the diagnosis was made. In the same way, it is not known when, or by whom, the diagnosis was entered into the patient register, and whether it was based upon information provided on their medical certificate or by one of the doctors attached to the homes. Thirdly, most of the analysis of patients at the Hostel of God is dependent upon second hand information recorded in the annual reports, making it impossible to know how accurate a reflection it is of the way in which it was recorded in the original case notes.

The other major disadvantage of the data is that neither the patient registers for St Joseph's Hospice and St Luke's House or the annual reports for Hostel of God state whether the patient actually died from the disease with which they were admitted. Evidently patients did, on occasion, die from a condition different to the one cited on admission. The Sisters of Charity annals record how several of the patients in 1934 contracted pneumonia as a result of an outbreak which occurred in the winter of that year,⁹⁴ but the entries in the patient registers make no reference to this fact. Similarly, the Medical Superintendent at St Luke's observed that in many instances patients originally admitted with cancer actually died from some other cause because the cancer progressed so slowly.⁹⁵

Fortunately, these limitations are not sufficient to distort the patterns and trends which emerge from an analysis of the data, particularly the predominance of cancer and

⁹⁴ SJHA, 1928-1935.

⁹⁵ 13th SLHAR, 1906, p.14.

phthisis (or consumption / pulmonary tuberculosis as it was alternatively known); the two principal ailments suffered by patients. Both diseases were thought to be particularly difficult to nurse at home, not least because of the health risks posed to others. In 1899 Howard Barrett wrote that consumptive patients were a “positive danger to other inmates at home,” particularly in the end stages, while cancer patients were a “physical offence and cause of ill-health to others around.”⁹⁶ Barrett’s comments on phthisis patients may have been influenced by ideas that were being taken up by certain leading members of the medical profession during the very early years of the twentieth century regarding the institutional segregation of phthisis sufferers. These ideas were first developed by Arthur Newsholme, Medical Officer of Health for Brighton. In December 1905 he delivered a paper to the Epidemiological Society in which argued that the most effective factor in bringing about the decline of phthisis mortality was the segregation of phthisis patients during the time when they were most infectious. Newsholme felt that the high number of phthisis patients in workhouse infirmaries, many of whom were in an advanced stage of their disease, was particularly importance in this decline.⁹⁷

The years 1895 to 1938 witnessed an identifiable shift in the proportion of inmates suffering from tuberculosis and cancer, which occurred at different times and in varying degrees in each of the homes. The following section examines the changing incidence of cancer and phthisis firstly, by analysing their frequency of occurrence among the total populations of the homes, and then by comparing male and female patients. A decision was made to look at the data on a five-yearly basis because analysis every ten years did not reveal sufficient nuances, particularly those for St Joseph’s. The number of patients suffering from each condition was analysed as a percentage of the total number of admissions for that year because simply looking at the actual numbers themselves did not reveal whether any real changes occurred in the rate of admission for each disease.

⁹⁶ 6th SLHAR, 1899, p.8.

⁹⁷ Wilson, L.G. (1990) The historical decline of tuberculosis in Europe and America: its causes and significance, *Journal of the History of Medicine and Allied Sciences*, Vol. 45, No. 3, pp.377-383.

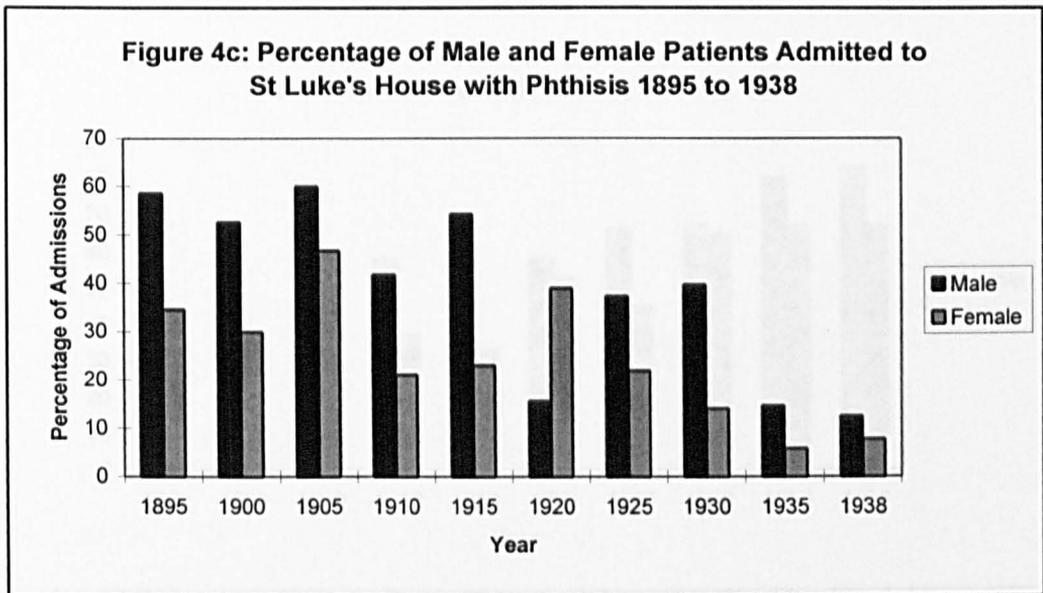
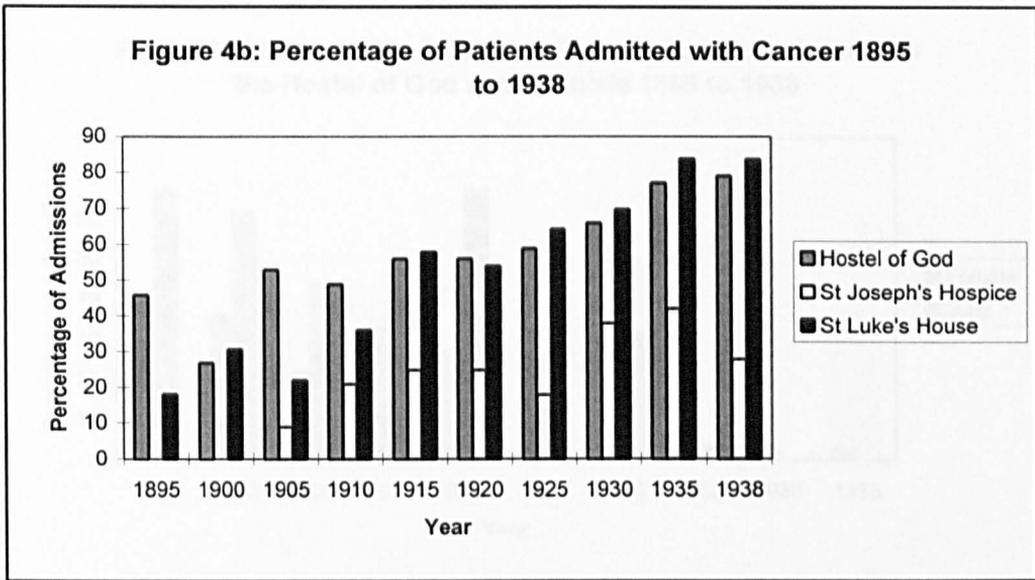
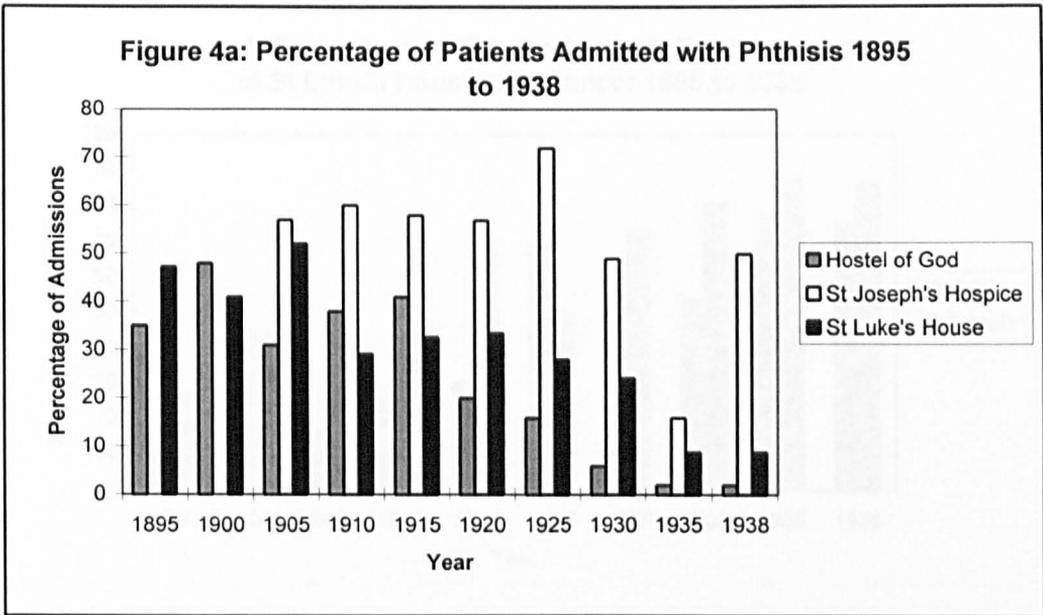
A comparison of the percentage of patients suffering from phthisis in each of the homes suggests that a much higher proportion of the inmates at St Joseph's suffered from this disease (figure 4a). While the percentage of phthisis patients at St Luke's House and the Hostel of God began to decrease after 1905, this trend did not occur at St Joseph's until much later. Before 1925 the number of phthisis patients in the Hospice remained consistently high and did not begin to decline until after this date. In 1938 this trend was suddenly reversed and the number of phthisis patients reverted back to the 1930 level. The decline in the percentage of phthisis patients was most marked at the Hostel of God where, after 1930, they only accounted for a very small number of inmates.

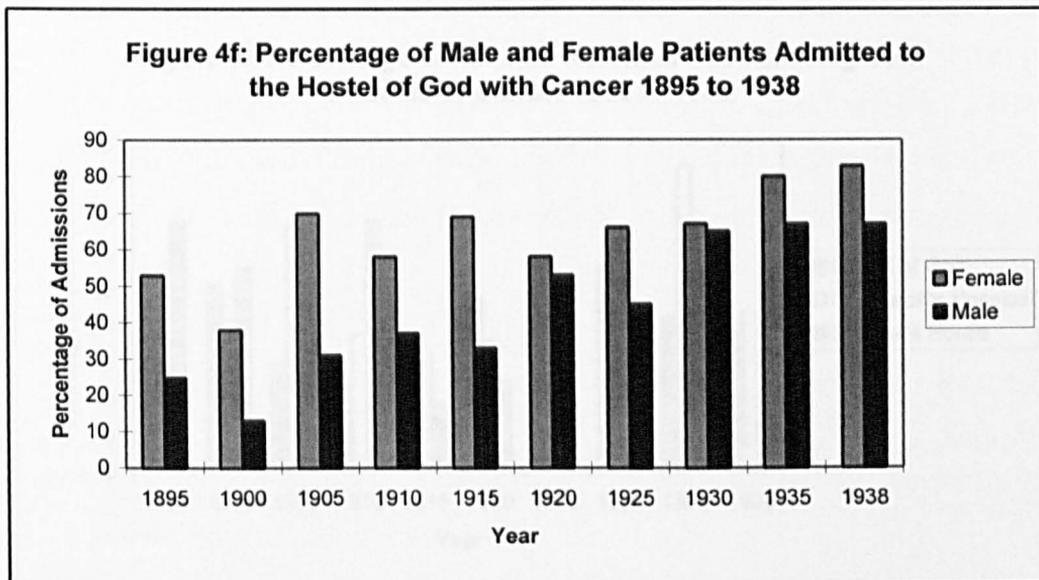
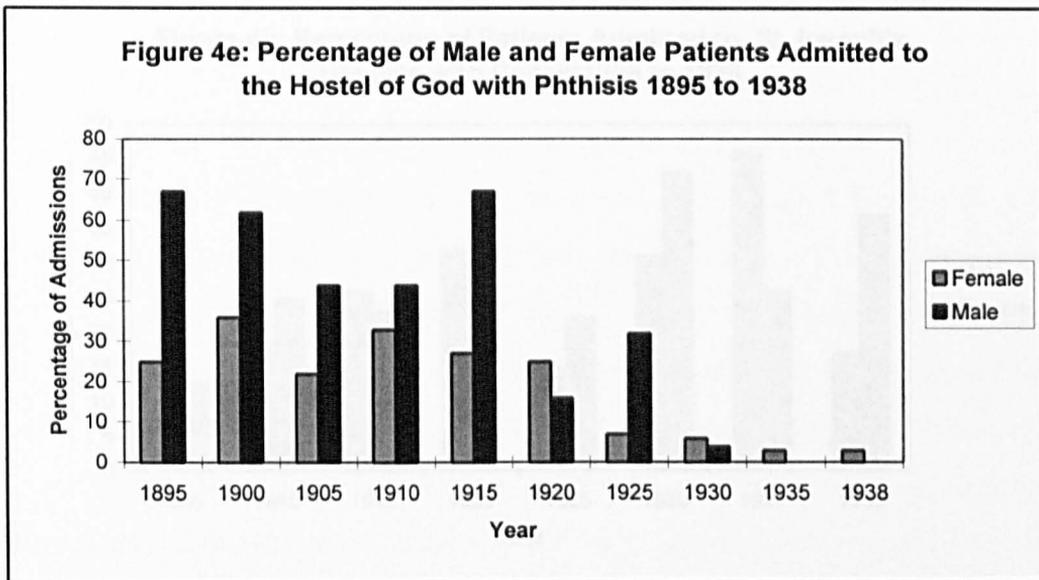
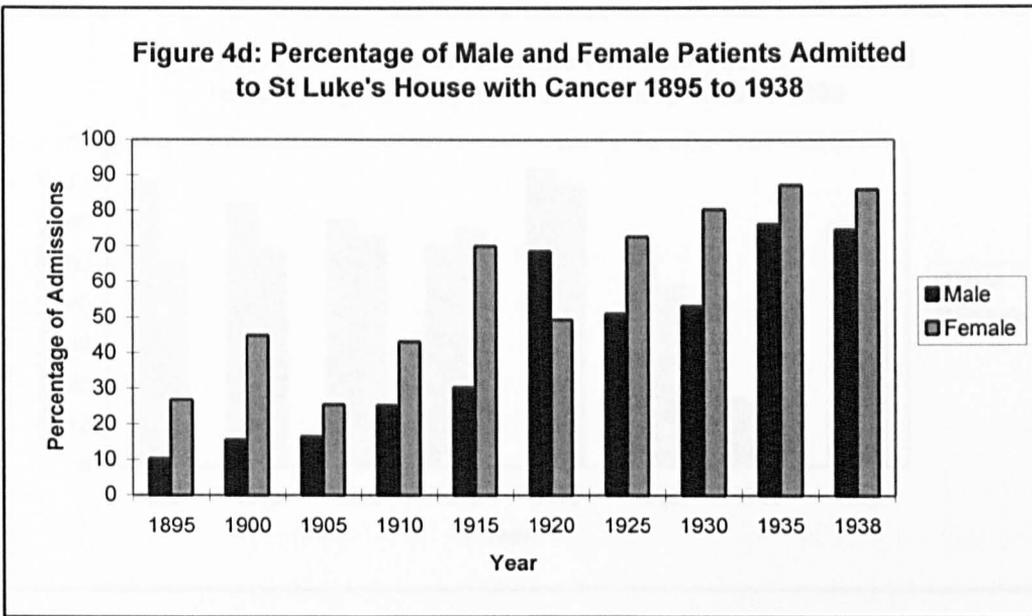
In contrast, the percentage of patients with cancer appears to have increased steadily throughout the period. After 1905 all three homes experienced a gradual rise in the number of cancer admissions. Figure 4b suggests that the proportion of patients with cancer at St Joseph's was considerably smaller, while the admission rate at the other two homes showed a much closer similarity, that for St Luke's being only slightly higher. Both the Hostel of God and St Luke's had a fairly high percentage of cancer admissions from early in their history, particularly the former institution.

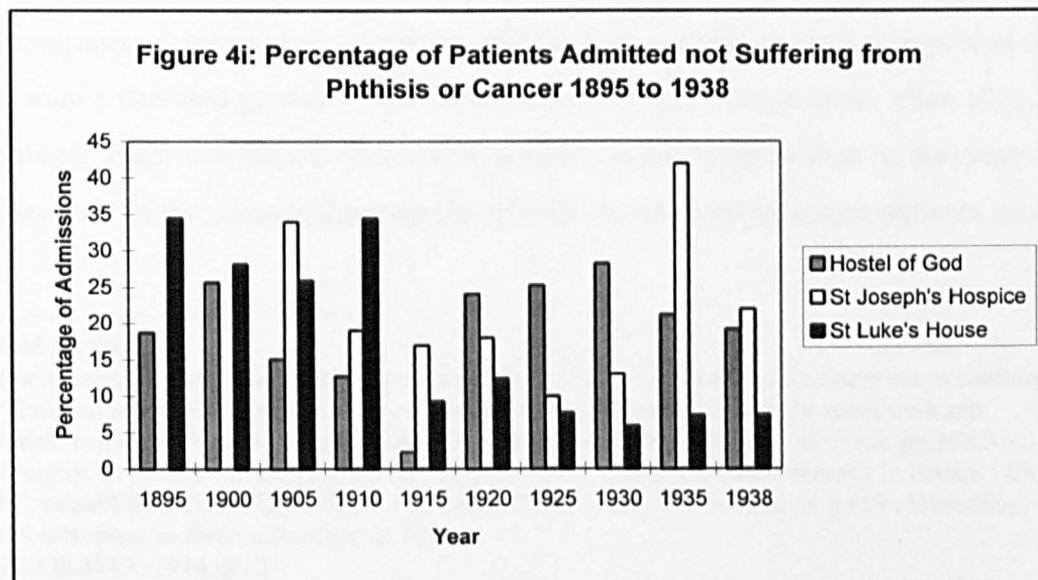
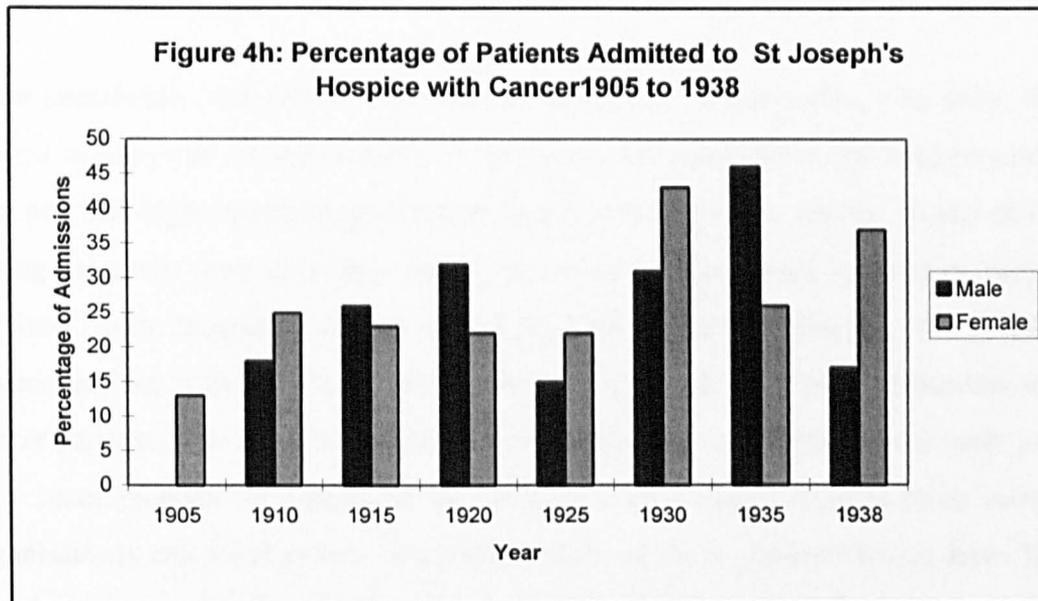
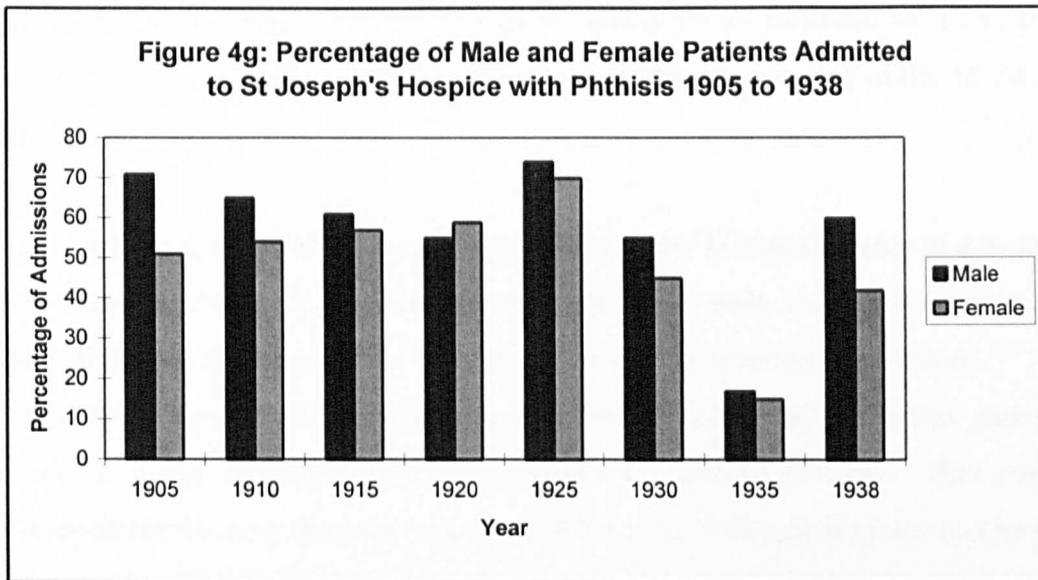
The percentage of male and female patients with phthisis and cancer in each home (figures 4c to 4i) reflected the patterns of admission for the total population. It also appears that, in general, a higher percentage of male cases in all three homes suffered from phthisis, while a significantly larger number of female patients were diagnosed as having cancer. Howard Barrett attributed the higher number of female patients at St Luke's House to the greater prevalence of cancer among women and their greater liability to its various forms.⁹⁸ The higher percentage of male patients suffering from phthisis may be linked to two factors; firstly, that London had one of the highest phthisis mortality rates for males but not for females, and secondly, that the death rate for phthisis declined faster among women.⁹⁹ The higher number of patients from younger age groups in the homes also coincided with those years in which there was a

⁹⁸ 1st SLHAR, taken from 7th WLMAR, 1894, p.5 ; 15th SLHAR, 1908, p.15.

⁹⁹ Cronje, G. (1984) Tuberculosis and mortality decline in England and Wales, 1851-1910, in R. Woods and J. Woodward (eds) *Urban Disease and Mortality in Nineteenth Century England*. London: Batsford Academic and Educational, pp. 83, 89-94.







large proportion of tuberculosis cases in the homes and reflected the wider prevalence of the disease among young people, particularly young adults. Between 1851 and 1910 over one-third of tuberculosis deaths in England and Wales occurred in the 15-34 age group.¹⁰⁰

The predominance of phthisis and cancer patients in the homes was part of a broader epidemiological change during the late nineteenth and early twentieth century; the gradual shift from acute infectious diseases to chronic degenerative conditions.¹⁰¹ The transition from phthisis to cancer patients also formed part of wider mortality patterns. Between 1850 and 1950 the tuberculosis mortality rate declined steadily, while cancer was responsible for an increasing number of deaths. By 1920 tuberculosis had lost its position as one of the leading causes of death and had been superseded by cancer.¹⁰²

More specifically, the different patterns of admission in the homes may have been related to the type of individual/s or organisations responsible for recommending patients. The higher percentage of cancer patients at St Luke's and the Hostel of God during the early years may have been due, in part, to the larger number of inmates received from hospitals. In his report for 1914 Edmund Barrett, the Medical Superintendent at St Luke's, wrote that most of the cases sent by the hospitals were cancer patients.¹⁰³ In contrast, the majority of patients at St Joseph's in the early years were recommended for admission by the Sisters on Mission, various other mission organisations and local priests and clergy. Most of these patients would have been found either in their homes or the local infirmaries, where there were a high concentration of tuberculosis sufferers. Although the number of patients received from this source declined gradually, the local authorities were responsible, after 1913, for sending a larger number of tuberculosis patients to the Hospice than to the other two homes (one of the reasons Edmund Barrett was so reluctant to accept patients sent by

¹⁰⁰ Ibid., p. 86.

¹⁰¹ For a discussion of the 'epidemiological transition' within a socio-medical context see Weindling, P. (1992) From infectious to chronic diseases: changing patterns of sickness in the nineteenth and twentieth centuries, in A. Wear (ed) *Medicine in Society*. Cambridge University Press, pp.303-316.

¹⁰² Murphy, C. (1986) 'A history of Radiotherapy to 1950: Cancer and Radiotherapy in Britain 1850-1950', unpublished thesis, UMIST, p.1.43 ; Smith, *The Retreat of Tuberculosis*, p.119 ; Weindling, 'From infectious to chronic diseases', p.304.

¹⁰³ 21st SLHAR, 1914, p.17.

the Insurance Commissioners was that it would mean St Luke's would soon become full of tuberculosis cases to the exclusion of cancer patients¹⁰⁴). The admission of tuberculosis patients sent by the local authorities only lasted a few years because the increase in pulmonary tuberculosis during the War galvanised the government into active intervention in the treatment of the disease. Under the Public Health Act of 1921 treatment became free and by the mid-1920's the number of beds and services available for tuberculosis sufferers provided by the state sector had risen dramatically.¹⁰⁵

The War also galvanised local authorities into taking responsibility for the provision of patients dying of tuberculosis. In 1926 the continuing decline in phthisis admissions gave cause for the new Medical Superintendent, Charles Buttar, to remark that the demand for patients in the last stages of tuberculosis could be met elsewhere.¹⁰⁶ The 1925 Report of the Medical Officer of Health for London noted that during the war the Metropolitan Asylums Board had adapted St George's Home in Chelsea so that it could receive advanced female cases. Advanced female cases were also admitted to the Northern Hospital at Winchester, while male advanced cases were sent to Downs Sanatorium. He argued that the problem of the advanced case had caused considerable difficulty for the Council both from the preventative and treatment points of view. The fact that 50% of the Council's expenditure on the treatment of tuberculosis was met by the Exchequer grant and was not available in the relief of poor law expenditure had resulted in continual pressure on the Council to provide for these cases. It was felt that such institutions should be close enough to patients' homes to enable relatives to visit and even permit patients, on occasion, to return home. Since infirmaries were generally local the Council felt that the extensive provision of new accommodation would only be a waste and that a large class of chronic cases more or less destitute and likely to live indefinitely should be accommodated in these institutions.¹⁰⁷

¹⁰⁴ Ibid., p.16.

¹⁰⁵ Lewis, J. (1992) Providers, 'consumers', the state and the delivery of the health care service in twentieth century Britain, in A. Wear (ed) *Medicine in Society*. Cambridge University Press, pp.332, 335 ; Abel-Smith, B. (1964) *The Hospitals 1800 - 1948*. London: Heinemann, pp.352-353 ; Pickstone, J.V. (1985) *Medicine and Industrial Society. A History of Hospital Development in Manchester and Its Region, 1752-1946*. Manchester University Press, pp.229-235.

¹⁰⁶ 33rd SLHAR, 1926, p.8.

¹⁰⁷ Report of the County of London Medical Officer of Health, 1925, pp.63-64, Wellcome Institute for the History of Medicine.

The Medical Officer went on to report that some advocates had urged the provision of small 'homes' of 20 to 30 beds where certain unavoidable features of large institutions which became irksome could be relaxed. However, he noted, investigation had indicated that such institutions, apart from other unfavourable considerations (these were not given) were comparatively costly, and it had therefore been necessary to meet the demands through the provision of large institutions. In addition to the aforementioned institutions, the MAB had also placed Colindale Hospital in Hendon, with approximately 325 beds, at the disposal of the Council and had adapted Grove Park Hospital for the accommodation of 320 patients. The Medical Officer concluded this section of his report by stating that there were, however, a small number of institutions in London (presumably these included the homes for the dying) and various parts of the country where specially selected cases were sent.¹⁰⁸

Under the 1929 Local Government Act the London County Council acquired the former Poor Law infirmaries and was able to use them to accommodate advanced cases. London County Council provision for advanced cases in the infirmaries was helped by a gradual change in attitudes towards both workhouses and infirmaries in the Edwardian and inter-war years in response to efforts by the government to raise the standard of care offered and to lessen the stigma attached to them. By the early decades of the twentieth century nursing and medical care in the infirmaries had improved significantly so that as well as serving the destitute the infirmaries were increasingly being used by non-pauper classes, particularly artisans earning good wages. Changing terminology in 1913 had also been designed to lessen the stigma of indoor relief and reflect its social purposes as a refuge for the helpless rather than its former deterrent objectives. During the 1930s chronic patients were concentrated in 12 out of the 29 public assistance institutions (as the former workhouses / infirmaries were now called) providing a total of 9-10,000 beds. The changing patient population of these institutions suggests that non-pauper classes looked increasingly upon them as acceptable places of care and were willing to be nursed there when dying.¹⁰⁹

¹⁰⁸ Ibid.

¹⁰⁹ Rivett, G. (1986) *The Development of the London Hospital System 1823-1982*. Oxford University Press, pp.176-199 ; Abel-Smith, *The Hospitals*, pp.131, 372-373 ; Crowther, M.A. (1981) *The Workhouse System 1834-1929*. Batsford Academic and Educational Ltd, pp.82-87, 184.

Although phthisis and cancer cases accounted for the large majority of the inmates in each home, patients with other types of ailments were also admitted. The medical staff at St Luke's House were strict about only accepting candidates with non-infectious diseases.¹¹⁰ The other two homes, however, were less forceful in applying this condition; each year a few patients suffering from pneumonia and bronchitis were admitted. Figure 4j gives the total number of non-cancer and non-phthisis cases as a percentage of overall admissions. In general, St Luke's received the highest percentage of cancer and phthisis admissions. After 1900 the number of inmates in the Home with other conditions gradually declined, especially after 1915 when the average yearly intake was only 6.4%. At the Hostel of God the proportion of patients with other types of ailment was generally lower during the early years. In contrast, although not shown very clearly in the table, this was more a characteristic of the later years at St Joseph's, particularly after 1933.

Three of the other most frequently occurring conditions were all types of cancer but were stated separately in the registers; various types of sarcoma (a tumour composed of some modification of the embryonic connective tissue), neoplasm (a term for new growths), rodent ulcers (a form of tumour) and epithelioma (a form of carcinoma - skin cancer). Different forms of cardio-vascular disease, particularly myocarditis (inflammation of the heart walls), dropsy (accumulation of serous fluid in the subcutaneous cellular tissue or in a serous cavity) and arteriosclerosis (a condition associated with the thickening of the arterial walls) were also commonly recurring afflictions. Conditions affecting the nervous system, such as paralysis agitans (a variety of Parkinson's disease), hemiplegia (paralysis of one side of the body) and paraplegia (paralysis of lower extremities) also occurred fairly frequently. The other principal types of ailment were rheumatoid arthritis, other forms of tuberculosis, disseminated sclerosis (hardening of interstitial tissue) and chronic nephritis (inflammation of the kidney).¹¹¹

¹¹⁰ 5th SLHAR, 1898, p.6.

¹¹¹ These are contemporary definitions and are taken from Quain, R. (1890) (ed) *A Dictionary of Medicine*. London: Longmans, Green and Co., Vol. 1, p.403 ; Vol.2, pp. 638, 1022, 1099, 1378, 1386.

It would appear, then, that the transition from phthisis to cancer patients, whilst characterising a pattern in all three homes, occurred significantly later at St Joseph's. Until 1925 the Hospice received a high intake of phthisis patients. In contrast, the shift towards a larger percentage of cancer patients at St Luke's House and the Hostel of God began much earlier, c1905 and c1910 respectively. By 1935 phthisis accounted for only a very small percentage of overall admissions. The explanation behind these different patterns may lie, in part, in their differing methods of patient intake.

vii. Length of stay

The length of time spent by patients in the homes, together with rates of mortality and discharge, was important for two reasons: firstly they were felt to be a reflection of their overall function as homes for the *dying*, and secondly, they helped to set them apart from those homes and hospitals which cared for incurable and chronic cases. The following section examines how long patients remained in the homes by dividing up the length of stay into different time periods and by looking at the average length of stay.

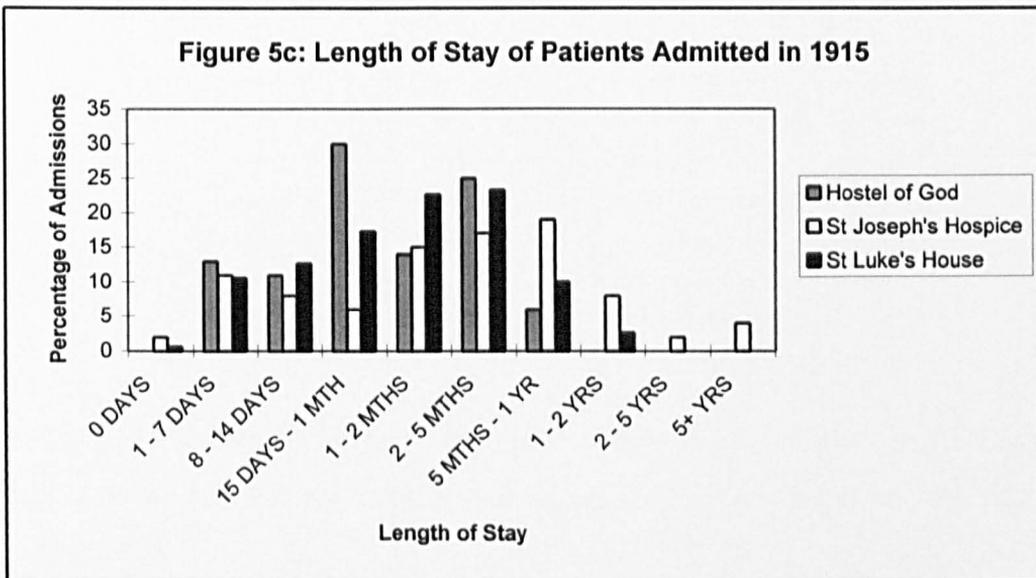
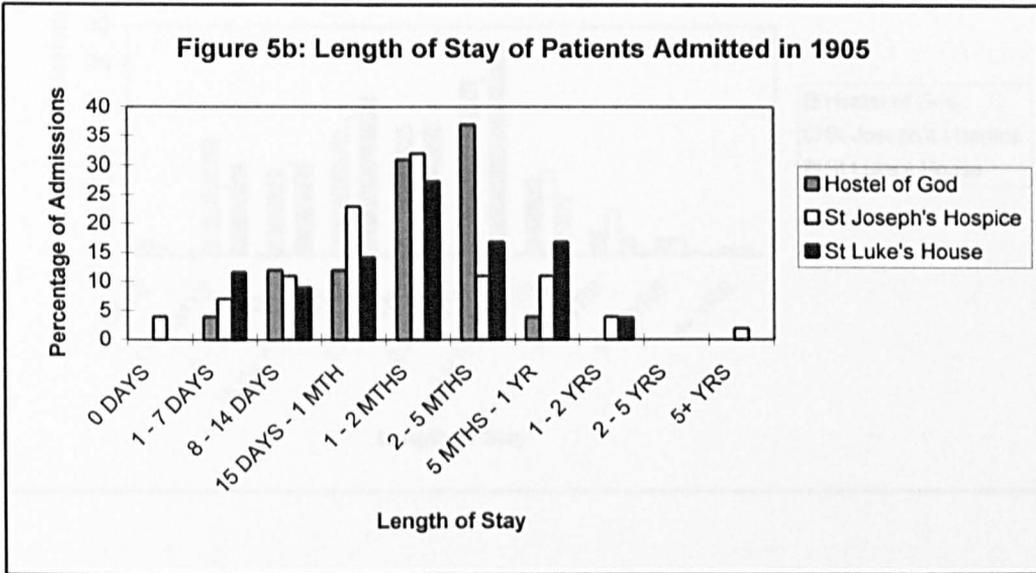
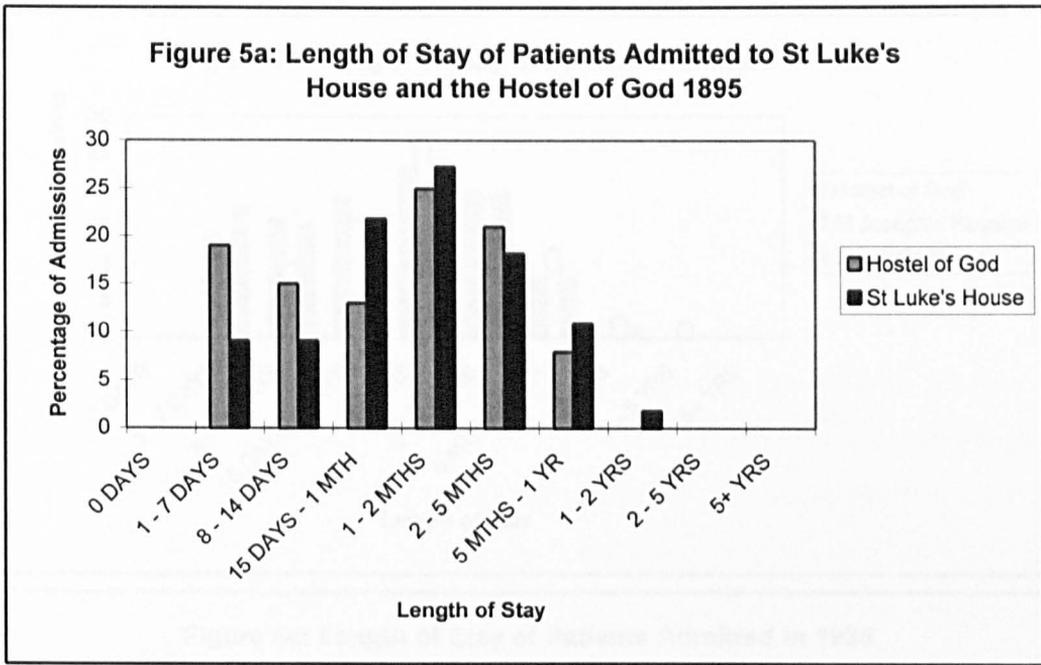
The information on the length of stay of patients in the Hostel of God records is not consistent throughout the whole period because it is recorded in different ways in the annual reports and the patient registers. The material in the annual reports has two major limitations. Firstly, it provides only the length of stay of patients who were admitted into the Home for that year and who died or were discharged during the same year. Those patients who were still alive on December 31st are referred to as 'remaining in the Home'. Thus both longer-term patients and short term patients who did not die before the end of the year are not included in the statistics and consequently the analysis of this data cannot be treated as a true reflection of the overall length of stay of all patients. However, this does not discount the figures that are provided which still give an insight into the length of stay of most of the short and medium stay patients admitted during that year. The other major drawback of the information in the annual reports is that it is given in three different types of format,

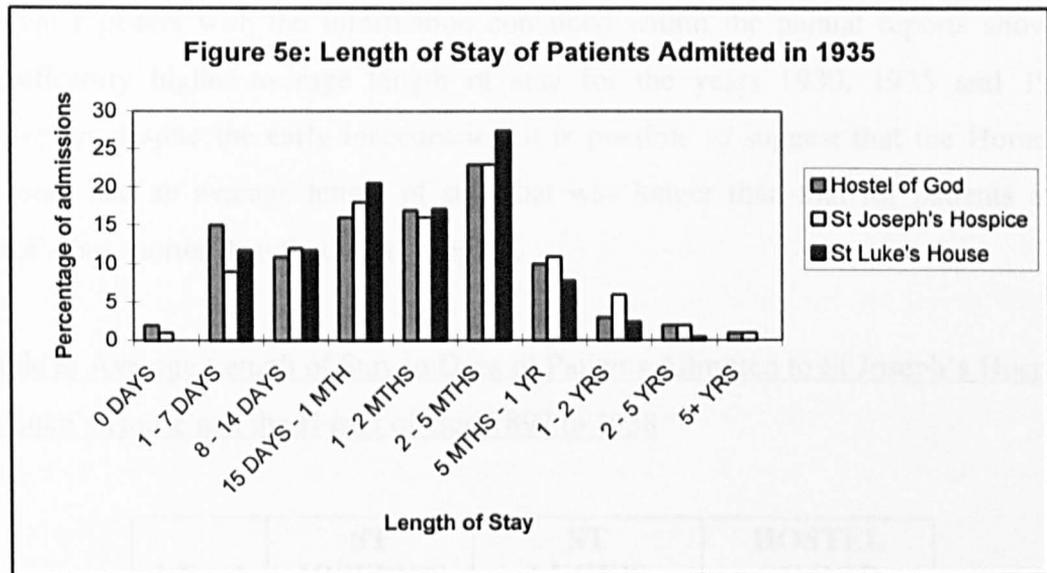
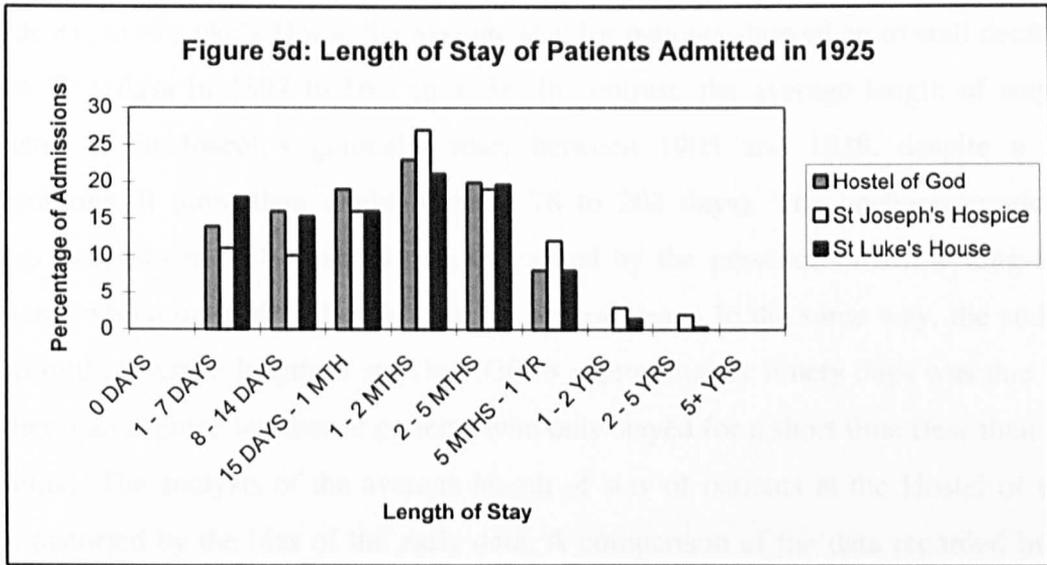
either the number of days, weeks or months. The latter of these are rounded up to the nearest whole week or month so it is uncertain just how accurate they are.

The data provided in the Hostel of God patient registers (1927 - 1938) was a more valid representation of the length of stay of patients admitted for each year because the information was recorded in two separate columns, one giving the date of admission and the other the date of discharge or death. From these figures it was possible to work out the total length of stay of each patient regardless of whether or not they outlasted the year. The figures were provided for every patient and were not restricted by the need to incorporate the statistics into an annual report. The patient registers for St Joseph's and St Luke's provided consistent data on the length of stay of the patients admitted each year throughout the period. The information was recorded in the same way as registers for the Hostel of God.

The graphs comparing the length of stay of patients in the three homes suggest somewhat different trends for St Luke's House and St Joseph's Hospice (Figures 5a to 5e). Between 1897 and 1935 the percentage of short term patients at St Luke's gradually increased; the percentage of admissions who stayed under 2 months rose from 66% in 1897 to 86% in 1935. At St Joseph's the reverse trend appears to have occurred. The number of patients who remained in the Hospice for more than two months increased gradually from 23% in 1905 to 44% in 1935.

A comparison of the length of stay of patients admitted to the Hostel of God between 1897 and 1925 (Figures 5a to 5d) can only make some tentative suggestions because of the afore-mentioned limitations of the data. It would appear that, with the exception of 1906, there was a higher percentage of patients who stayed for less than two months. However, given the limited reliability of the data and its bias towards short term residents this is slightly misleading because patients who stayed over a year were not included. The chart for 1935 which is based on data from the patient registers suggests that there were a number of long-term patients in the home.





| YEAR | ST JOSEPH'S HOSPICE | ST LUKE'S HOUSE | HOSTEL OF GOD |
|------|---------------------|-----------------|---------------|
| 1927 | 23.1 | 21.0 | 68 |
| 1930 | 14.3 | 11.0 | 45.4 |
| 1934 | 27.6 | 27.0 | 63 |
| 1939 | 14.1 | 10.7 | 30 |
| 1945 | 219.3 | 20.9 | 31 |
| 1950 | 105.8 | 70.6 | 54 |
| 1952 | 105.0 | 67.5 | 37 |
| 1946 | 81.9 | 71.9 | 47 |
| 1948 | 33.3 | 33 | 68 |
| 1948 | 20.4 | 20.7 | 73 |

The longer average length of stay at St Joseph's suggests that patients at the Hospice tended to be more long-term than those at St Luke's and the Hostel of God, perhaps

An analysis of the average length of stay of patients appears to confirm these trends (table 8). At St Luke's House the average stay for patients showed an overall decrease from 72.1 days in 1897 to 56.7 in 1938. In contrast, the average length of stay of patients at St Joseph's gradually rose; between 1905 and 1938, despite a few aberrations, it more than doubled (from 78 to 203 days). The uncharacteristically sharp increases in 1910 and 1915 were caused by the presence of a few long-term patients who remained in the Hospice for several years. In the same way, the sudden drop in the average length of stay in 1930 to approximately ninety days was due to a higher than average number of patients who only stayed for a short time (less than two months). The analysis of the average length of stay of patients at the Hostel of God was distorted by the bias of the early data. A comparison of the data recorded in the patient registers with the information contained within the annual reports shows a significantly higher average length of stay for the years 1930, 1935 and 1938. However, despite the early inaccuracies, it is possible to suggest that the Home, in general, had an average length of stay that was longer than that for patients at St Luke's but shorter than that at St Joseph's.

Table 8: Average Length of Stay in Days of Patients Admitted to St Joseph's Hospice, St Luke's House and the Hostel of God 1897 to 1938

| YEAR | ST JOSEPH'S HOSPICE | ST LUKE'S HOUSE | HOSTEL OF GOD |
|-------------|----------------------------|------------------------|----------------------|
| 1897 | | 72.1 | 68 |
| 1900 | | 114.2 | 45.4 |
| 1905 | 77.6 | 87.3 | 65 |
| 1910 | 131.1 | 60.7 | 63 |
| 1915 | 218.3 | 72.5 | 51 |
| 1920 | 106.8 | 70.6 | 54 |
| 1925 | 105.6 | 63.5 | 53 |
| 1930 | 91.9 | 71.9 | 97 |
| 1935 | 133.5 | 73 | 108 |
| 1938 | 203 | 56.7 | 73 |

The longer average length of stay at St Joseph's suggests that patients in the Hospice tended to be more long-term than those at St Luke's and the Hostel of God, perhaps

signifying that the Sisters of Charity were less preoccupied with the need to admit 'dying' patients. A newspaper article told the story of a patient who had been discharged from St Luke's and transferred to St Joseph's because the former institution could "only keep patients for a limited period."¹¹² The declining length of stay of patients at St Luke's also suggests that the staff there were, by the latter half of the period, more successful in their efforts to admit only patients with less than four months left to live.

a. Chronic patients

Given that these were homes for the dying, a remarkably high number of the inmates stayed for several months or even years, particularly at St Joseph's. One female patient remained there for thirty-nine years, whilst another was an inmate for fifteen years!¹¹³ The longest staying patient at the Hostel of God was there for a modest six years and ten months.¹¹⁴ By contrast, the longest length of stay at St Luke's was two years and one month.¹¹⁵ One of the main problems encountered at St Luke's House and the Hostel of God in the early years was the admission of too many chronic patients. The medical personnel in both homes were very aware of this problem and anxious to counter it. At St Luke's it was particularly apparent because the four month stipulation served as an additional source of pressure. Howard Barrett felt that the presence of chronic patients reflected upon the overall statistical performance of the Home, particularly the number of deaths and the number of admissions. He wrote that only patients who died within the time limit allowed by the Home "proved the fitness of their entrance and the beneficent mission of the Home."¹¹⁶ However, during the early years many patients stayed for considerably longer and concern was often shown over the low number of deaths. Their presence in the Home was partly attributed to the administrative difficulty of not being able to visit the patients before admission.¹¹⁷ In 1931 the Hostel of God purchased an adjacent property for the care of more long-

¹¹² Author unknown, 'Miracle or Coincidence?', Newspaper unknown, date c1908, St Joseph's Archive.

¹¹³ St Joseph's Hospice for the Dying Female Patient Register January 1905 to May 1939.

¹¹⁴ Hostel of God Patient Register January 1927 to June 1942.

¹¹⁵ St Luke's Hospital for Advanced Cases Patient Case Book 24 June 1937 - 29 September 1939, No.277.

¹¹⁶ 6th SLHAR, 1899, p.14.

¹¹⁷ Ibid., p.12.

term patients which may have gone some way to helping solve the problem of chronically sick inmates.¹¹⁸

viii. Mortality patterns

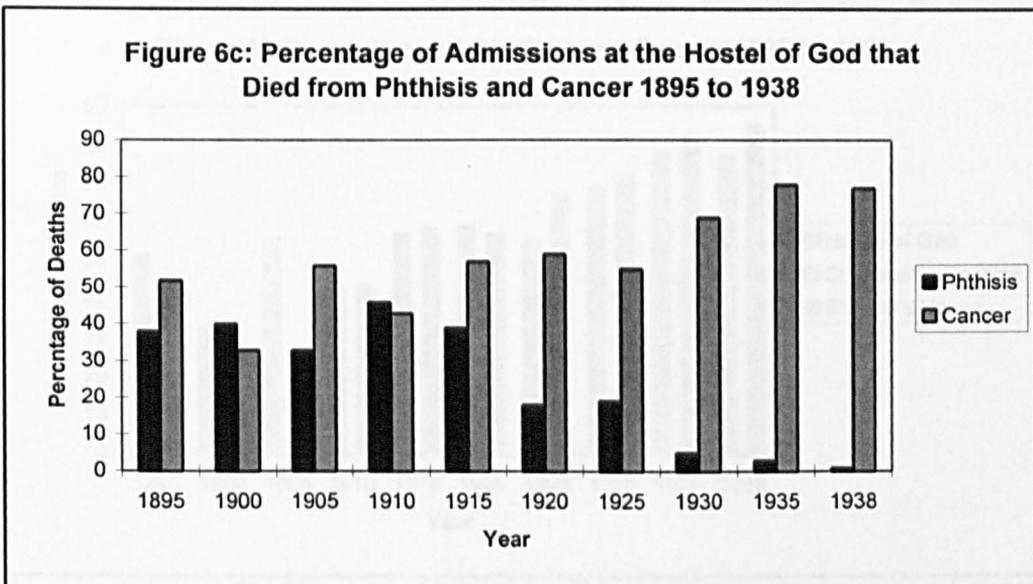
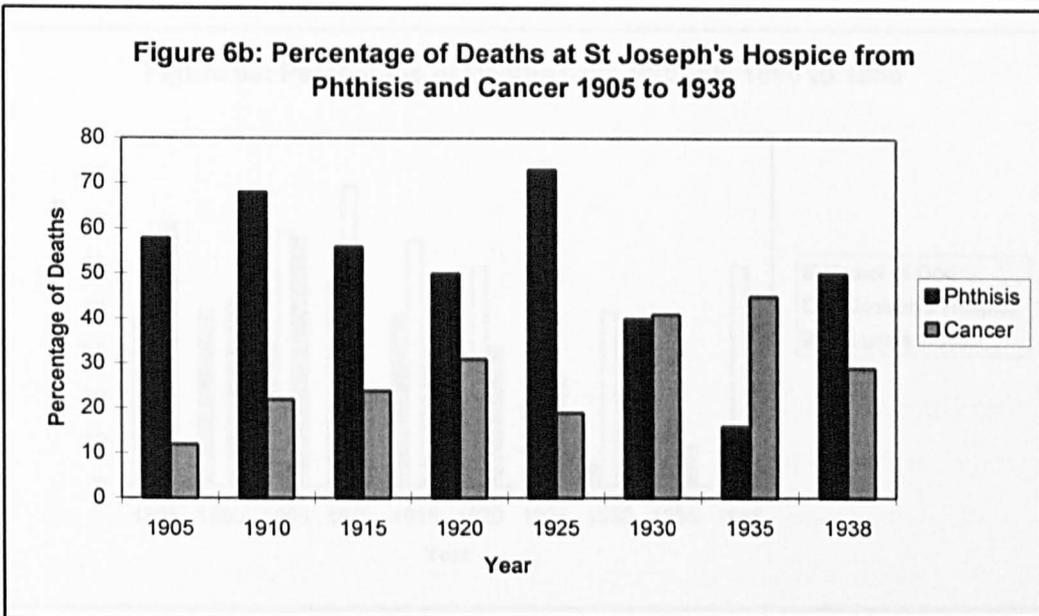
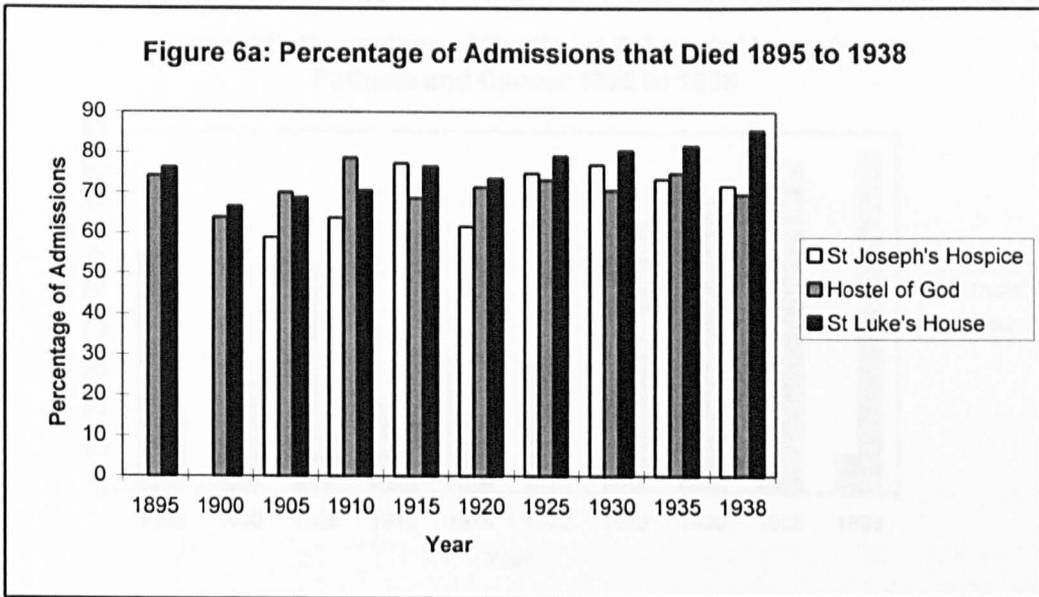
Mortality and discharge patterns were also examined on a five-yearly basis in order to reveal their various nuances, particularly those for St Joseph's. The following discussion begins with a comparison of the mortality rate for the total population in each of the homes. It then moves on to an analysis of the mortality rate for the two principal causes of death, cancer and phthisis; firstly, by looking at each home separately and then by comparing them.

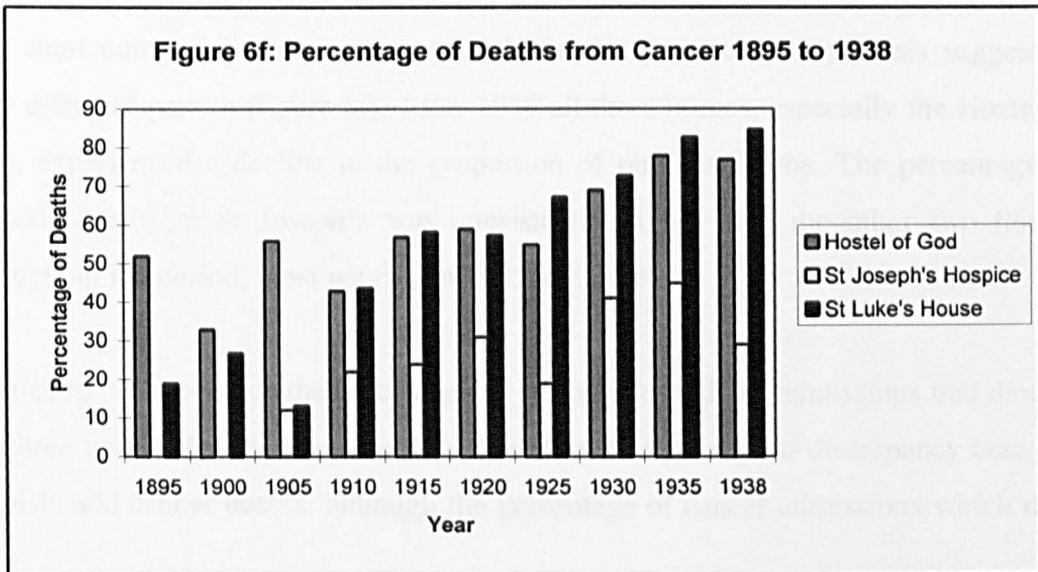
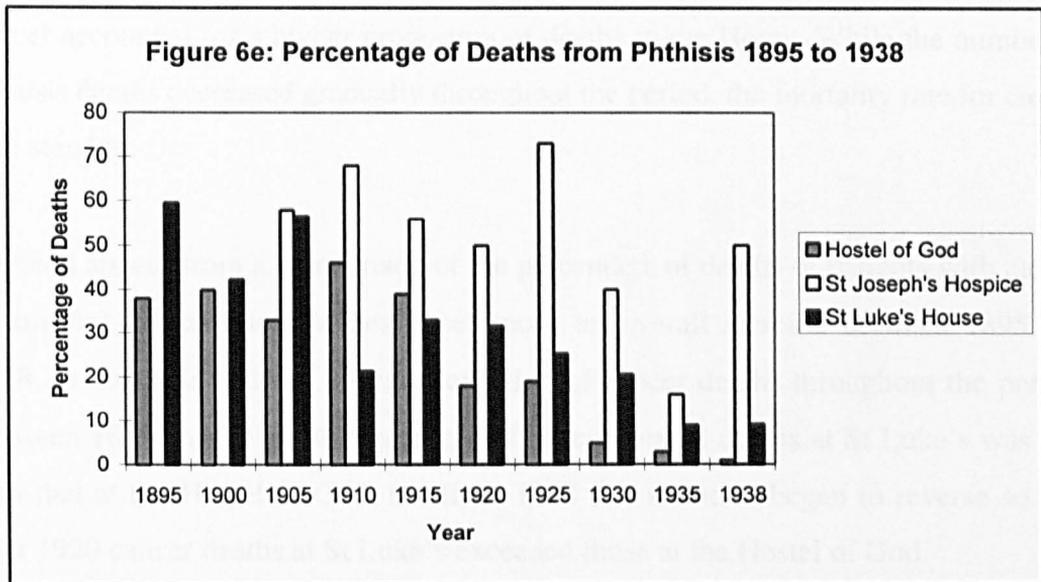
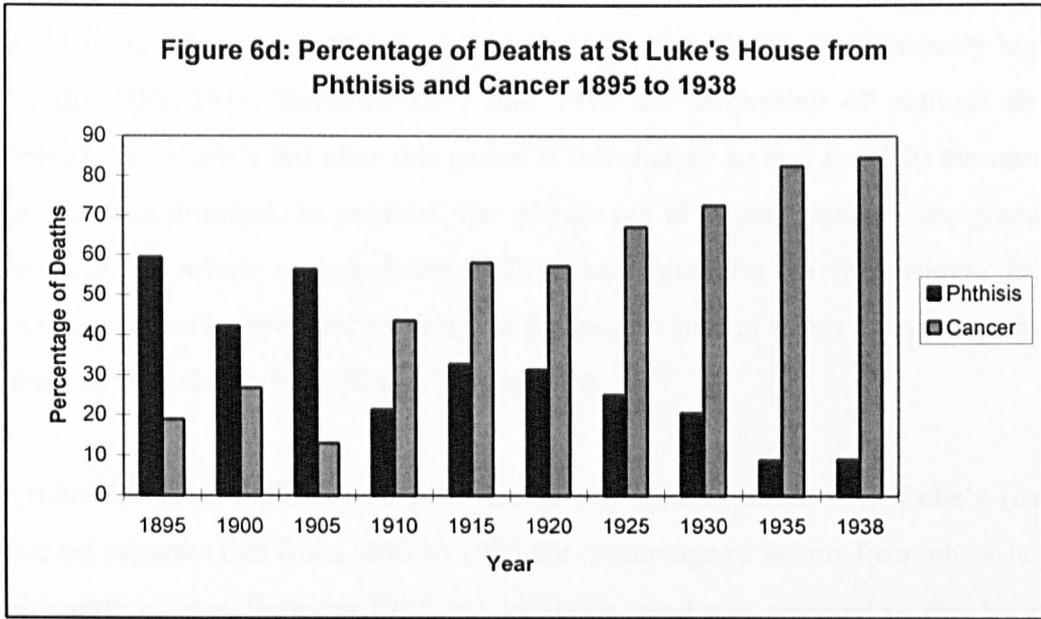
Figure 6a compares the total number of deaths that occurred in each of the three homes. This comparison is based on an analysis of the number of deaths as a percentage of the total number of admissions for that year. It would appear that the death rate was very similar for each of the homes over the years; that for St Luke's House was, in general, slightly higher throughout the period. Approximately 75% of admissions ended in death, although this was subject to fluctuation. Both St Joseph's and St Luke's experienced a gradual increase in their mortality rate.

a. Phthisis and cancer mortality rates

Figure 6b suggests that between 1905 and 1925 a significantly higher percentage of deaths at St Joseph's Hospice occurred among patients suffering from phthisis than cancer. After 1910 phthisis-related deaths declined slowly, with the exception of 1925 when this process was interrupted by a sudden rise in the percentage of phthisis deaths (due to the increase in admissions after the extension was built). In contrast, the percentage of cancer deaths increased gradually throughout the period (except for 1925) so that by 1935 they accounted for a significantly higher proportion of overall deaths (45% : 16%). In 1938 this trend was suddenly altered again due to the substantially higher intake of male and female patients with phthisis.

¹¹⁸ HOGAR, 1931, p.6.





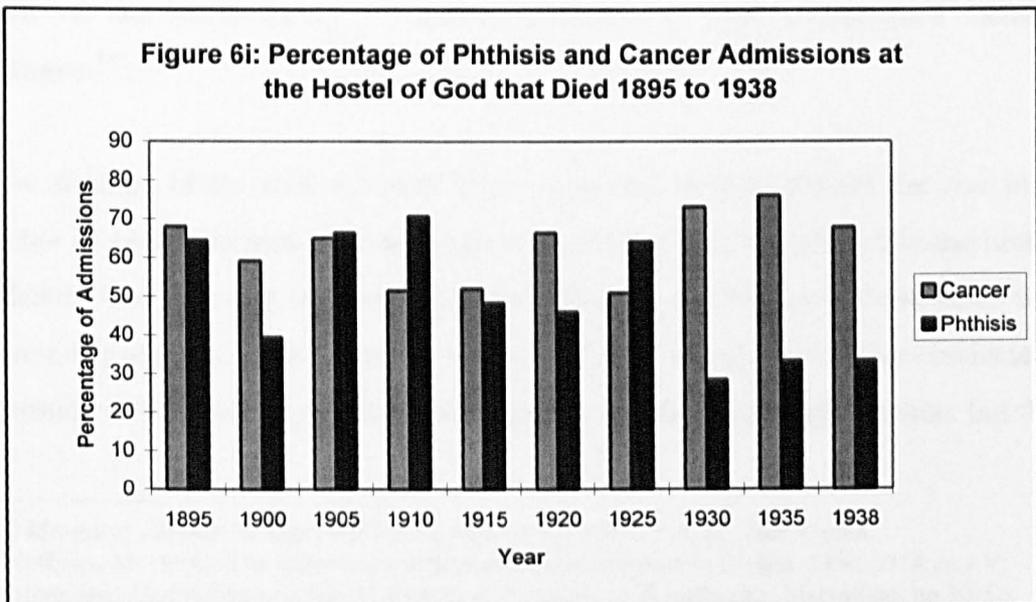
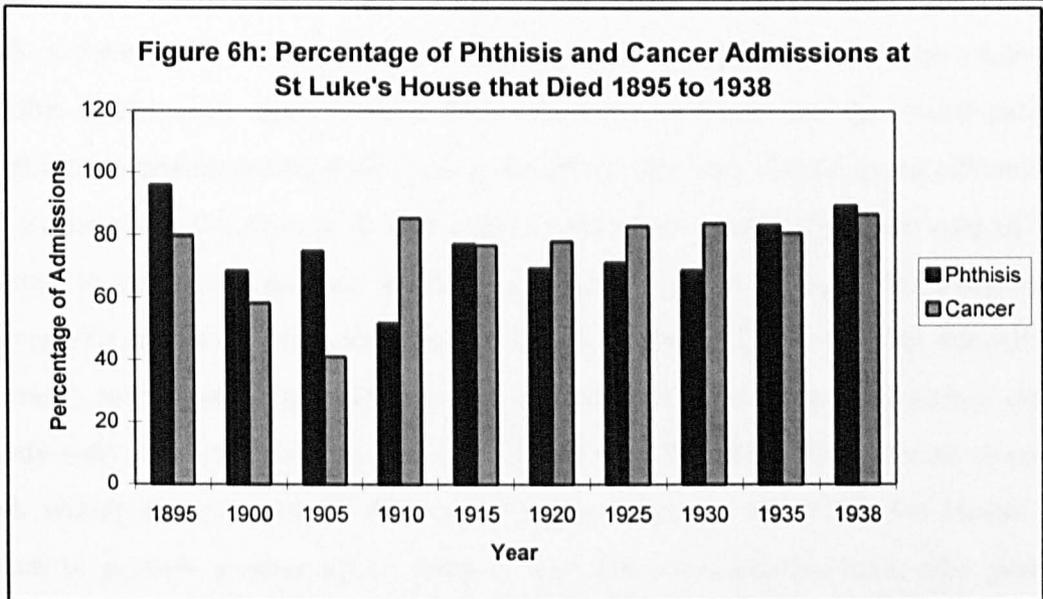
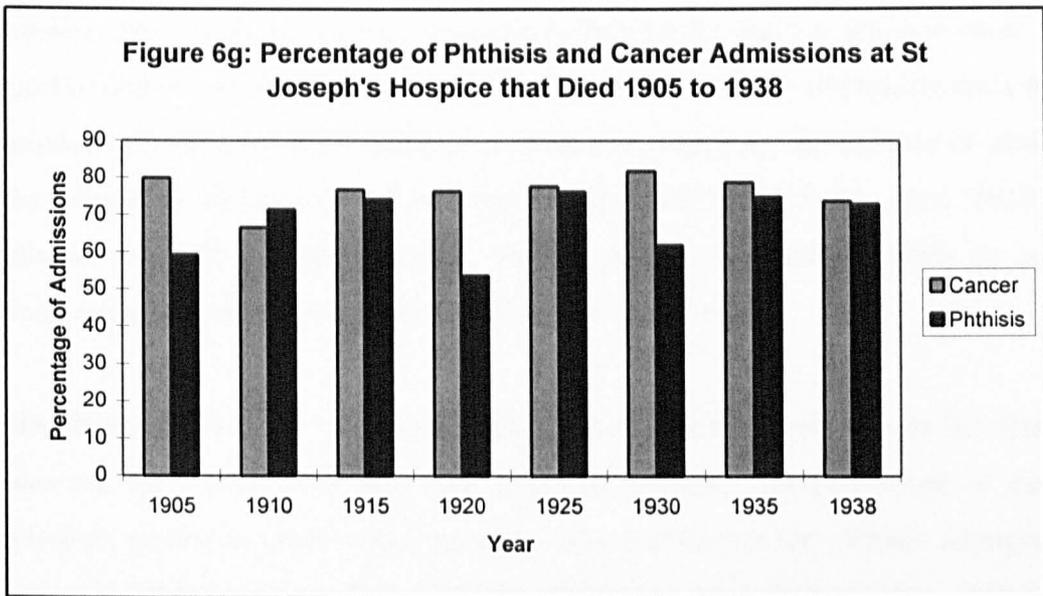
A comparison of the percentage of deaths at the Hostel of God caused by phthisis and cancer (figure 6c) suggests that the percentage of cancer deaths was generally higher, especially after 1914. Between 1897 and 1914 the proportion of phthisis deaths increased very slightly but after this period it fell sharply so that by 1930 the number of deaths was minimal. In contrast, the percentage of cancer deaths rose gradually throughout the whole period. From 1920 it accounted for an increasingly higher percentage of deaths and after 1930 it was the major cause of death, being responsible for over 69% of deaths in 1930 and 77% in 1938.

The transition from phthisis to cancer deaths was most apparent at St Luke's House. Figure 6d suggests that from 1895 to 1905 the percentage of deaths from phthisis was significantly greater. Between 1905 and 1910 this trend was reversed so that by 1910 cancer accounted for a higher proportion of deaths in the Home. While the number of phthisis deaths decreased gradually throughout the period, the mortality rate for cancer rose steadily.

It would appear from a comparison of the percentage of deaths of patients with cancer (figure 6e) that all three homes experienced an overall increase between 1895 and 1938. St Joseph's had the lowest proportion of cancer deaths throughout the period. Between 1895 and 1910 the percentage of cancer related deaths at St Luke's was less than that at the Hostel of God, but from 1910 this situation began to reverse so that after 1920 cancer deaths at St Luke's exceeded those at the Hostel of God.

The chart comparing the percentage of deaths for patients with phthisis suggests a very different pattern (figure 6f). After 1910 all three homes, especially the Hostel of God, experienced a decline in the proportion of phthisis deaths. The percentage of phthisis deaths at St Joseph's was consistently higher than the other two homes throughout the period, most notably in 1925 and 1938.

Figures 6g to 6i contrast the percentage of cancer and phthisis admissions that died in the three homes. On the whole St Joseph's Hospice showed less discrepancy between phthisis and cancer deaths, although the percentage of cancer admissions which died



was generally slightly greater. The proportion of cancer admissions resulting in death remained consistently high throughout the period, while that for phthisis cases was subject to slightly more fluctuation. At St Luke's the percentage of phthisis and cancer admissions resulting in death showed considerable variation, the number of phthisis cases who died declined by almost half between 1895 and 1905. After 1910 the numbers remained consistently high, suggesting that the staffs' efforts to admit patients with an accurate prognosis were more successful.

At the Hostel of God both cancer and phthisis deaths showed considerable fluctuation. It was not until after 1925 that they began to stabilise; the percentage of cancer admissions ending in death remained more than double that for phthisis admissions. The considerably lower number of deaths of patients with phthisis after 1925 (over 60% of these cases were discharged from the home) suggests that perhaps prognosis for this disease was more difficult than for cancer sufferers and that many patients went into remission during their time in the Home, possibly due to recent advances in the treatment of the disease. It also appears that by the early 1930s the type of care offered to tubercular patients at the Home had begun to change. The issue of *St Margaret's Magazine and Half-Yearly Chronicle* for 1931 stated that outside the women's ward there was a balcony with a glass roof at one end and a screen on the windy side in which there were two permanent beds for tubercular patients to use in both winter and summer.¹¹⁹ This might suggest that by the 1930s the Hostel had begun to provide a more active form of care and treatment for tubercular patients based on the same theory - 'outdoor treatment' - that underpinned sanatoria treatment.¹²⁰

Close scrutiny of the data for each home suggested that in general the rise in the number of cancer patients over the years was paralleled by an increase in the number of deaths. The data also suggested that the death rate was higher in those years when the number of cancer admissions was especially high. Analysis was also conducted to determine if there was any relationship between length of stay and outcome, but there

¹¹⁹ *St Margaret's Magazine and Half-Yearly Chronicle* (1931), Vol. III, Part 3, p.88.

¹²⁰ Worboys, M. (1992) The sanatorium treatment for consumption in Britain, 1890-1914, in J.V. Pickstone (ed) *Medical Innovations in Historical Perspective*. Basingstoke: Macmillan, pp.50-52.

does not appear to have been an identifiable link in any of the homes, except perhaps at St Luke's House, where the percentage of deaths occurring within a month increased gradually from 38% in 1897 to 55% in 1938. At the same time, the proportion of patients discharged after a month during the same period rose slowly from 41% in 1897 to 65% in 1935, suggesting that by the latter half of the period the outcome for patients who remained in the Home for less than a month was more likely to be death than discharge.

ix. Patterns of discharge

The personnel who ran the homes were particularly conscious of the number of patient discharges each year, especially at St Luke's House where it was felt to be a reflection upon the overall performance of the Home. A high percentage of discharges was viewed by Howard Barrett as "deplorable" because it represented a "misappropriation of our funds."¹²¹ Figure 7a, which compares the three homes, suggests that the rate of discharge between 1895 and 1938 in each institution was subject to considerable variation. Again, the figures are given as a percentage of admissions. The number of discharges at St Luke's was, despite Barrett's frequent laments, generally lower than at St Joseph's and the Hostel of God. All three homes experienced an overall decline in the number of discharges. Although this decline occurred at a slightly faster rate at St Joseph's and the Hostel of God, it was prone to greater fluctuation, while at St Luke's the fall in the number of discharges was a much more gradual process.

a. Phthisis and cancer discharge rates

During the very early years at the Hostel of God (1897 to 1902) phthisis appears to have accounted for a considerably higher percentage of the total discharges (figure 7b). After 1902 both phthisis and cancer rates fluctuated somewhat but from 1920 onwards there was a growing trend towards a predominance of cancer discharges and by 1935 phthisis discharges were no longer a factor. A comparison of the percentage of discharges made up of cancer and phthisis patients at St Joseph's Hospice (figure

¹²¹ 12th SLHAR, 1905, p.12.

Figure 7a: Percentage of Admissions Discharged 1895 to 1938

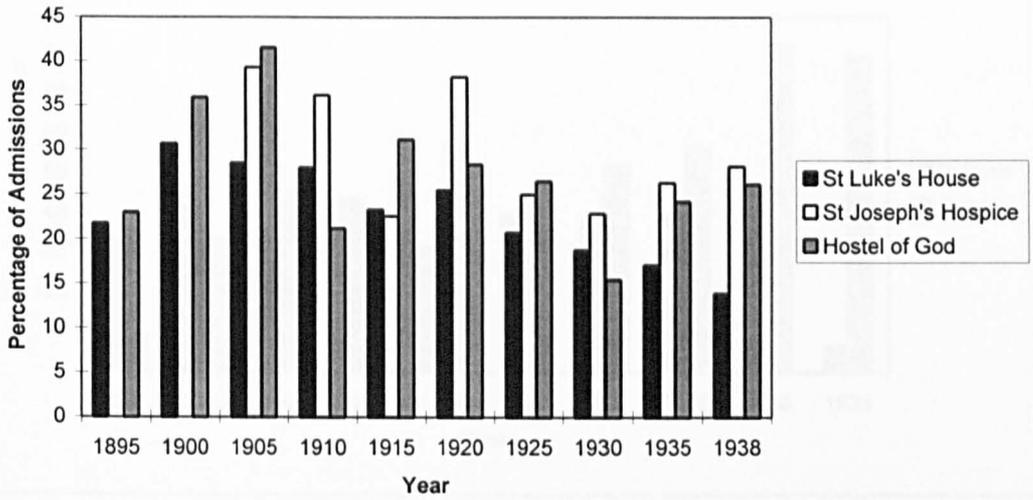


Figure 7b: Percentage of Discharged Patients at the Hostel of God with Phthisis and Cancer 1895 to 1938

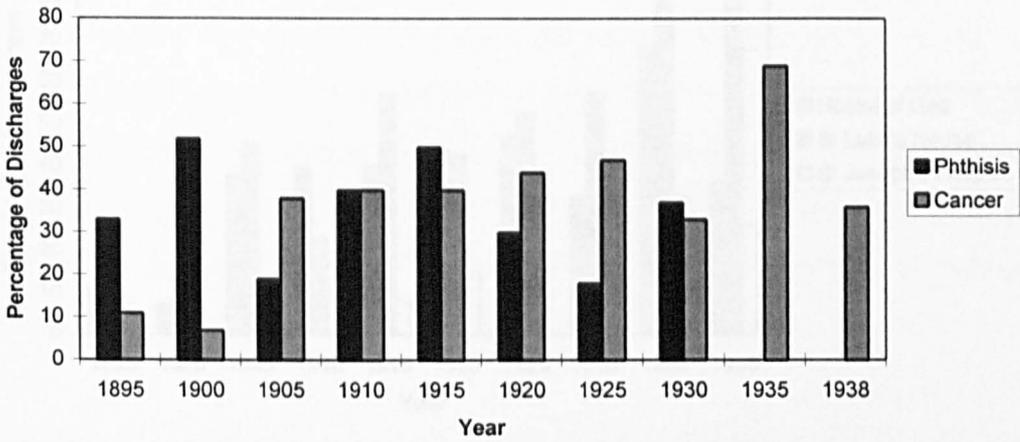
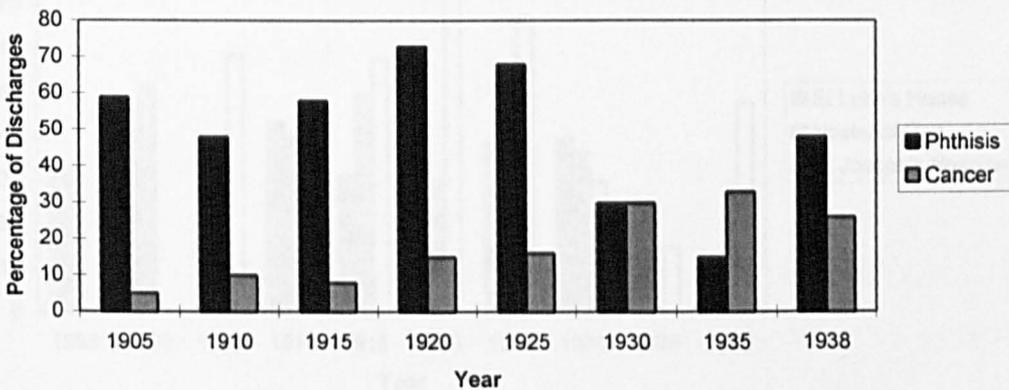
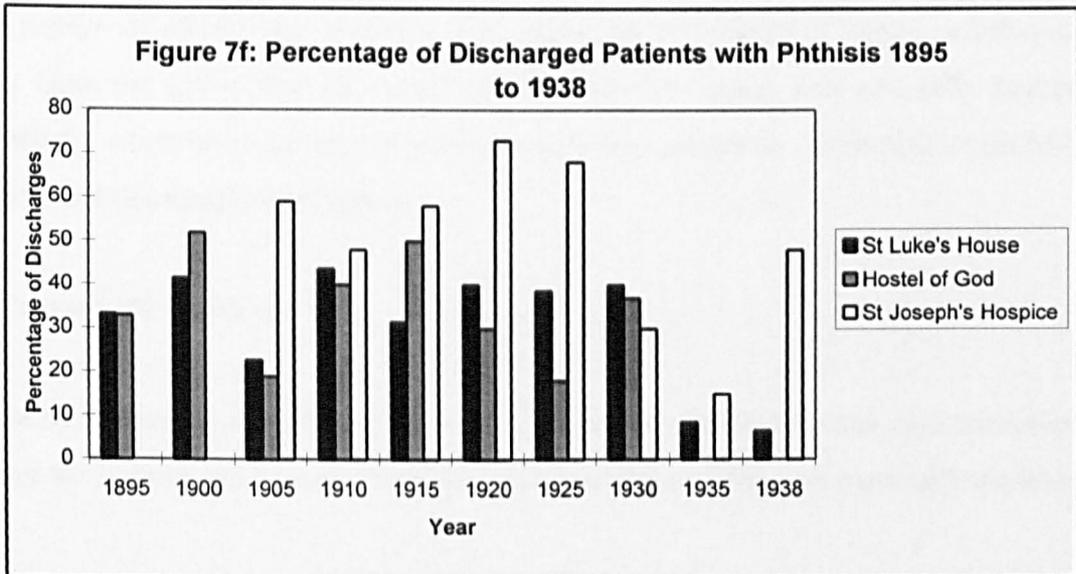
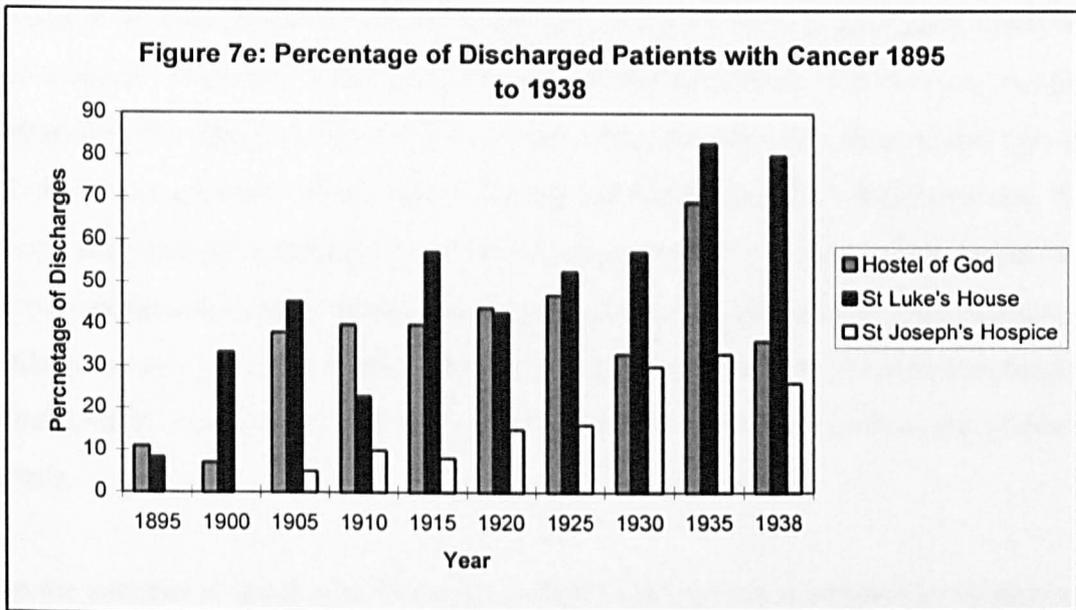
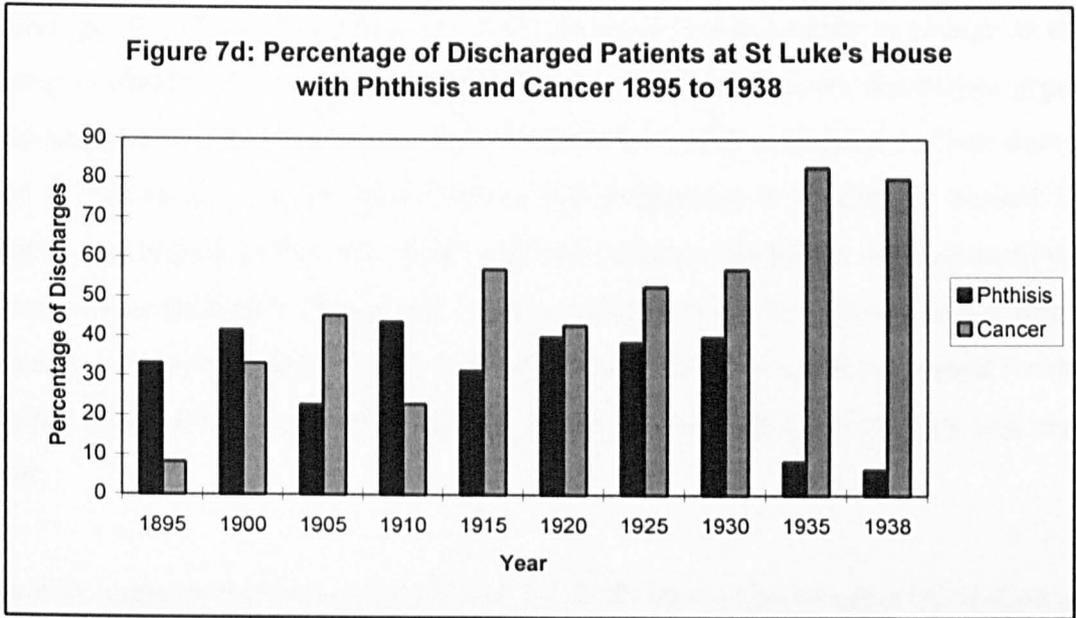


Figure 7c: Percentage of Discharged Patients at St Joseph's Hospice with Phthisis and Cancer 1905 to 1938





7c) suggests that the period from 1905 to 1925 was characterised by a much higher percentage of phthisis discharges. By 1930 this trend was beginning to change as the number of phthisis discharges fell rapidly and the number of cancer discharges began to increase, although even by the mid 1930s the latter still accounted for less than a third of discharges. At St Luke's House the proportion of discharges caused by phthisis was highest in the early years when the number of phthisis admissions to the Home was much higher (figure 7d). As the number of cancer patients in the home increased, the percentage of cancer discharges rose. By 1935 cancer accounted for the majority of discharged patients, while the proportion of phthisis discharges was very small.

Figure 7e suggests that between 1895 and 1938 all three of the homes experienced an increase in the percentage of patients discharged suffering from cancer, particularly St Luke's House. St Joseph's had a significantly lower proportion of cancer discharges compared to the other two homes. By contrast, the percentage of cancer discharges at St Luke's was generally much higher throughout the period. The discharge rate for patients suffering from phthisis was more erratic, particularly before 1920 (figure 7f). The only noticeable feature during this period was that the percentage of discharges at St Joseph's was generally higher. After 1920 the percentage of phthisis discharges declined fairly rapidly. In 1938 St Joseph's was the only home discharging phthisis patients.

Both the patterns of death and discharge at each of the homes corresponded largely to the pattern of admissions: in those years when the percentage of cancer admissions was high the percentage of cancer deaths and discharges was generally higher. Similarly, when the proportion of phthisis cases was greater the percentage of phthisis deaths and discharges was higher.

b. Reasons for discharge

As well as being preoccupied with rates of discharge, the homes were also concerned about the various reasons *why* patients were discharged. This was especially apparent

at St Luke's House where the Medical Superintendent included statistical information on the reasons for discharge in his report each year. The information recorded in these provides further insights into the social attitudes which governed interactions between the patients and the personnel who ran the homes. From 1894 to 1913 the reasons were individually broken down but after 1914 they were sub-divided into various categories, such as "considerably improved" and "left for treatment." In order to examine the reasons for discharge throughout the whole period, an attempt was made to organise the reasons given in the earlier years under the same headings, adding additional ones only where necessary.

Table 9 suggests that the three principal reasons for discharging patients were that they improved considerably, they left at their own request or they were chronic cases. The other major reason was that patients were not sufficiently advanced in their condition. A considerable number of patients were also discharged each year at the request of their relatives. One sub-group within the class of patients who left at their own request consisted of those who soon after admission witnessed a death in the ward. Howard Barrett attributed this to the lack of private wards to which those about to die could be transferred.¹²²

Several patients each year were sent to other institutions, such as sanatoria, hospitals or convalescent homes, some leaving to receive treatment, others to have an operation. Occasionally patients were admitted temporarily before being sent elsewhere, or were discharged and then readmitted at a later date. The latter usually occurred in instances where the patient improved sufficiently to be sent home for a while but would then have to return after suffering a relapse. All these types of discharges had implications for the homes fulfilling their purposes as institutions for the 'dying' and suggest that on occasion they acted as places of respite and more general care.

Although table 9 only shows homesickness as a specific reason for discharge in 1905, it was cited on several other occasions during the early years when the reasons for discharge were individually recorded. In 1898 Howard Barrett wrote that many

¹²² 21st SLHAR, 1914, p.15.

Table 9: Reasons for Discharge at St Luke's House 1896 to 1938

| REASON FOR DISCHARGE | PERCENTAGE OF TOTAL NUMBER OF DISCHARGES | | | | | | | | | |
|--|--|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| | 1896 | 1900 | 1905 | 1910 | 1915 | 1920 | 1925 | 1930 | 1935 | 1938 |
| Considerably Improved | 50 | | 19 | 31 | 34 | 16 | 31 | 31 | 41 | 58 |
| Left At Own Desire | | 20 | 33 | | 49 | 13 | 16 | 20 | 15 | 6 |
| Left At Relatives Request | | 10 | | 25 | 3 | 3 | 2 | 9 | 3 | 3 |
| Chronic | 7 | | | 23 | | 38 | 20 | 6 | 9 | 3 |
| Not Sufficiently Advanced | | | | | | 16 | 8 | 14 | 12 | 9 |
| Unsuitable | 7 | 10 | 10 | | 14 | 6 | | | | |
| Sent To Sanatorium | | | | | | 9 | 8 | | | |
| Left For Operation | | | | 2 | | | | | | |
| Temporarily Admitted | | | | | | | 4 | | | |
| Mental | | | | 4 | | | | | 6 | |
| Sent To Other Institution | | 10 | | 2 | | | | | | |
| Not Realise It Was A Home For The Dying | 21 | 10 | 5 | 2 | | | | | | |
| Left For Further Treatment | | | | | | | 8 | 6 | | |
| Discharged And Readmitted | | | | | | | 4 | 14 | 15 | 21 |
| Wanted To Die At Home | | 20 | 5 | | | | | | | |
| Became Unmanageable | 14 | 10 | 14 | 8 | | | | | | |
| Home Sick | | | 10 | | | | | | | |
| TOTAL NUMBER OF DISCHARGES | 14 | 10 | 21 | 48 | 35 | 32 | 51 | 35 | 34 | 33 |

Categories in bold correspond to those in the Annual Reports 1914-1938

patients suffered acutely from homesickness, sometimes so strongly that he felt “constrained to let them go.”¹²³ Some patients were discharged because they were considered unsuitable for the home. This often referred to cases in which the personnel, usually the Medical Superintendent, thought that the infirmary was a more appropriate place for them to be.

Another frequently cited reason for discharge was that the patient became delirious, mentally unstable or unmanageable in some way. The latter category was sometimes used to refer to “over-dosed morphia cases” - patients who were dependent upon taking large amounts of morphia. One of the application forms contained a question asking whether the applicant “is or was ‘light-headed’, ‘delirious’, or ‘difficult to manage’.”¹²⁴ These types of cases were often sent to the infirmary. Occasionally cases of mental instability were sent to the asylum.¹²⁵ The disturbances created by such inmates could also lead to requests from other patients to be discharged.¹²⁶

Other reasons for discharge recorded individually before 1910 but not specifically mentioned in the later period included patients who wished to die at home and those who did not realise it was a home for the dying until after they had been admitted. Once this fact was discovered they too usually wanted to return home to die. Edmund Barrett remarked that many of the soldiers and sailors who were admitted to St Luke’s suffering from tuberculosis contracted during the War requested to return home because they had come to the Home imagining they would be cured. The nature of their disease meant their stay was usually long-term and many were unable to withstand it because “their powers of duration are usually long exhausted before they get to us. They find they are getting worse not better and insist on returning home.”¹²⁷ Occasionally patients were forced to enter against their will by friends or relatives and would subsequently request to return home.¹²⁸ Others wanted to leave because of “domestic troubles.”¹²⁹ It is highly probable that all these factors and homesickness

¹²³ 5th SLHAR, 1898, p.11.

¹²⁴ 12th SLHAR, 1905, p.12.

¹²⁵ 8th SLHAR, 1901, p.14.

¹²⁶ 12th SLHAR, 1905, p.12.

¹²⁷ 26th SLHAR, 1919, p.10.

¹²⁸ 9th SLHAR, 1902, p.10.

¹²⁹ 11th SLHAR, 1904, p.10

continued to be a reason for discharging patients during the later years but did not show up in the statistics because they were subsumed within categories such as 'left at own request'.

At St Luke's House moral considerations not only influenced the decision to admit cases but could also be used as a reason for discharging them. This was particularly apparent in the early years when Howard Barrett was Medical Superintendent and the individual reasons for discharge were described by him in more detail. Patients were often referred to as being "spoilt" and criticised for exhibiting "bad behaviour."¹³⁰ Two discharged patients in 1899 were deprecated for being "morose, quarrelsome and very troublesome and rude to the nurses."¹³¹ Some of the "unsuitable" patients who were recorded as being more appropriate cases for the infirmary were dismissed over the question of moral suitability. Two cases discharged in 1914 were described as "most objectionable men of the infirmary class" who were "quite unable to appreciate the kind of relief we offer."¹³² The way in which the reasons for discharging patients were written about and the fact that they were recorded so meticulously can also be seen as part of the process of constructing the Home's underlying ideology and prescribing the types of patient eligible for admission and retention.

One of the problems occasionally encountered at St Luke's House concerned the admission of patients who were not actually in a dying state. The impossibility of distant candidates being seen by the medical staff prior to admission meant that they were sometimes deceived as to the patient's true condition. The diagnosis on the certificate sent by the candidate's local medical man did not always correspond to what the medical personnel at the Home thought it should be. This was particularly apparent in the patient registers for 1915 to 1918 which had one section for recording the diagnosis stated on the admission form and another detailing their diagnosis in the Home. The latter often gave a different diagnosis or one that was more detailed than that provided on the application form. For example, the admission form of one female patient in 1915 noted that she was suffering from a pelvic tumour but the doctor who

¹³⁰ 12th SLHAR, 1905, p.12.

¹³¹ 7th SLHAR, 1900, pp.11-12.

¹³² 22nd SLHAR, 1915, p.15.

examined her in the Home discovered that she in fact had fibro-sarcoma of the uterus.¹³³

Another major problem was the admission of 'incurable' and 'chronic' patients. Many of the annual reports referred to the difficulty people had in distinguishing between "dying," "incurable" and "bed-ridden."¹³⁴ Very often the high number of discharges was due to what was seen as the unnecessarily high proportion of unsuitable cases.

"But many charitable people, and even a few Hospital Sisters and District Nurses seem to have no conscience in the matter, and either mistake one who is sick with incurable disease for a dying person.....or else do not trouble at all about the matter so long as they can shift the object of their care from their own hands to ours."¹³⁵

Howard Barrett was particularly averse to the practice of "dumping," a term used to describe the deliberate attempts of friends and families to pass on the responsibility of caring for the patient despite being, in his view, perfectly capable of carrying out the task themselves. He described these instances as:

"aspects of selfishness, some of them wrapped up in a diaphanous veil of sanctimoniousness, hypocrisy, or 'economy of the truth'. No tariff reformer can be more opposed than I am to *dumping* [his italics], especially when it takes the form of feeble and invalid persons in St Luke's House by relatives and friends who are well able and bound by every tie of nature and humanity to care for themselves."¹³⁶

By contrast, those patients who, because of the nature of their disease and the wretchedness of their want, were dying when admitted, but who began to amend once they were brought to the Home, were looked upon more favourably. Such patients were sent home with the promise of readmission when it became necessary.¹³⁷

Occasionally unsuitable, patients could not be discharged and this would result in a lower than average number of admissions.¹³⁸ In the annual report for 1908 Howard Barrett listed the reasons why unsuitable patients were sometimes allowed to stay: (1) they had nowhere else to go, (2) their friends or relatives refused to resume the burden

¹³³ St Luke's House Patient Case Book 2 March 1915 - 31 December 1918, No. 21.

¹³⁴ 3rd SLHAR, taken from 9th WLMAR, 1896, p.3

¹³⁵ Ibid., p.7.

¹³⁶ 12th SLHAR, 1905, p.8.

¹³⁷ 3rd SLHAR, taken from 9th WLMAR, 1896, p.7.

¹³⁸ 8th SLHAR 1901, p.12.

of looking after them and (3) patients sometimes fluctuate. He went on to write that in the first two cases the infirmary was the only alternative but he “disliked intensely that anyone should have to go there.”¹³⁹ This statement, although, a direct contradiction of comments made in other annual reports in which he openly confessed to having no qualms about sending unsuitable patients to the infirmary, reflected Barrett’s ambivalent attitudes towards the respectable and non-respectable poor.

The Hostel of God patient registers only record the reasons for discharge for the years 1927 to 1930 but this is sufficient to show that patients were discharged for many of the same reasons as the inmates at St Luke’s: they did not know that they were dying or realise the nature of the home; they left to go to other institutions (including the infirmary); they wanted to die at home; they were chronic rather than dying; they improved enough to leave; they developed mental symptoms; they were too well or they were worried about things at home. It is impossible to make any kind of statistical comparison with St Luke’s because there are too many missing entries in this column in the Hostel of God registers.

Occasional references to the reasons for discharging patients were also contained within the annual reports. Again, many of these were the same as those recorded in the patient registers. The few exceptions not mentioned in the registers were patients discharged because they were dissatisfied with the Home or because there was only a limited supply of stimulant available (this latter type may refer to, or include, morphia dependants similar to those mentioned at St Luke’s).¹⁴⁰

The relatively high number of patients discharged because they did not realise they were entering a home for the dying prompted a fairly detailed comment by the Medical Officer of the Home in his report for 1921.

“As time goes on I am struck with the number of cases that enter the Hostel without the slightest idea that they are afflicted with a mortal illness - indeed some think they are entering a Convalescent Home and are speedily to be nursed back to health! When as is sometimes necessary, the state of affairs

¹³⁹ 15th SLHAR, 1908, p.14.

¹⁴⁰ HOGAR, 1896, p.11.

has gently to be conveyed to them, the resultant shock makes them make up their minds to leave the home without giving the matter due thought.”¹⁴¹

Thus it appears that at St Luke’s and the Hostel of God there were tensions between the different perceptions people had about the homes. Despite the efforts of the staff to restrict entrance to patients who were ‘dying’, patients who only used the homes as a temporary measure were occasionally admitted. It also seems that a number of those who used the homes were under misconceptions as to their real purpose; some thought they were a nursing home, while others were simply not aware that they were in an institution for the *dying*, and on discovering this felt compelled to leave. Barrett’s comments on hospitals and families trying to use the home as a “dumping” ground for chronic and aged patients suggests that others saw them as way to rid themselves of the responsibility of caring for these types of patient.

On very rare occasions it appears that patients could actually be “cured.” In 1931 the Medical Director at the Hostel of God cited the example of two cancer cases in which the success of radiation treatment they had undergone prior to admission was not manifested until they came to stay in the Home.¹⁴² It is unlikely that a strict definition was always applied to the use of the term cure given the relatively limited medical understanding of the types of conditions that were admitted to these homes and the lack of available treatments. For example, one female patient, admitted to the Hostel of God in May 1930 with heart disease, was recorded as being discharged less than two months later because she was apparently cured.¹⁴³ Heart disease is rarely cured and certainly would not have been in 1930. It is more likely that so called ‘cured’ patients were actually those whose recovery was so pronounced that the threat of imminent death disappeared and they were able to return, at least temporarily, to their former lives.

The patient registers for St Joseph’s Hospice did not include reasons for discharge but the annual reports stated that most patients left because they were “temporarily improved.” A newspaper article written a few years after the Hospice opened also

¹⁴¹ HOGAR, 1921, p.6.

¹⁴² HOGAR, 1931, pp.8-9.

¹⁴³ Hostel of God Patient Register January 1927 to June 1942.

confirmed this. The author helped to explain the longer average length of stay at the Hospice:

“It might be expected that in an institution set apart exclusively for the dying there should be a more rapid change of inmates, but the explanation of this apparent paradox is simple. When the sufferers, especially the very poor among them, attain the fulfilment of their desires, find themselves securely sheltered and tenderly nursed, with their pains assuaged and their spirits comforted by the daily visits of the skilful and kind physicians, these semi-moribund patients revive for a time under such beneficent influences, and linger longer than could have been anticipated.”¹⁴⁴

The accounts of 'patients in the annals also cite this as the principal reason for discharging patients. The other reason stated in the annual reports was that patients who were mentally affected were sent to the infirmary. However, it is also reasonable to conjecture that many of the same reasons given at St Luke's and the Hostel of God would have applied to the Hospice.

x. Conclusion

The data which has formed the basis of the discussion in this chapter essentially reflects the perceptions of the personnel who ran the homes - the medical staff and / or sisters - and is informative about their behaviour in dealing with a large and varied patient population. These perceptions were shaped by a variety of factors; medical, moral, religious, social and economic. Although the information was not provided immediately by the patients and therefore cannot provide *direct* insight into their individual experiences, the fact that it was divided up into discrete units does provide a few indications as to the type of patients using the home and what might have happened to them inside; namely, what they suffered from, how they ended up in the home, how long they stayed and what their eventual outcome was.

Several distinct trends and patterns have emerged from the analysis of the records. The homes were very obviously founded for a particular type of patient; members of the 'respectable poor' who lacked the means to care for themselves after the onset of a fatal disease. The emphasis upon the need for 'respectability', especially at St Luke's

¹⁴⁴ 'St Joseph's Hospice for the Dying', Newspaper unknown, c1909, St Joseph's Hospice Archive.

House, was in keeping with wider upper and middle class attitudes towards the poor. Many other philanthropic institutions established by members of these social groups during this period adopted the same principle. The preoccupation with a certain type of patient was particularly pronounced at St Luke's House where several other conditions were attached to admission. Patients were not only expected to die within four months but they also had to be suffering from certain types of disease (non-infectious) and to come from within a specific geographical radius (London and its environs). Moral considerations were especially influential in the Home, not only in formulating admission policies but also in determining reasons for discharge.

During the early years of their history the homes were very much small, independent, community based institutions. Many of the patients, especially at St Joseph's, were sent by local ministers and religious organisations. St Joseph's also centred much of its work upon the local, predominantly Irish, Catholic population in the East End. Over the years the homes became recognised as specialised institutions (in the sense that they specialised in the care of a particular section of the patient population) which formed part of a broader network of medical provision in London. St Joseph's became part of local authority provision and St Luke's and the Hostel of God were integrated into the London hospital system. Although St Joseph's Hospice and the Hostel of God continued to be looked upon as homes, St Luke's, after 1917, adopted the title of St Luke's Hospital for Advanced Cases and assumed the status of a small, special voluntary hospital.

The religious affiliation of patients reflected the denominational basis of the homes. At St Joseph's Hospice the large majority of patients before the early 1920s were Catholic. After 1925, possibly in response to the rise in the number of patients sent by local authorities, the number of Catholic inmates began to decline while the proportion of Anglican patients coming into the Hospice increased. However, despite these changes Catholics continued to account for a higher percentage of inmates. At the Hostel of God most of the patients continued to be Anglican throughout the period. Although St Luke's House was a Methodist run institution, patients were recorded as belonging to a much wider diversity of denominations and religions.

However, this still accorded with the religious underpinnings of the Home because Methodist theology was more concerned with the need to be Christian, rather than to belong to a certain denomination. The social, religious and geographic backgrounds of the patients all reflected the cultural heterogeneity of London.

The epidemiological basis of the homes also changed dramatically during this period, from a majority of tuberculosis patients to a higher preponderance of inmates with cancer. The predominance of patients with phthisis and cancer was part of a broader epidemiological change which occurred during the late nineteenth and early twentieth century: the shift from acute infectious diseases to chronic degenerative conditions. The transition from phthisis to cancer patients formed part of wider mortality patterns: the steady decline in the tuberculosis mortality rate and the increase in the number of cancer deaths. It can also be explained, in part, by local authority efforts in the 1920s and 1930s to take on responsibility for advanced tuberculosis cases. The transition from phthisis to cancer was particularly apparent at St Luke's House and the Hostel of God where it occurred at a considerably earlier date than at St Joseph's Hospice (1905-1910 as opposed to 1925) and was numerically greater. The higher percentage of phthisis patients at St Joseph's before the mid 1920s was possibly related to the higher number of patients sent to the Hospice by local mission led work and local authorities during this period. The larger percentage of cancer patients at the other two homes was probably due to a much greater number of hospital referrals.

During the early years the homes appear to have experienced certain difficulties in fulfilling their purpose as institutions for the *dying*; the proportion of discharges was generally higher. At St Luke's House the personnel were particularly strict about the need for patients to be in a dying condition and beds often had to be closed because there were insufficient patients to fill them.¹⁴⁵ Over the years, however, the number of deaths in the Home increased gradually while the average length of stay of patients shortened, suggesting that they became more successful in admitting only patients who were in a dying condition. The Sisters at St Joseph's were willing to accept longer term patients and the number of discharges was often relatively low compared

¹⁴⁵ Minute Book of St Luke's House Committee of Management, 18 June 1912 - 27 May 1918; 19/05/1914, pp.8-10.

to the number of beds provided. Some of the reasons for discharging patients at St Luke's and the Hostel of God suggest that on occasion the homes were used for purposes other than simply caring for the 'dying'. They also give insight into the difficulties involved in trying to carry out a policy whereby only patients whose death is not far off are admitted.

The focus of this chapter has been upon understanding the patients as a group and the insights that this can give into what their experience in the homes might have been. The largely quantitative analysis, generated by an examination of the statistical information, provides the basis for a more qualitative assessment of the role of the different staff in the homes and their relationship with the patients in the next chapter.

Chapter 5

Management of the Death Bed:
Medical, Nursing and Spiritual
Roles in Care of the Dying

The first homes for the dying in England were founded during a period which saw several new developments in the medical management of the dying and changes in attitude towards related areas, such as pain. During the late nineteenth and early twentieth centuries medical care of the dying emerged, for the first time, as an area of special interest as doctors began to address their role in the management of patients in the advanced stages of disease. In response to this and wider religious and social changes the fundamental components of care of the dying - medical, nursing and spiritual care - were re-prioritised, while scientific and therapeutic breakthroughs led to new ways of thinking about the concept of pain. The homes for the dying responded to, were shaped by, and contributed towards, many of these developments, although they did not necessarily conform to them.

Pat Jalland argues that care of the dying in the late nineteenth and early twentieth centuries was characterised by an increase in the role of the medical profession and a decline in spiritual concerns. She maintains that, despite the therapeutic limitations of late nineteenth and early twentieth-century medicine, the medical profession began to occupy a more prominent and active place at the deathbed. She has linked this to the gradual transition that occurred between 1830 and 1920 from an emphasis upon spiritual concerns at the deathbed to a growing anxiety to minimise physical suffering. This shift in priorities was, Jalland claims, partly due to the decline in religious beliefs and the gradual change in attitudes towards death and disease in the late Victorian era. By the early twentieth century religious belief had come to be seen as subordinate to medical imperatives which she interprets as evidence of the influence of secularism on late Victorian and Edwardian doctors.¹

Jalland's interpretation of the relationship between medicine and religion, however, fails to account for the persistence of existing trends within late nineteenth century medical philanthropy. Many charitable institutions, outside of the voluntary hospitals, which offered medical treatment or nursing care continued to have some kind of religious basis and to serve as an important refuge for many of the sick poor, particularly those excluded from the hospitals. The personnel who ran them were

¹ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press, pp.77-86.

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.

Jalland's discussion is also flawed in two other respects: her failure to qualify her arguments by differentiating between the various social groups which made up Victorian society and her assumption that these ideas applied to all the different groups within the medical profession. Many hospitals and doctors continued, until well into the twentieth century, to refuse admission to working-class patients diagnosed as incurable, thereby denying them treatment in what, for many, was the most painful stage of their disease. These patients, unable to afford the fees they would have been expected to pay as private patients, were left to fend for themselves, many of them ending up in the workhouse infirmaries where treatment was still relatively undeveloped.²

Victorian doctors also behaved differently towards their rich, private, paying clients and the sick poor whom they treated in the hospitals and other voluntary institutions. The paying patient still ultimately controlled the purse-strings upon which the doctor was dependent for his livelihood, and thus was able to retain a degree of control over the doctor-patient relationship. In contrast, hospital patients were subjected to what Nicholas Jewson has termed an "object oriented medical cosmology" which gradually came to characterise doctor-patient relationships during the nineteenth century.³ Within this relationship the patient assumed a passive role and was afforded little opportunity to exercise control over the activities of the medical personnel. Thus historians cannot simply assume that changing attitudes among late Victorian doctors and their wealthier clientele were transplanted across the social divide to poor, working-class patients.

² Granshaw, L. (1989) 'Fame and fortune by means of brick and mortar': the medical profession and specialist hospitals in Britain 1800-1948, in L. Granshaw and R. Porter (eds) *The Hospital in History*. London: Routledge, p.201; Abel-Smith, B. (1964) *The Hospitals 1800-1948: A Study in Social Administration in England and Wales*. Cambridge, Massachusetts: Harvard University Press, pp.26, 44.

³ Jewson, N. (1976) The disappearance of the sick man from medical cosmology, 1770-1870, *Sociology*, Vol.10, pp.225-244.

The nineteenth century witnessed a shift in attitudes towards pain which inevitably impacted upon wider attitudes towards care of the dying. Under eighteenth century Enlightenment influences pain had been viewed in a paradoxical light: although doctors understood the suffering individual's fear of pain because it represented something that was intolerable and irrational, they sometimes felt constrained to inflict pain in order to achieve a cure. Isabelle Baszanger argues that the principal value of pain during this period was diagnostic; once it had helped the physician to identify the patient's condition, it was felt that it would disappear of its own accord after the illness or lesion associated with it was cured or had disappeared. Pain itself was neither a specific area of medical activity, nor was it the target of therapeutic intervention.⁴ During the Victorian era, however, pain began to be understood differently and, together with the development of clinical disciplines and therapeutic innovations, wrought a change in ways of thinking about it. Although pain still remained a peripheral area of medicine, the belief that it had a beneficial role to play in healing declined gradually. Instead, there were increasing efforts among physicians to alleviate pain and minimise suffering, which in turn influenced patients' expectations about the doctor's role in reducing pain.⁵ Rosalind Rey has argued that the development of anaesthesia was particularly instrumental in shaping new attitudes towards pain; the discovery and use of anaesthesia "deeply changed the relationship of men to pain by putting an end to its inevitable nature."⁶

The desire to relieve patients' pain and ease their suffering was especially apparent among those physicians who, in the late nineteenth century, began to develop a special interest in care of the dying. The major pain-relieving drug during this period was opium and its derivatives and these played a crucial and integral part in the management of patients in an advanced stage of disease. Medical and social attitudes towards opium had also undergone a change during the nineteenth century. During the early Victorian era it had been used widely as a means of alleviating pain, but after

⁴ Baszanger, I (1998) *Inventing Pain Medicine: From the Laboratory to the Clinic*. London: Rutgers University Press, p.2.

⁵ Rey, R. (1993) *The History of Pain*. Massachusetts: Harvard University Press, pp.131-139, 182 ; Porter, R. (1993) Pain and suffering, in W.F. Bynum and R. Porter (eds) *Companion Encyclopaedia of History of Medicine*. London: Routledge, pp.1586-1589.

⁶ Rey, *The History of Pain*, pp.131-139, 182.

1850, amidst concerns about the dangers posed to working-class morality by unregulated usage, severe restrictions were imposed to try and curtail its use. As a result, doctors attending to the dying in the late Victorian era exercised greater restraint in administering opium for the treatment of pain.⁷

Opium was also used in the treatment of various forms of cancer as a means of retarding the development of the disease and ameliorating some of its symptoms. Herbert Snow, Surgeon to the Cancer Hospital, Brompton, was a strong advocate of the value of opium in helping to relieve some incurable forms of cancer. He disagreed with what he felt was the general medical view - that no therapeutic treatment existed for malignant disease and that all doctors could do was sustain general health by tonics and dealing with pain or other unpleasant features as they may arise. Rather, he believed that in many instances malignant cell proliferation could be contained. In a lecture given to the Cancer Hospital in 1890 he argued that certain prevalent forms of malignant disease had a neurotic origin and that in such cases the administration of opium and morphine was paramount because it not only served to relieve painful symptoms, but could also, by promoting mental cheerfulness and tranquillity, help to curb cancer growth. He felt that smoking was the best way of administering the drug and inducing an opium habit because it afforded the means of minutely graduating the dose and avoided some of the side effects of oral administration or hypodermic injection.⁸ In 1893 Snow used a combination of opium and cocaine to help provide pain relief and published his results in 1896. This mixture formed the basis of what was later known as 'the Brompton cocktail', but at the time it appears to have attracted little attention.⁹

Traditionally, the Church regarded pain as an integral part of sickness and dying because it allowed the sick or dying person to demonstrate fortitude and courage in the face of suffering. Pain and suffering were also accepted within the homes for the

⁷ Berridge, V. and Edwards, G. (1981) *Opium and the People: Opiate Use in Nineteenth Century England*. London: Allen Lane, pp.105-109, 113, 228.

⁸ *British Medical Journal* (1890), Vol.2, pp.689-690 ; Snow, H. (1896) Opium and cocaine in the treatment of cancerous disease, *BMJ*, Vol. 2, p.718.

⁹ *Ibid.*, pp.718-719 ; Murphy, C. (1990) From Friedenheim to hospice: a century of cancer hospitals, in L. Granshaw and R. Porter (eds) *The Hospital in History*. London: Routledge, pp.226-227.

dying because they were believed both to be part of God's will and to play an essential role in the patient's spiritual development. However, at the same time, it was recognised that patients experiencing extreme pain were unable to focus on the condition of their soul because they could not see beyond their pain. These tensions were resolved by acknowledging that the two were not mutually exclusive and that the alleviation of bodily suffering in fact helped to facilitate spiritual ministrations.

The aim of this chapter is to look more closely at how care of the dying was perceived among the medical and nursing professions in the late nineteenth and early twentieth century and to assess where and how the homes for the dying fitted into the broader picture. Most of the information for the former comes from emergent literature on medical and nursing management of the dying in the late Victorian and Edwardian eras, while the latter is drawn primarily from committee minute books and annual reports. The first section examines the wider context of medical and nursing care of the dying during this period and the major issues which they encompassed. Between the late 1880s and 1938 attitudes towards medical care of the dying altered significantly. During the late Victorian era, through the pioneering work of Dr William Munk, it was recognised as an area requiring special medical knowledge and treatment. Munk, while enhancing the role of the doctor at the deathbed, at the same time kept it within a strictly defined moral parameter: the prolongation of life. Although spiritual care was still considered the most important form of care the dying patient could receive, it was beginning to be looked upon as clearly separate from medical care, the latter being the province of the physician and the former the responsibility of the chaplain. By the 1930s attitudes within the medical profession had begun to change. Spiritual care was declining in importance but the moral boundaries of the physician's role widened gradually to encompass the belief that in situations where patients were experiencing extreme pain it was acceptable for the doctor to curtail life if this would lessen their suffering.

The second section narrows the focus down to the three homes and tries to unravel the three major components of care of the dying within each institution: medical, nursing and spiritual care. Three principal themes are explored: firstly the organisation of each

type of care within the three institutions and how it changed over time. This period saw the beginnings of a separation of medical, nursing and spiritual care of the dying, but, as will be shown in the case of the homes, the boundaries between them sometimes overlapped considerably. The homes represent the first attempts to institutionalise care of the dying in England, and therefore it is of intrinsic historical interest to look at such issues as the recruitment of the various staff, their designated roles, their responsibilities, the various problems encountered and any external criticisms of the care they provided. Most of the discussion on medical and nursing care focuses upon St Luke's House and the Hostel of God because the absence of any minute books or annual reports for St Joseph's means that there is only a limited amount of information available on this aspect of the Hospice's work. Secondly, the way in which medical, nursing and spiritual care were carried out in practice is explored and the relationship between them. The provision of nursing and spiritual care at St Luke's was carried out very differently, the latter changing significantly in the second decade of the twentieth century, which had important implications for the Home's overall development. Finally, consideration is made of the location of the homes within the wider context of late nineteenth and early twentieth century care of the dying. In order to facilitate the analysis each type of care is examined separately for each home, although where appropriate comparisons and contrasts are drawn between them. The final section moves away from the providers of care in an attempt to begin to understand what life might have been like for those at the receiving end.

i. Medical care of the dying 1880 - 1938

Until the late 1880s medical care of the dying inspired little interest among doctors. Medical attention in the early and mid-Victorian era had focused more on the dead body; dissection of the dead and scientific study of the corpse were regarded as crucial to an understanding of the living body.¹⁰ As physicians themselves noted, by the second half of the nineteenth century a considerable body of medical literature had accumulated on the subject of death itself and the physiological processes involved in different modes of dying, but relatively little had been written on the medical

¹⁰ Richardson, R. (1987) *Death, Dissection and the Destitute*. London: Routledge and Kegan Paul Ltd, p.31.

management of the dying. Doctors did not receive any formal training in care of the dying because it was not included in any of the medical schools' curricula. Any knowledge they acquired was through their own personal experience in hospitals and with private patients. Similarly, it was felt that nurses received little guidance on how to nurse the dying. The subject was not covered in any of their lectures and nursing manuals contained only a very small number of references.¹¹ It was only in the late nineteenth century that the first serious attempts were made to begin to address medical and nursing care of the dying and that both these subjects began to be looked upon as a significant area within medical and nursing practice.

The first major recognition of the importance of medical care of the dying as a special area of study was Dr William Munk's textbook *Euthanasia: or Medical Treatment in Aid of an Easy Death*, published in 1887. His position as Consultant Physician at the Royal Hospital for Incurables meant that he would have been able to draw upon his own experience of working with patients with fatal diseases. Munk aimed to provide a systematic outline of the subject as far as it related to the work of the physician. Like most of his contemporaries he used the term Euthanasia in the classical sense of 'a calm and easy death'. He argued that until then the usual practice in the management of the dying had been for the doctor to withdraw during the final few hours and for nurses and/or relatives to assume responsibility.¹² Munk, however, advocated a greater role for the medical attendant in the last hours, claiming that the physician could use his skills to bring as much relief as possible to the patient's pain and discomfort. *Euthanasia* was based partly on Munk's own observations and experience and partly on the work of other leading medical personnel.¹³

The largest section of *Euthanasia* focused on the general and medical management of the dying, particularly the alleviation of pain and distress, the area in which Munk felt the physician had supreme authority. He argued that physicians' efforts in the care of the dying were "limited to the relief of certain urgent conditions, such as pain,

¹¹ *The Lancet*, (1888) Vol.1, p.21 ; Munk, W. (1887) *Euthanasia: or Medical Treatment In Aid of an Easy Death*. London: Longmans, Green, and Co, pp.v, 4 ; Browne, O. (1894) *On the Care of the Dying: a Lecture to Nurses*. London: George Allen, pp.7.

¹² *The Lancet*, 1888, Vol.1, p.22.

¹³ Munk, *Euthanasia*.

exhaustion, dyspnoea, spasm and the like.” He began by drawing attention to the importance of the correct administration of nutriment, claiming moderation and discretion were required when deciding which food should be given and should be guided by the patient’s wishes. He felt the use of alcohol had a special place in the treatment of the dying because of its properties as a stimulant. Munk considered opium to be next in importance after stimulants; it was “worth all the rest of the *materia medica*.” Its two primary functions were as an anodyne to relieve pain and as a cordial to relieve the sinking and anguish about the stomach and heart which occurred frequently among the dying and were often worse than the pain itself. He argued that it should not be given hesitantly or in insufficient doses: “If judiciously and freely administered it is equal to *most* of the emergencies in the way of pain that we are likely to meet with in the dying.” However, at the same time, he emphasised that the nature and effects of opium should be clearly understood.

“Opium must be administered in such doses as will appease suffering and disorder, and in this respect we are to be governed solely by the effect and relief afforded.”

Munk did not believe that it should be given as a hypnotic simply to help the patient sleep, although he acknowledged that this could be a side-effect of the drug, and there were certain conditions in which the administration of opium was not advisable because it might hasten death, for example, in cases where there was obstruction of the air passages.¹⁴

Although Munk praised the virtues of opium in the treatment of the dying, he erred on the side of caution when discussing its administration. He wrote that “the fewer the drugs and the less of medicine.....the better,” arguing that there were many cases in which medicine of any kind was not required; provided stimulants and nourishment were carefully administered they would often suffice to meet all the patient’s needs. However, in cases where the patient was suffering from extreme pain or experiencing a sinking sensation he continued to advocate opium as the best alleviative.¹⁵ Other medical authorities followed Munk in endorsing the use of opium in care of the dying. A reviewer of *Euthanasia* in *The Lancet* noted:

¹⁴ Ibid., pp.68-81.

¹⁵ Ibid., p.85.

“It is simply a neglect of duty, and a fault in our conduct of the last days or hours of many patients, to withhold the inestimable boon afforded by opium in full doses.”¹⁶

Like most Victorian doctors Munk was a Christian. He emphasised the influence that the mind and emotions, particularly the presence of hope, could have upon the bodily process of dying and said that this must continually be borne in mind by the physician. He believed that the most important form of comfort that the patient could have was spiritual: “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.” He said that in his experience the deaths of “disbelievers and agnostics” were accompanied by doubt and anxiety as to their future which served only to “render such euthanasia as we contemplate, impossible.”¹⁷

The value of spiritual care was augmented by enabling patients to have sufficient time to prepare to meet their Creator and Judge. For this reason Munk felt that it was important to acquaint sufferers with the prognosis of their disease as early as possible. He also argued that fear of death tended to occur at the stage when the individual first realised that death was imminent and that once the initial shock had passed the sense of terror gradually subsided to be replaced by a sense of calm. The responsibility for informing the patient rested primarily with family and friends; the doctor was only to undertake this duty if the latter were absent. Munk also identified the “*mental anguish*” (his italics) which patients experienced, particularly during the last moments. He said that although fear of death itself was unusual the final moments for many were often a time of distress brought on by their anxiety for those they were to leave behind.¹⁸

The authority of Munk’s text rested partly on his willingness to acknowledge that many of his ideas were drawn from the experience and work of earlier nineteenth century eminent physicians, particularly Sir Henry Hallford, accredited by both *The Lancet* and Munk as “a master in all that concerns the management of the Dying.”¹⁹ In

¹⁶ *The Lancet*, 1888, Vol.1, p.22.

¹⁷ Munk, *Euthanasia*, pp.22-23.

¹⁸ *Ibid.*, pp.24-27.

¹⁹ *Ibid.*, p.vi ; *The Lancet*, 1888, Vol.1, p.22.

1833 Halford, the President of the Royal College of Physicians and Physician in Ordinaire to the King, had published a small volume of *Essays and Orations*, based on a talk he had delivered to the College, which contained a few references to the physician's role in administering to patients with a fatal malady.²⁰ Although Halford's work suggests an earlier stage of interest in the medical management of the dying and helped to provide some of the inspiration for *Euthanasia*, his ideas, as Munk correctly noted, were largely in the form of incidental remarks rather than a coherently presented argument and, as such, exerted only a limited influence.²¹

Euthanasia remained the authoritative text on medical care of the dying during the late Victorian and Edwardian eras. Although a few other leading medical personnel expressed interest in the subject and published their own work, they contributed very little that was new. In 1894 Oswald Browne, physician to the Royal Hospital for Diseases of the Chest, wrote a pamphlet entitled 'On the Care of the Dying: a Lecture to Nurses'. Although Browne's work was written from a physician's perspective and reiterated many of Munk's ideas in *Euthanasia*, it represented the first attempt by doctors to address the role of nursing in the care of the dying and to make available to nurses the medical literature which already existed.²² Four years earlier, in 1890, a manual for district nurses by Mrs Dacre Craven had been published. It did include a very brief section on dying patients but only gave suggestions on "the best positions for the dying according to their ailment" and guidance on the laying out of the dead.²³ Browne's treatise offered more comprehensive advice on how nurses might assist in the care of the dying.

Browne argued that "amongst the many privileges which fall to us who wait upon the sick, there is none that touches or approaches this [the care of dying persons]." Although his lecture focused upon care of the dying from a scientific and

²⁰ Halford, H. (1833) *Essays and Orations*. London: John Murray, Wellcome Institute for the History of Medicine.

²¹ Munk, *Euthanasia*, p.vi.

²² Browne, *On the Care of the Dying*.

²³ Dacre Craven, Mrs (1890) *A Guide to District Nurses and Home Nursing*. London: Macmillan and Co., pp.100-107.

physiological perspective, he also acknowledged the importance of the spiritual dimension.

“There can be no view more short-sighted than that which in ministering to the body would forget the soul, and that in the last hours of this dying life would forget the life that will not die. We know how much such ministrations may do for peace of mind and spirit.”

Browne felt it was the nurses’ responsibility to direct spiritual provision for patients, arguing that it was their duty always to encourage, and even advise, patients to receive spiritual ministration at as early a stage of the illness as possible. However, the effects of visits from ministers were to be very closely monitored, short frequent visits being preferable. He also agreed with Munk that patients had a right to know their prognosis, but felt that it was the doctor’s duty to tell them.²⁴

Browne believed that the “special secret” of nursing the dying was constant unwearying waiting upon patients and the closest attention to the littlest things and to the least indication of their feelings. He emphasised the importance of “extreme *quietness*” and the need for privacy which could be secured by the use of screens. He also endorsed the use of morphia and opium derivatives in providing pain relief but, like Munk, cautioned against their over-use, emphasising the desirability of being able “to meet death with the unclouded use of such intellectual powers as might then remain to us.”²⁵

It is not certain just how much of an impression Munk and Browne made upon the wider medical and nursing professions. Although Munk’s treatise was read as far afield as America and his ideas were embraced by the few other doctors who wrote about care of the dying during this period, the extent of his influence among the profession as a whole is unknown.²⁶ Nevertheless, *Euthanasia* was a valuable and unprecedented breakthrough in medical literature on care of the dying and its contribution should not go unrecognised.

²⁴ Browne, *On the Care of the Dying*, pp.8, 26-27.

²⁵ *Ibid.*, pp.30-31, 37-38.

²⁶ ‘Some notes on how to nurse the dying’ by a Hospital Nurse (1890) *The Trained Nurse*, Vol. IV, 5: 17-21.

The late Victorian medical literature on care of the dying suggests that doctors were beginning to assume overall responsibility for the management of the deathbed. The growing importance attached to physical comfort and the alleviation of pain through the controlled administration of opium, which only they could provide, suggests that death was becoming increasingly medicalised during this period, a process whose roots can be traced back to the eighteenth century.²⁷ Although doctors continued to advocate the supreme importance of spiritual care for dying patients, they were beginning to look upon care of the soul and care of the body as separate areas, the former belonging exclusively to the province of the doctor and the latter to the sphere of the clergyman. Munk, despite endorsing the value of spiritual ministrations, did not envisage this as part of the physician's role. In the same way Browne, although he entreated nurses to encourage patients to receive spiritual care, also felt that its administration was primarily the responsibility of the clergyman. During the early decades of the twentieth century these trends became increasingly more apparent.

Between the 1890s and early 1920s there was very little published discussion by members of the medical profession on care of the dying but in 1921 an article appeared in *The Lancet* by J. Norman Glaister, the Chief Medical Assistant at the Royal Free Hospital, on the subject of 'phantasies of the dying'. Glaister focused in particular on the relationship between these 'phantasies' and the issue of whether or not to withhold from patients the truth about their prognosis and the implications that this had for the management of the dying.²⁸ His article not only reflected the declining reference to spiritual matters among the medical profession but is also revealing about a new area of interest that was beginning to emerge among those involved in care of the dying.

Glaister argued that the tendency for patients' friends to conceal from them the true nature of their condition produced a state of continual mental conflict in which patients inwardly knew the truth but were unable to communicate it to anyone. This conflict manifested itself in a world of dreams and 'phantasies' which only caused yet

²⁷ See Porter, R. (1989) Death and the doctors in Georgian England, in R. Houlbrooke (ed) *Death, Ritual and Bereavement*. London: Routledge, pp.79-94.

²⁸ Glaister, J.N. (1921) Phantasies of the dying: some remarks on the management of death, *The Lancet*, Vol.2, pp.315-317.

more anxiety for the patient. The emphasis upon mental communication was part of a newly emerging trend within medicine during this period through the work of Sigmund Freud and others; the development of psychology and the growing importance attached to psychological factors. Glaister emphasised the need for plain-speaking so that patients had time to adjust to what could be “a mental operation of considerable difficulty,” after which they could discuss with the medical attendant “the best possible use of the remainder of life.” He evidently did not envisage spiritual care as having a primary role to play in the management of the dying: the main actors were all from secular professions. He used the example of incurable cancer patients to illustrate the type of persons that he thought should be involved, arguing that, in cases such as these, the principal agents would be the surgeon, radiologist and psychologist.²⁹ As well as denoting a decline in spiritual concerns among the medical profession in the early twentieth century, such evidence suggests a growing concern for patients’ mental welfare.

The increasing separation of medicine and religion and the declining preoccupation among doctors with non-medical matters happened for a number of reasons. The decline in acute epidemic diseases, a decreasing mortality rate and an increasing life expectancy meant that death was no longer such an immediate threat or everyday occurrence. The rise of naturalistic explanations for disease and the rapid growth in medical and scientific advances during the nineteenth century provided a more central role for the physician; even though he could not offer the hope of a cure he could at least help to reduce the pain, discomfort and fear experienced by the patient.³⁰

During the late Victorian and Edwardian eras, deciding when to cease active treatment of the patient did not contain all the ethical permutations that it does today. Leading medical authorities, including Munk, agreed that stimulants should not be given indefinitely and that doctors should know when to stop their administration. Historically, the term ‘Euthanasia’ has had three different meanings. Under its

²⁹ Ibid.

³⁰ Gilbert, A. (1980) *The Making of Post-Christian Britain: a History of the Secularisation of Modern Society*. London: Macmillan, pp.10, 61 ; Prochaska, F.K. (1987) Body and soul: Bible nurses and the poor in Victorian London, *Historical Research*, Vol.60, pp.346-347 ; Jalland, *Death in the Victorian Family*, pp.77-81.

traditional classical usage it simply meant 'a calm and easy death'. However, during the eighteenth century its meaning altered slightly to denote the *means* of bringing about a gentle and easy death.³¹ Munk's emphasis upon the medical treatment to be used in "*aid of an easy death*" [my italics] reflected this change in meaning. He supported the use of those 'materia medica' (opium, alcohol etc.) which might help to alleviate the dying patient's pain and discomfort, but warned that they should never be administered in a way which might hasten death.³² During the late nineteenth century the meaning of Euthanasia began to alter again. Most Victorian doctors continued to use it in its more traditional sense, to mean 'a calm and easy death', but by the turn of the century, certain members of the medical profession were applying a different definition to the term. For the first time serious consideration was being given by some doctors to the possibility of actively *inducing* a gentle and easy death by deliberately deciding to terminate the life of a patient suffering extreme pain.³³ The extent to which this new meaning had taken hold among certain members of the medical profession and other groups was demonstrated by the foundation of a Voluntary Euthanasia Society in 1935 and an attempt in 1936 to secure Parliamentary legalisation of Euthanasia, as it related to this third definition.³⁴

Although, the majority of the profession in the 1930s did not support the legalisation of Euthanasia, and it failed to become law in 1936, medical opinion of the physician's duty in the management of the dying had undergone considerable change. Until the late nineteenth century the doctor's role was confined to the relief of suffering as long as it did not precipitate death. An editorial in *The Lancet*, in 1887, stated that the treatment of the dying was confined to certain rules. Drugs and stimulants should only be applied "to the extent of alleviating acute sufferings, and, without hastening death, of making the approach to death peaceable. To this extent medical art may go; no further."³⁵ Over the next fifty years the moral boundaries which regulated the physician's duty 'in caring for the dying seem to have widened gradually. The

³¹ *Oxford English Dictionary* (1989) 2nd edition, Vol.5. Oxford: Clarendon Press, p.444.

³² Munk, *Euthanasia*, p.81.

³³ *Oxford English Dictionary* (1989) 2nd edition, Vol.5, p.444 ; Jalland, *Death in the Victorian Family*, pp.93-94.

³⁴ Emanuel, E.J. (1994) The history of Euthanasia debates in the United States and Britain, *Annals of Internal Medicine*, Vol.121, No.10, pp.797-798.

³⁵ 'Euthanasia Secundem Artem', *The Lancet*, 1887, Vol.2, p.1178.

arguments put forward in the House of Lords debate in 1936 are illuminative of how ways of thinking among the medical profession had begun to change. Viscount Dawson, an honorary consulting physician at St Luke's House, physician to the King and the main spokesman for the medical profession in the House of Lords,³⁶ spoke about the change which had occurred in both medical and lay opinion since the 1880s. He argued that formerly doctors had concentrated on the maintenance of life, in spite of the nature of the disease and imminence of death: "It was an accepted tradition that it was the duty of the medical man to continue the struggle for life right up to the end." Since then, however, moral standards had slowly altered so that it was increasingly felt that the main priority was to minimise patients' suffering; to "make the act of dying more gentle and more peaceful even if it did involve the curtailment of life." He argued that this evolution in attitudes was a good thing and that it was better to allow this to continue rather than to try and give it legal expression.³⁷ Such thinking was part of a more humanitarian approach among the medical profession in the early decades of the twentieth century in which greater concern was shown towards the quality, rather than quantity, of human life.³⁸

Such a view was not incompatible with Anglican theology, although Catholic clergymen remained adamantly opposed to it. The Archbishop of Canterbury, whilst refusing to sanction the passing of the Bill, supported Viscount Dawson's argument that there were certain circumstances in which it was morally acceptable to shorten a life of pain. He felt these should be left to the "intimate and responsible judgement" of the medical profession rather than being controlled by complex legal procedure.³⁹

Thus by the end of the period there had been a discernible shift in attitudes among leading members of the medical profession towards medical management of the

³⁶ Webster, C. (1993) The metamorphosis of Dawson Penn, in D. Porter and R. Porter (eds) *Doctors, Politics and Society: Historical Essays*. Amsterdam: Rodopi, p.212.

³⁷ The Parliamentary Debates (Official Report) House of Lords, 5th series, Vol. 103, 3 November to 18 December 1936-1937, pp.480-485.

³⁸ Lawrence, C. and Weisz, G. (1998) Medical holism: the context, in C. Lawrence and G. Weisz (eds) *Greater than the Parts: Holism in Biomedicine*. Oxford University Press, p.4 ; Lewis, J. (1992) Providers, 'consumers', the state and the delivery of health care services in twentieth-century Britain, in A. Wear (ed) *Medicine in Society*. Cambridge University Press, pp.320-321.

³⁹ The Parliamentary Debates (Official Report) House of Lords, 5th series, Vol. 103, 3 November to 18 December 1936-1937, pp.486-489.

dying. Many doctors no longer felt that spiritual care was part of their responsibility to the patient and anxiety over patients' spiritual health gave way to concern over other issues, such as their physical suffering and mental condition. Ministering to patients' spiritual needs was seen as the separate role of the clergy. Doctors' perceptions of their own role in the care of the dying had also begun to change; the belief that physicians should struggle to hold on to life for as long as possible had given way to the view that the doctor's priority should be to make the act of dying as painless as possible, even if this meant shortening the patient's life. Such attitudes were even sanctioned by leading authorities within the Established Church.

ii. The homes for the dying: medical management

In all three homes medical care of the patients was the sole responsibility of the medical personnel. At St Luke's House the medical staff were headed by the Medical Superintendent who also acted as a visiting physician. When the Home first opened the only medical assistance he had was from two other visiting physicians, Dr James Gwyther and Dr Reginald Poulter,⁴⁰ but as the accommodation expanded the number of medical staff not only increased but also began to incorporate other branches of the profession. In 1896 two consulting physicians and two consulting surgeons were appointed.⁴¹ The Constitution formed in 1912 also provided for a surgeon, a surgeon-dentist and stipulated a minimum of three visiting physicians.⁴² In 1913 an Honorary Registrar and Pathologist was appointed and in 1926 the position of Honorary Bacteriologist was created.⁴³ The services of a pathologist would have been used for carrying out *post-mortem* examinations. In his report for 1923 Charles Buttar, the Medical Superintendent, wrote that such examinations were "likely to benefit the living by increasing our knowledge of morbid conditions."⁴⁴ Similarly, the Bacteriologist was probably recruited to investigate the pathological course of advanced diseases and to identify their microbial causes, in an attempt to understand

⁴⁰ 1st St Luke's House Annual Report (hereafter SLHAR), taken from 7th West London Mission Annual Report (hereafter WLMAR), 1894.

⁴¹ 3rd SLHAR, taken from 9th WLMAR, 1896.

⁴² 19th SLHAR, 1912, p.41

⁴³ 21st SLHAR, 1914, p.6 ; 34th SLHAR, 1927.

⁴⁴ 30th SLHAR, 1923, p.10.

more about their nature and possible treatment. In 1924 a fourth visiting physician was appointed to help meet the rise in the number of beds after the new premises opened the following year, and in 1932, in response to concern that in the past year the Home had been without the services of a physician from Friday until the following Wednesday, a fifth visiting physician joined the staff.⁴⁵

The medical personnel at the Hostel of God were presided over by the Medical Officer. When the Home first opened he was supported by a Medical Adviser, Dr Cecil Lyster, but this office appears to have been disbanded by 1896.⁴⁶ The Medical Officer and the Medical Superintendent at St Luke's both exercised supreme medical authority within their respective homes. They had the power to decide both patients eligible for admission and those requiring discharge.⁴⁷ Over the years, despite a gradual increase in admissions, the number of honorary staff attached to the Hostel of God fluctuated somewhat. In 1898, despite only sixteen beds in the Home, the medical personnel were expanded to include four consulting physicians and two consulting surgeons and in 1914 an honorary pathologist and an honorary dental surgeon were added to the staff.⁴⁸ By the 1920s, although the number of beds had risen to thirty, the number of staff had decreased. When the 1920 annual report was published it showed only one consulting physician, an honorary pathologist and an honorary dental surgeon. In 1925 the position of consulting surgeon was reinstated but there continued to only be two consulting staff for the remainder of the period.⁴⁹

When St Joseph's opened in 1905 the medical personnel consisted of four honorary physicians. Over the years the number of staff remained fairly constant, apart from the addition of a consultant surgeon to the staff after 1916.⁵⁰ The honorary physicians tended to remain for longer than those attached to St Luke's and the Hostel of God; for example, Dr James Ross, a local Hackney doctor, served as an honorary physician

⁴⁵ Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 23 June 1918 - 25 March 1925: 21/10/1924, p.312 ; Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 25 March 1931 - 26 April 1939: 28/10/1931, pp.19-23, 27/01/1932, p.35.

⁴⁶ Hostel of God Annual Report (hereafter HOGAR), 1893-1894.

⁴⁷ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24 ; HOGAR, 1896, p.6.

⁴⁸ HOGAR, 1898 ; 1914.

⁴⁹ HOGAR, 1920, 1925.

⁵⁰ *The Medical Directory*, 1916. London: J & A Churchill, p.436.

to the Hospice from 1905 to 1923, when he was replaced by Dr Arthur Ambrose, a former Senior Honorary Physician at Westminster Hospital.⁵¹ Several of the honorary medical staff had trained originally in Ireland and were licentiates of the Royal Colleges in Ireland. James Harold and John McNaboe both trained in Ireland and practised at St Vincent's Hospital in Dublin (also run by the Sisters of Charity) before coming over to London and joining the staff of the Hospice. The Sisters of Charity may have looked upon these appointments as a further way of reaching out to the Irish poor of the East End; some patients may have felt more comfortable being treated by a doctor from their homeland. Both doctors would also have been familiar with the work of the Sisters and their primarily spiritual agenda.

All the medical staff at St Luke's House and St Joseph's held honorary positions. The same was true for the Hostel of God, with the exception of the Medical Officer. When the Home first opened this post was an honorary appointment but in 1895, because of the gravity of cases admitted, its honorary status was removed and it was converted into an official position, with a small stipend to cover the cost of the doctor's conveyance to and from the Home.⁵² The post of Medical Officer was occupied by three different doctors between its opening and 1938. None of them occupied the same status as the honorary staff; Dr Malcolm Mackintosh, the first Medical Officer, had been Clinical Assistant at the Central London Throat and Ear Hospital, while his two successors, Dr Joseph Brownlie Wallace and Dr William Ryan, were both Medical Officers, for the Battersea and Wandsworth Union and the West African Medical Staff respectively.⁵³ The comparatively lower status of the Medical Officers of the Home suggests that a permanent, salaried post in a home for the dying was not looked upon favourably by more eminent doctors, many of whom were opposed to any form of salaried appointment in a voluntary institution. The size of the stipend paid to the Medical Officer gradually increased over the years in response to the growing number of patients and the added responsibility this incurred. In 1896 the

⁵¹ *Ibid.*, 1907, p.280 ; St Joseph's Hospice Annals (hereafter SJHA), 1923 ; *The Medical Directory*, 1907, p.6.

⁵² 6 June 1896 Charity Organisation Society Report (hereafter COS), London Metropolitan Archives (hereafter LMA).

⁵³ *The Medical Directory* 1910, p.238 ; *The Medical Directory* 1921, pp.299, 352.

Medical Officer's salary was £30 per annum. By 1920 it had increased to £150 and in 1938 totalled £200 annually.⁵⁴

Medical attendance at St Luke's House was divided up between the visiting physicians who were each allocated a specific day of the week. Their visits were usually made during the afternoons.⁵⁵ At the Hostel of God regular visitation of the patients was the sole responsibility of the Medical Officer. A Charity Organisation Society representative who visited the Home in 1896, reported that the Medical Officer, Dr Mackintosh "attends regularly every other day, and at other times when necessary." By 1908, in response to the increase in the number of patients the Medical Officer was reported as visiting the home every morning and later in the day if necessary.⁵⁶ The fact that the position of Medical Officer at the Hostel of God was a permanent salaried post would account for the absence of any other regular visiting physicians and the smaller number of consulting physicians.

The way in which the medical personnel at St Luke's were appointed varied over the years, although personal acquaintance and recommendation were important and usually featured large in the decision-making process, particularly in the choice of Medical Superintendent. At St Luke's, after the retirement of Howard Barrett as Medical Superintendent in 1913, the position devolved onto his son Edmund Barrett who had joined the Home in 1906 as a visiting physician and on the understanding that he would be trained to eventually replace his father.⁵⁷ Edmund Barrett died in 1925 after suffering a complete breakdown and was succeeded by Dr Charles Buttar, a close friend of his and an honorary visiting physician to the Home from 1919 to 1924.⁵⁸ Buttar held the Superintendency for six years until his death in 1930, after which the Committee was faced, for the first time, with the predicament of not having anyone to naturally succeed as Medical Superintendent. Mr Warren Low, the senior

⁵⁴ HOGAR, 1896, p.12 ; 1920, pp.12-15 ; 1938, p.9.

⁵⁵ Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 25 March 1931 - 26 April 1939: 28/10/1931, pp.19-23 ; 1st SLHAR, taken from 7th WLMAR, 1894.

⁵⁶ 6 June 1896 COS Report ; 27 October 1908 'Report of a Visit to the Hostel of God (Free Home for the Dying) Clapham Common, by H. Kelly, p.1, [LMA].

⁵⁷ Minute Book of St Luke's House Committee of Management 11 October 1905 - 21 May 1912: 10/10/1906, p.47.

⁵⁸ 33rd SLHAR, 1926, pp.4-5.

consultant surgeon at St Luke's, was invited to advise the Committee on the consideration they owed to the existing honorary visiting physicians. He said that, in his opinion, medical etiquette did not require that the choice be limited to the existing staff. A sub-committee was formed to consider the matter and it was eventually decided to appoint Dr Edward Price Furber, Anaesthetist at the Hostel of St Luke and the West End Hospital for Nervous Diseases, who was personally known to a number of the honorary visiting staff and was a friend of the Treasurer.⁵⁹

After 1897 all medical appointments and decisions concerning medical matters at St Luke's House had to be authorised by the Committee. Most candidates were either personally known to Howard Barrett or to other members of the committee and medical staff.⁶⁰ Several were attached to St Mary's Hospital in Paddington, the local teaching and general voluntary hospital. Until 1936 the honorary visiting staff, those who attended the Home on a regular basis, were content to fall in with this procedure but at the committee meeting in May a motion was put forward to increase their medical authority. Dr David Muir Scrimgeour, one of the honorary visiting physicians, suggested that in future the appointment of honorary visiting physicians and other medical matters should be discussed and approved by the medical staff themselves. The Committee agreed to this and a small medical sub-committee, consisting of the Medical Superintendent and the honorary visiting physicians, was formed.⁶¹

Most of the visiting doctors at St Luke's only remained on the staff for a few years. Individual resignations usually occurred for two principal reasons: their appointment to another position elsewhere or an increase in the demands placed upon them by their existing commitments. The consultants tended to occupy their positions for longer, probably because their services were required less frequently. It appears that not all the medical staff enjoyed working with dying patients. Dr Jackson who left St Luke's

⁵⁹ 38th SLHAR, 1931, p.4 ; Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 30 April 1925 - 26 February 1931: 22/10/1930, pp.315-16, 28/01/1931, 327 ; *The Medical Directory*, 1930, p.118.

⁶⁰ 4th SLHAR, taken from 10th WLMAR, 1897, p.13.

⁶¹ Minute Book of St Luke's Hospital for Advanced Cases Committee of Management, 25 March 1931 - 26 April 1939: 04/05/1936, p.196.

House in 1928, after four years as an honorary visiting physician, was recorded in the minutes as finding the nature of the work “too disheartening” and as “getting on his nerves.”⁶²

Although the medical personnel volunteered their services free of charge, they would have expected to receive something in return. Members of the Victorian and Edwardian medical profession rarely acted from purely altruistic motives, many could not afford to. Most doctors sought to be associated with institutions which would either help to enhance their medical reputation, bring financial benefits or provide teaching and research opportunities.⁶³ A home for the *dying* did not carry the same status as the large voluntary hospitals or confer the same benefits. Howard Barrett interpreted this as a sign that the physicians care “is rendered from the highest motives only, as the position of Physician with us carries with it neither money, medical prestige, nor special educational advantages.”⁶⁴ In 1935 this principle was reiterated by the Treasurer of the Home who commented that the services of the medical staff were “entirely altruistic,” inspired only by “feelings of humanity,” and offered little prestige or experience.⁶⁵ However, as Barry and Jones have argued, medical practitioners were also interested in supporting new institutions outside the existing patterns of charity.⁶⁶ The homes represented an innovative form of medical philanthropy and thus would have attracted the attention of members of the medical profession. Such charitable associations not only served as a way of further enhancing their individual and collective reputations but also provided opportunities to try out new types of treatment. In 1929 Buttar wrote: “the work is not purely expectant - trial has been made of such treatments as lead in cancer and tuberculin in pulmonary tuberculosis.”⁶⁷ Four years later Edward Furber, the new Medical Superintendent, wrote that, although the medical staff themselves were not chosen with a view to

⁶² Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 30 April 1925 - 26 February 1931: 23/05/1928, pp.198-199.

⁶³ Rivett, G. (1986) *The Development of the London Hospital System 1823-1982*. Oxford University Press, pp.34-35.

⁶⁴ 4th SLHAR, taken from 10th WLMAR, 1897, p.10.

⁶⁵ Minute Book of the Annual General Meetings of the Governors of St Luke's House 16 April 1912 - 20 Dec 1946: 01/05/1935, p.188.

⁶⁶ Barry, J and Jones, C. (eds) (1994) *Medicine and Charity Before the Welfare State*. London: Routledge, p.9.

⁶⁷ 36th SLHAR, 1929, p.12.

research, they were, on occasion, approached by people who “believe they are on the brink of a discovery of the cure for cancer” and who asked permission to try out their remedies. In such instances only patients for whom everything possible had been done before admission were allowed to participate.⁶⁸ The trials and experiments carried out on patients might be another reason why the Home retained the services of a pathologist and a bacteriologist.

In the same way, the choice of medical personnel, particularly the consultant staff, was not based simply on the need to have qualified doctors attending the patients. Decision-making would also have been motivated by concerns about kudos and influence and the ongoing need to obtain funding. Most of the consultant staff were attached to one, sometimes more, of the big general or specialist voluntary hospitals in London and often held consultancy positions with other hospitals and institutions. The ability to show that an institution, particularly one relying on voluntary contributions from the public, had the support of distinguished and prominent physicians and surgeons was an important way of attracting both benefactors and patients. Many of the medical staff were Fellows of the Royal Colleges and members of the British Medical Association and Harveian Society. A few of the personnel were particularly renowned physicians or surgeons. Lord Dawson, one of the honorary consultant staff at St Luke’s, was physician to four successive kings and a member of the House of Lords, while Sir Rickman John Godlee, a Consulting Surgeon, held the position of Surgeon in Ordinary to the King. Both held several prestigious positions in other institutions as well. At the Hostel of God, Sir William Watson Cheyne, a Consulting Surgeon, also acted as Surgeon in Ordinary to the King.⁶⁹ The smaller number of medical staff at St Joseph’s, most of whom were lower ranking members of the medical profession than their counterparts at St Luke’s and the Hostel of God, could relate to the more marginal status of the Hospice as a Catholic institution.

It is highly probable that a considerable proportion of the patients who were listed as being sent to the homes by the various general and specialist hospitals in London came through the recommendation of those members of the medical staff who held

⁶⁸ 40th SLHAR, 1933, p.10.

⁶⁹ *The Medical Directory*, 1917, p.130 ; 1921, pp.114, 154.

appointments at these institutions. These men were also likely to have been responsible for heightening awareness of the homes among the London hospital system. Similarly, those medical staff in the homes who worked for assurance companies, county councils and the Ministry of Pensions would also have recommended patients.

Many of the medical personnel had a special interest in one or more fields, as shown by the subject area of their publications or their appointment to a specialist hospital or institution. Some of the conditions they wrote about, such as arterio-sclerosis, bronchitis, dropsy and rheumatoid arthritis, were those suffered by patients in the homes. For example, Sir John Broadbent, an Honorary Visiting Physician at St Luke's House from 1894 to 1897, had a particular interest in heart disease and published a number of books on the subject.⁷⁰ Several of the staff had a special interest in phthisis and cancer, the two diseases which predominated, and would have been able to use their expertise in prescribing treatment for patients. At St Luke's Dr Frederick Roberts, one of the consulting physicians, had become an authority on thoracic phthisis through his experience working as physician at the Brompton Hospital, while Sir Alfred Pearce Gould, a consulting surgeon, was a cancer specialist. At the Hostel of God Theodore Dyke Acland and Sir William Watson Cheyne, consulting physician and consulting surgeon respectively, were recognised authorities in pulmonary tuberculosis and both William Sampson Handley and Archibald Leitch were cancer experts. Handley was Surgeon at the Middlesex Hospital and published several articles and a book on various aspects of cancer, for example, 'Dissemination of Mammary Carcinoma', published in *The Lancet* in 1905, while Leitch was Director of the Cancer Research Laboratory at the Middlesex.⁷¹ The publications of Dr P. Hamill, the Consultant surgeon, at St Joseph's denote a particular interest in the action of drugs, for example, in 1909 he wrote an article for the *Journal of Physiology* entitled 'The Mode of Action of Drugs and Specific Substances With Reference to Secretin'.⁷² The appointment of these doctors suggests that the homes drew upon the specialist

⁷⁰ Brown, G. (1955) *Lives of the Fellows of the Royal College of Physicians of London 1826 - 1925*. London: Royal College of Physicians, pp.458-459.

⁷¹ *The Medical Directory*, 1921, pp. 36, 89, 157, 168, 213 ; *BMJ*, 1918, Vol.2, p.147.

⁷² *The Medical Directory*, 1921, p.167.

interest and knowledge that was developing in such areas as phthisis, cancer and heart disease, and that patients were able to benefit from this.⁷³

Sir Alfred Pearce Gould was the only one of the medical personnel who had a special interest in the care of incurable and dying patients. He served as both an Honorary Consulting Surgeon at St Luke's House from 1895 until his death in 1922, and as a Consultant Surgeon at St Columba's Hospital (formerly the Friedenheim) from at least 1894 to 1922. He was also the only doctor with experience in the institutional care of dying patients. Gould's main hospital appointment was Senior Consultant Surgeon at the Middlesex Hospital, where he worked on the surgical staff for forty years. From the 1890s he spent more than half of his time at the Middlesex in charge of patients in the Cancer Charity which provided care for advanced cancer patients. In 1912, on the basis of his experience there, he delivered a lecture to the West Kent Medico-Chirurgical Society which was subsequently published in *The Lancet*. The lecture was entitled 'The Treatment of Inoperable Cancer'. Although the second half of the paper was devoted to a discussion of ways of removing cancer other than by operation, the first section dealt with the subject of the more general treatment of inoperable cancer cases. Many of his ideas corresponded to those prescribed by Munk but others, particularly his theories on pain relief, differed considerably, suggesting that certain doctors were beginning to question some of the late Victorian orthodoxies.⁷⁴

Gould strongly endorsed the institutional care of patients with advanced cancer. He believed that hospital treatment was of great value and nearly always led to the prolongation of life. The two principal reasons for this were, he felt, the opportunity it afforded for physical and mental rest:

"the relief of anxiety when a very poor man or woman is removed from a poverty-stricken home into a well appointed hospital, with the assurance that the stay there is to be as long as life lasts, is very great."

Mental quietude was also felt to be instrumental in achieving greater physical well-being: "The influence of mind on matter is seen with quite special force and clearness

⁷³ Of the publications which I looked at none of the authors seem to have drawn explicitly on their experiences within the homes.

⁷⁴ Gould, Sir Alfred Pearce (1913) The treatment of inoperable cancer, *The Lancet*, Vol. 1, p.215.

in cases of advanced cancer.”⁷⁵ The importance attached to patients’ mental well-being was part of the growing influence of psychology upon the medical profession.

Gould believed that, despite the frequent wish of friends not to reveal to patients that they are suffering from cancer, knowing the truth about their illness actually had a beneficial influence. His comment that he could not “share the common [i.e. popular] opinion that patients with malignant disease are to have this fact most carefully concealed from them,” when taken together with similar observations made by Munk and Glaister in 1887 and 1921 respectively, suggest that the belief by these doctors that patients should be informed of their prognosis was a reaction to what they perceived as popular opinion.⁷⁶

The most important aspect of the general management of inoperable cancer after rest, according to Gould, was maintaining the personal cleanliness of patients, particularly those areas affected by disease. Like Munk, he advocated a simple and moderate diet but, unlike Munk, who emphasised primacy of alcohol, he argued that alcohol stimulants of any kind should be abstained from because they had a tendency to enhance greatly the activity of the disease and cause increased distress for the patient. He also used opium and its derivatives as sparingly as possible because he felt that they often had more adverse effects than the cancer for which they were prescribed. He said that thirty years ago the practice in the cancer wards had been very different - alcohol and morphia had both been prescribed freely - with the result that the patients had suffered more and had been more irritable and difficult to deal with.⁷⁷

Unfortunately, there is very little direct information available on the actual treatment that was offered to patients in the homes, particularly the way in which their pain was controlled. The few references there are suggest that on the whole the attitudes of the medical staff in the homes towards the use of pain-relieving drugs corresponded more closely to those of Dr William Munk than those of Sir Alfred Pearce Gould. It appears that in cases where the patient was suffering from extreme pain the administration of

⁷⁵ Ibid.

⁷⁶ Ibid.

⁷⁷ Ibid., p.216.

anodynes was felt to be essential. Dr Ryan, Medical Officer at the Hostel of God from 1931, wrote that anodynes were of paramount importance in the treatment of cancer cases which were especially painful in the final stages.⁷⁸ Howard Barrett in his medical report for 1906, recounted how a patient suffering from extreme pain caused by cancer of the face was given the strongest anodynes.⁷⁹ A few of the entries in the patient registers for the Home noted when a patient had to be supplied with particularly generous doses of morphia. For example, one female patient suffering from cancer of the rectum was described as being in a “truly terrible physical condition” and “had to have quantities of morphia” which “she could not get on without.”⁸⁰ Given that throughout the period the largest part of the money spent on ‘surgery and dispensary’ by the homes each year went towards the purchase of drugs, it is reasonable to assume that their administration underpinned the pain relief treatment given to patients. Wines and spirits were also listed under the expenditure for the ‘surgery and dispensary’, suggesting that stimulants too had an important part to play in medical care of the dying.

In all three homes, however, the amount of morphine administered seems to have been closely monitored; several patients at the Hostel of God and St Luke’s who were addicted to morphine on admission subsequently left because they were not allowed the unlimited quantities they had been used to.⁸¹ The application form for St Joseph’s stated that no stimulants were given unless ordered by the Medical Officer.⁸² The regulation of morphine and alcohol by the staff in the Homes, together with their Christian 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.

At the same time as countenancing the spiritual benefits of pain, there is also evidence that the physicians at St Luke’s House shared the more humanitarian attitudes of their

⁷⁸ HOGAR, 1934, p.10.

⁷⁹ 14th SLHAR, 1907.

⁸⁰ St Luke’s Hospital For Advanced Cases Patient Case Book 19 September 1918 - 3 April 1922, No. 120.

⁸¹ HOGAR, 1896, p.11 ; 11th SLHAR, 1904, p.10.

⁸² Application Form for Admission to St Joseph’s Hospice for the Dying, Religious Sisters of Charity Generalate (hereafter RSCG).

medical brethren expressed by Lord Dawson in the House of Lords' debates on Euthanasia. In his report for 1903 Barrett recorded the account of a female patient who had come to the Home from the London Hospital "the subject of shocking and nameless mutilations, chiefly by disease, which is fast extending, but partly, also by surgical procedure." He went on to write that these had been "undertaken to prolong a life which had really better have been allowed to come to a speedier close. The gain of a few months of existence has had to be paid for in one long and almost unbroken agony."⁸³ How far these attitudes extended into practice, or whether it was a purely rhetorical device on the part of Barrett for the purposes of attracting readers' attention, is not known, but it does at least indicate an engagement on his part with wider medical thinking.

The growing importance attached to patients' mental welfare and its relationship to their physical state was also shared by the doctors in the homes. However, unlike broader medical opinion which, by the early decades of the twentieth century attached less immediate importance to spiritual issues, the homes' religious underpinnings, meant that many of their physicians ultimately saw patients' mental health as linked to their spiritual well-being.⁸⁴

At both the Hostel of God and St Luke's House the attitudes of the medical staff to the spiritual and medical work of the home corresponded to broader medical opinion; in both homes they were seen as clearly divided roles which centred on the care of the soul and care of the body respectively and belonged to different members of staff. The spiritual care of patients at St Luke's was felt to belong primarily to the chaplain and visiting sisters while medical responsibility devolved onto the medical staff.⁸⁵ In his report for 1898 Barrett wrote that the physicians role was to "care for the body, anxiously and tenderly, as long as life may last" and that once they had "composed the wasted form for its long sleep" their work was finished. He compared this to the work of the religious personnel the fruition of which he said, "is but now commencing, and lasts forever."⁸⁶ Likewise, at the Hostel of God, the medical and spiritual work of the

⁸³ 11th SLHAR, 1904, p.18.

⁸⁴ See chapter 3 for a more detailed discussion of this.

⁸⁵ 3rd SLHAR, taken from 9th WLMAR, 1896 ; 7th SLHAR, 1900, p.18.

⁸⁶ 6th SLHAR, 1899, pp.21-22.

home were also seen as separate roles; alleviation of patients' "bodily sufferings" was the doctors' function and providing for patients' "spiritual wants" was the responsibility of the Sisters and the Chaplain.⁸⁷ In 1930 Dr Wallace, the Medical Officer, summed up the work of the medical personnel as "the ultimate use of medical means for the alleviation of pain."⁸⁸

At St Joseph's the division between medical and spiritual roles may not have been quite so clearly divided. The Sisters of Charity apparently felt it was important to have a Catholic doctor attending their patients. In the Annals it was noted that Dr James Ross, who acted as Visiting Physician to the Hospice from 1905 until 1923, was a Catholic doctor.⁸⁹ The advantages of such an appointment were obvious: a Catholic physician would be more sympathetic to the Catholic underpinnings of the Hospice and its primarily spiritual mandate. One of the accounts in the annals told the story of a non-Catholic patient who was under instruction to be received into the Catholic Church. One evening after a "great change" suddenly came over him "Dr Ross was sent for and knowing his intentions advised him not to defer anything till the next day as he feared he would not live through the night."⁹⁰ It may also have been the case that Ross' role as physician extended into the spiritual domain and that it was part of his task to recommend to the patients the eternal benefits and comfort provided by the Catholic faith.

Edward Berdoe, one of the honorary medical staff at St Joseph's during its early years, also recognised the important role played by faith and religion in medical care, particularly for incurables. In 1895 he published an article entitled 'A Medical View of the Miracles at St Lourdes' in which he argued that miracles should not be dismissed by doctors because they have always had a role to play alongside medicine and would continue to do so. Even though his scientific training qualified his full acceptance of divine explanations for the miracles that sometimes occurred at Lourdes, he felt that religion was still very important because as long as a cure

⁸⁷ HOGAR, 1895, pp.5-6.

⁸⁸ HOGAR, 1930, p.9.

⁸⁹ SJHA, May 1915 to May 1921.

⁹⁰ 'Notes of the Annals of St Joseph's Hospice', 1905-1909, pp.31-32, [RSCG].

resulted its real origins did not matter; the hope that the sick and incurables found in their faith was ultimately what mattered.⁹¹

The transition in the meaning of the term 'euthanasia' among the medical profession in the late nineteenth and early twentieth centuries was shown in its changing usage at St Luke's House. In 1906 Barrett still used the term in its more traditional sense when he described the Home's objective as "*Euthanasia*, the promotion of all means and influences that can render less painful, less sorrowful, less terrible, the process of dissolution."⁹² However, at the same time, he could sympathise with some of the arguments used by the proponents of mercykilling, even if he could never condone them in practice. He wrote that the degree of suffering endured by some patients, particularly those "mutilated by disease or by surgery unavailingly taken.....tempt one at times almost to wish that the 'lethal chamber' could be judiciously extended from animals to men."⁹³

By 1935 mercykilling had obviously become the more familiar meaning of the term. Attitudes towards the new form of euthanasia among the medical staff in the Home echoed those of the majority of the profession. In his report for that year Furber strongly criticised the recent proposal that Euthanasia should be legalised. He said that he thought few doctors would allow themselves to become "legalised murderers" and doubted that it would ever be legally sanctioned. Instead, he argued that the *raison d'être* of the home undermined the claims of those who supported Euthanasia:

"We have the means to prevent undue suffering and it would open the eyes of advocates of such a Bill if they would visit our wards and see for themselves that agony is non-existent."⁹⁴

At St Luke's House, in response to the medical staffs' perceptions of wider changes in public opinion, there was a shift in attitude towards the appropriateness of using the words 'home' and 'dying' in the title. As early as 1911 Edmund Barrett had

⁹¹ Berdoe, E. (1895) A medical view of the miracles at Lourdes, *Nineteenth Century*, pp.614-618.

⁹² 13th SLHAR, 1906, p.16.

⁹³ 11th SLHAR, 1904, p.15.

⁹⁴ 43rd SLHAR, 1936, p.11.

questioned the advisability of retaining the sub-title of the Home.⁹⁵ By 1917 other members of the medical staff shared this view and felt that such a name was no longer acceptable. Howard Barrett spoke about the change in public opinion in recent years: 'homes' were increasingly looked upon with suspicion and were generally felt to be less efficient. Dr Murray Leslie, one of the honorary visiting physicians, communicated his opinion via a letter which was read out at the Committee meeting. He was recorded in the Minutes as stating that the term was a "most repellent and unfortunate one." He referred to the military hospital where he worked and how the Commanding Officer had said that he would not send any of his patients to a home for the *dying*: "If a patient had but a month to live there was an element of hope but the knowledge that one was going to a home for the dying denied such a possibility."⁹⁶ The disapprobation of the medical staff towards homes for the dying was an important factor in the decision in 1917 to change the title of the home to 'hospital'.

iii. Nursing care

The day to day running of all three homes was the responsibility of the nurses; they were the only members of staff whose service was provided, and whose care was required by the patients, on a full-time basis. The provision of nursing care at the Hostel of God and St Joseph's was organised along similar lines and reflected the overall structure of their management. At the Hostel of God nursing was carried out by the religious order which ran the Home, initially the Sisters of St James' Servants of the Poor and, after 1896, the Sisters of East Grinstead, with the help of lay nurses and under the authority of the Sister Superior. In the early years the Sisters provided the majority of the nursing; in 1896 the nursing staff comprised four Sisters and a trained nurse. However, by 1908, in response to the increase in patients in the Home, the number of lay nurses had risen to five.⁹⁷ Likewise, the nursing at St Joseph's was divided between the Sisters and lay staff. Most of the Sisters were trained at St

⁹⁵ Minute Book of St Luke's House Committee of Management 11 October 1905 - 21 May 1912: 21/11/1911, p.301.

⁹⁶ Minute Book of St Luke's House Committee of Management 18 June 1912 - 27 May 1918: 26/06/1917, pp.281-282.

⁹⁷ COS Report, 6 June 1896 ; H. Kelly 'Report of a Visit to the Hostel of God (Free Home for the Dying) Clapham Common', 27 October 1908, [LMA].

Vincent's Hospital in Dublin, also run by the Sisters of Charity, but some had already been trained before they entered the religious life.⁹⁸ It also appears that some of Sisters / nurses had more specialist training. One of the Sisters who cared for the cancer patients in the early years of the Hospice had been head nurse in a cancer hospital before she became a nun.⁹⁹ In contrast, the nursing staff at St Luke's House were all lay persons. The patients were nursed by a team of trained staff nurses and probationers, under the supervision of a Matron.¹⁰⁰ In all three homes the lay nurses and probationers received a stipend.

The professional and social status of candidates applying to the nursing staff at St Luke's House was felt to be an important consideration. At a Committee meeting in 1895 Howard Barrett specified that the new nurse they were trying to recruit must be "well trained and a lady."¹⁰¹ In 1917 his son wrote about the need to obtain "the right class of nurse for such responsible and compassionate work."¹⁰² The first Matron of the Home was chosen because she was a "fully trained nurse as well as a cultivated lady." By 1937 the requirements for the office of Matron had altered slightly. The successful candidate was expected to possess four essential qualifications: (1) She must be a State Registered Nurse ; (2) She must be a woman of great tenderness ; (3) she must possess infinite patience and (4) she should be prepared to accept a certain amount of medical responsibility. In addition to these she had to be under the age of forty.¹⁰³

The importance of having trained nurses, belonging to the correct social class and possessing a sound moral character, was essentially an echo of those concerns which motivated Florence Nightingale and her fellow reformers during the second half of the nineteenth century. It was also bound up in the Methodist preoccupation with moral respectability. The importance of having a "cultivated lady" to act as Matron was

⁹⁸ *Hackney Annals*, 1928-1935, p.11.

⁹⁹ 'A London Gate to Heaven', reprinted c1919 from the *Ave Maria*, p.10, [RSCG].

¹⁰⁰ 9th SLHAR, 1902, p.4.

¹⁰¹ Minute Book of St Luke's House Committee of Management 15 November 1895 - 19 July 1905: 20/12/1895.

¹⁰² 24th SLHAR, 1917, p.14

¹⁰³ 'The Report of St Luke's House', taken from 6th WLMAR, 1893, p.24 ; Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 25 March 1931 - 26 April 1939: 27/10/1937, pp.239-40, 23/11/1937, p.249.

considered necessary because of her position within the Home and the authority she exercised over both the patients and the nursing staff. The stipulation in 1937 that the new Matron be a Registered Nurse was part of the movement towards nursing professionalisation that occurred in the late Victorian and Edwardian era and the change in nursing training objectives from an emphasis upon social status and moral character training to concerns for a professional model based on science.¹⁰⁴

At St Luke's House the recruitment of nursing staff was a recurring problem. In 1907 Edmund Barrett gave a course of lectures to the nurses not only for the purposes of "enlarging and making more precise their knowledge" but because "nurses are more ready to both come and go where lectures are given."¹⁰⁵ Whether or not this became standard practice is not known, but it does suggest that at St Luke's there was the beginnings of a recognition of the need for a more specialist training for nurses working with dying patients. The decision to change the name of the Home in 1917 was also linked to the problem of recruitment. The Matron felt that one of the reasons for the difficulty in obtaining nurses was that in the nursing world St Luke's House was not regarded as a hospital. She also commented on criticisms made by nurses about comfort which in a hospital they would not expect to receive, and their objection to arduous or trying work which in a hospital would be taken for granted. She believed that it would be considerably more conducive to their contentment if probationers could look back upon the place where they started their career as a hospital rather than a home.¹⁰⁶ Again, such thinking was part of the movement towards nursing professionalisation.

Wider social perceptions about nursing care of the dying were also felt to impact upon the recruitment of nurses. In 1928 the Matron again experienced difficulty in trying to obtain probationers which she thought was caused by the aversion of relatives and

¹⁰⁴ Rosenberg, C.E. Florence Nightingale on contagion: the hospital as moral universe, in C. E. Rosenberg (ed) *Healing and History*. Folkestone: William Dawson and Sons Ltd, pp.116-136 ; Abel-Smith, B. (1960) *A History of the Nursing Profession*. London: Heinemann, pp.17-35 ; Rafferty, A.M. (1996) *The Politics of Nursing Knowledge*. London: Routledge, p.42.

¹⁰⁵ 14th SLHAR, 1907, p.20.

¹⁰⁶ Minute Book of St Luke's House Committee of Management 18 June 1912 - 27 May 1918: 26/06/1917, pp.277-279.

friends to young girls nursing advanced cases of tuberculosis and cancer.¹⁰⁷ Both Barrett at St Luke's and Wallace at the Hostel of God felt that cancer cases were a particularly "terrible class of case to nurse"¹⁰⁸ and called for "self-sacrifice and devotion"¹⁰⁹ on the part of the nurses. The Medical Officers at the Hostel of God were particularly aware about the effect of working with dying patients upon the medical personnel and nursing staff. Dr Wallace wrote in his report for 1930 about the absence of hope for the medical staff in cases in which there was no prospect of recovery: doctors were deprived of the "inspiration and joy" usually associated with the treatment of human ills. For this reason he felt the spiritual work of the Sisters was important because it provided an element of hope.¹¹⁰ In 1936 Dr Ryan spoke in his report to the Council about the Probationer Nurses who had to work in an environment "without any of the excitement and interests to be found in the General Hospital, or the encouragement afforded by the hope that their efforts were helping to bring restored health."¹¹¹ The importance of having accommodation for the nurses that was separate and "distinct from work" was recognised and provided for in both homes.¹¹² Efforts to involve the 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.

The annual reports for St Luke's House give some insight into the nurses' daily routine. The report for 1894 includes the time-table for a typical day in the Home. According to this schedule, both the day nurses and the night nurse were expected to work long shifts, over twelve hours each. The day nurses were on duty from 7:00 in the morning until 9:30 at night. They did not breakfast until 8:15am and the rest of the morning was spent washing the patients, renewing dressings and tidying the wards. Sometimes an extra lady-nurse was brought in to help with these tasks. The afternoons were comparatively quieter because visitors came to the Home every day except Sundays. Between 5:30 and 7:30 preparations were made for bed; the patients were

¹⁰⁷ Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 30 April 1925 - 26 February 1931: 21/02/1928, p.183.

¹⁰⁸ 1st SLHAR, taken from 7th WLMAR, 1894, p.5.

¹⁰⁹ HOGAR, 1921, p.6.

¹¹⁰ HOGAR, 1930, p.9.

¹¹¹ Hostel of God Council Minutes February 1918 - 1977: 17/02/1936.

¹¹² 15th SLHAR, 1908, p.24. ; HOGAR, 1922, p.4.

again washed and their dressings renewed. Initially there was only one night nurse who came on duty at 9:30 and did not finish until 10:00 the next morning.¹¹³ By 1900 the day nurses shift had been extended further so that work now commenced at 5:30 in the morning.¹¹⁴ The increase in nursing staff in 1907 meant that extra night nurses could be employed and also allowed for a few alterations in the daily routine of the Home. The night nurses were responsible for waking the patients at 6:00am and beginning the process of washing and dressing them. The day nurses did not come on duty until 7:20 and assisted the night nurses until the latter went off duty at 8:30am. They remained on duty until 8:00pm when they were once again replaced by the night nurses.¹¹⁵

The role of Matron at St Luke's House was also very demanding because it encompassed a wide range of duties. In 1899 Barrett wrote that the responsibilities of the Sister were heavier than those in a fully organised hospital because she was not only Nursing Sister, with a staff of nurses and several wards of patients under her authority, but "housekeeper, representative of the Home, and personal friend of the patients."¹¹⁶ It was also her job to interview the families when a patient died and to offer them consolation. The absence of a house-surgeon immediately at hand to advise her was an added responsibility not experienced by her hospital counterpart.¹¹⁷ In 1925 her duties were further extended when she was required to act as an Almoner for regulating patient payments.¹¹⁸ In an attempt to relieve the Matron of some of her responsibilities, an Honorary Assistant Matron, Miss Inglis, was appointed briefly in March 1898.¹¹⁹ However, after Miss Inglis left, in September of the same year, her position was not refilled.¹²⁰ A further attempt was made to relieve Matron of some of her duties in 1905, when a part-time dispenser was engaged, but it was not until 1913 that the post of Assistant Matron was made a permanent appointment.¹²¹

¹¹³ 1st SLHAR, taken from 7th WLMAR, 1894, p.11.

¹¹⁴ 7th SLHAR, 1900, p.23.

¹¹⁵ 15th SLHAR, 1908, pp.23-24.

¹¹⁶ 6th SLHAR, 1899, p.20.

¹¹⁷ 13th SLHAR, 1906, p.23.

¹¹⁸ 32nd SLHAR, 1925, p.13.

¹¹⁹ Minute Book of St Luke's House Committee of Management 15 November 1895 - 19 July 1905: 03/03/1898.

¹²⁰ Ibid: 28/09/1898.

¹²¹ Ibid: 19/07/1905 ; Minute Book of St Luke's House Committee of Management 11 October 1905 - 21 May 1912: 18/11/1913, p.81.

The role of the nursing staff was not always so clearly delineated as it was for the medical staff. At the Hostel of God and St Joseph's the Sisters combined their role as nurses with spiritual ministrations. Their religious calling would have meant that tending to the patient's spiritual condition (discussed more fully in the next section) was the highest of the two objectives and that nursing care was looked upon as a means to facilitate this. At St Luke's House the Matron, although primarily responsible for providing physical care for the patients, was also expected to undertake simple spiritual tasks such as saying morning and evening prayers in the wards. The requirement in the early years of the Home that she be a Christian, together with the few accounts of patients written by the Matron in the early annual reports, also suggest that when the occasion presented itself she was willing to provide simple spiritual ministrations, or at the very least encourage patients to seek it.¹²² It is uncertain whether this aspect of her work continued throughout the whole of the period because neither the Committee minutes or the later annual reports contain any mention of it, although it is probable that if it did continue it would, in light of the overall decline in significance of the spiritual work, have assumed less importance.

It appears that the work entailed in the position of Matron at St Luke's House was not suited to all its occupants, particularly in the long-term. Between 1893 and 1938 the post changed hands nine times. Miss Barclay resigned in 1901, after eighteen months as Matron. The Annual Report for that year stated the reason for this decision as: "the work was not quite satisfactory to her taste."¹²³ However, the Committee minutes suggest that her aversion was somewhat stronger. They recorded that she wanted to leave because of the "arduous and depressing nature of the work."¹²⁴ According to the annual reports, the demanding and distressing nature of the work was also responsible for two other resignations. In 1920 the Matron left to open a private nursing home for children.¹²⁵ Edmund Barrett wrote that after so many years of association with

¹²² 13th SLHAR, 1906, p.23 ; 15th SLHAR, 1908, pp.23-24.

¹²³ 9th SLHAR, 1902, p.5.

¹²⁴ Minute Book of St Luke's House Committee of Management 15 November 1895 - 19 July 1905: 04/07/1901.

¹²⁵ Minute Book of St Luke's Hospital For Advanced Cases Committee of Management 23 June 1918 - 25 March 1925: 28/03/1919.

sickness and death she needed a change of occupation. Her successor, although she served as Matron for eighteen years, resigned in 1938 because she too was unable to continue the “arduous and trying duties.”¹²⁶

It was also the case that the Matron herself might not be seen as adequately fulfilling her duties and when this occurred little hesitation was shown in securing her dismissal. Such an occasion occurred in 1904 when the Committee decided that, in the interests of the Home, a change of Matron was advisable in order to introduce “greater efficiency” and “a better tone throughout the household.” This decision caused considerable consternation among the rest of the staff and immediately after she handed in her resignation all the other nurses and servants gave notice of their intention to leave on the same day. As a result of this move the new Matron had to start as quickly as possible and engage a whole new set of nurses and servants.¹²⁷

The care provided by the nursing staff was occasionally subject to criticism from internal and outside sources but, because these were essentially isolated complaints by one individual and lacking in corroborative evidence, they were not followed through. The records for both the Hostel of God and St Luke’s House include evidence of accusations of cruelty levelled against members of staff. In 1925 the nursing care of patients at the Hostel of God was reproached by the Secretary of the local Charity Organisation Society Committee for Wandsworth and Putney who sent a written complaint to Edward Price, Secretary of the Central Committee. She expressed herself dissatisfied with the treatment of one of the patients who had been placed there by their committee. The patient was dying from consumption and it was anticipated that the end was very near. Despite suffering from severe sweats, he was only allowed to change his things once a fortnight and had not had a single bath since he had been there. He was only given a very small amount of water to wash in which was brought to his bedside in a basin and he was left to manage with it as best he could. After he had finished washing himself he was then expected to wash his handkerchiefs. The Central Committee, however, after consulting the Clapham and Battersea branch,

¹²⁶ 27th SLHAR, 1920, p.8 ; 45th SLHAR, 1938, p.5.

¹²⁷ Minute Book of St Luke’s House Committee of Management 15 November 1895 - 19 July 1905: 23/11/1904, 18/01/1905.

could not find anything to substantiate the complaint and nothing further was done about it.¹²⁸

The only instance where allegations of cruelty did succeed in effecting a change was at St Luke's House, but even then the result was not quite that intended by the person making the charges. The Committee minutes for June 1898 contain an account of charges which were brought against the management of the House, the Matron and some of the staff, by Mrs Hume, one of the Lady Visitors. These were statements which "she had caused" some of the discharged patients to draw up of alleged acts of cruelty and neglect suffered or witnessed by themselves. The charges were dismissed by the Committee as based on superficial evidence because, although most were directed against Miss Breton, the majority of the patients had been inmates during the time Miss Inglis had occupied the post of Matron. Miss Inglis herself denied the truth of most of the statements. Other members of staff and visitors to the patients produced evidence which also proved the allegations lacked adequate foundations and it was therefore resolved not to take any action. As a result of the incident both Miss Breton and Miss Inglis resigned voluntarily from their positions and Mrs Hume was dismissed from the Home.¹²⁹

iv. Spiritual care

Chapter three examined how the religious underpinnings of each home shaped the attitudes of the staff towards death and dying and their perceptions of patients' experiences. This next section discusses the way in which spiritual care was provided; in particular those who were responsible for its administration and their perceptions of their particular role within the home. Like nursing care, the provision of spiritual care in the three homes reflected the overall structure of their management. At St Luke's House it was divided between the two Chaplains and the Visiting Sisters from the West London Mission whose services were based on a part-time visitation of the patients. Under the Superintendance of Howard Barrett and his son Edmund this was

¹²⁸ Letter to Mr E.C. Price from Secretary of Wandsworth and Putney COS Committee, February 1925, [LMA].

¹²⁹ Minute Book of St Luke's House Committee of Management 15 November 1895 - 19 July 1905: 15/06/1898 ; 29/09/1898.

considered the most beneficial and fruitful aspect of the work of the Home. In 1899 Howard Barrett wrote that all that the doctors and nurses could do was to:

“alleviate their [the patients] pain and remove as far as may be from the Valley of the Shadow of Death its worst physical terrors.....But those who, as instruments of the Holy Spirit, may be the means of curing the soul, even in the last days of its tenancy of its earthly house, are the real physicians of the home.”¹³⁰

Barrett also believed that there was a close relationship between medical, nursing and spiritual care: tending to patients’ bodily needs facilitated ministration to the soul.

Accordingly, the Visiting Sisters were attributed a more important role during the early years of the Home, particularly when Barrett was Medical Superintendent. Initially there were two Visiting Sisters, each coming to the Home one afternoon a week. In 1901, at the request of the existing Sisters, two more Sisters were appointed as Visitors because, with the increasing number of patients entering the home, they did not feel that they could talk to all the patients individually.¹³¹ However, in 1926, a decision was made by the Governors to reduce the number of Sisters visiting the Home, despite a further rise in the number of patients.¹³²

Although the Sisters’ role was felt to be primarily spiritual, it also encompassed another important element: social care. The latter, although not specifically defined as such, was clearly implicit in the way in which both Barrett and the Sisters themselves wrote about the nature of their work.

“It is theirs to make themselves the friends, the real friends (not the preaching, lecturing friends) of patients, to enter cordially with them into all the troubles and difficulties of their home life, which are many, and also into their joys and aspirations; to find out what they can actually *do* to help them, and so make their friendship visible; and lastly with the utmost gentleness and delicacy to lead them to speak of their deeper thoughts, their spiritual difficulties, their hopes and fears; to offer prayer with them and for them, to show them as far as human creature can, the Christ of the Gospels stretching forth His hands in love and mercy to each one of them.”

(Barrett, 11th St Luke’s House Annual Report, 1904, p.13)

¹³⁰ 6th SLHAR, 1899, pp.21-22.

¹³¹ Minute Book of St Luke’s House Committee of Management 15 November 1895 - 19 July 1905: 15/03/1901.

¹³² Minute Book of the Annual General Meeting of the Governors of St Luke’s House 16 April 1912 - 20 Dec 1946: 20/04/1926, p.119.

One of the Visiting Sisters to the Home in 1896 described her role in the following way:

“My relationship to them [the patients] is a purely *friendly* one, I am not able to minister to their physical need, but simply sit and listen to the story of their lives, with their struggles and difficulties and sorrows; glad if in the hour of quiet loneliness and suffering, I can turn their thoughts to One who was known as the ‘Man of Sorrows, and acquainted with grief’.”¹³³

The Sisters also saw their task as to minister to the mental suffering experienced by patients. Although offering spiritual comfort was the prime consideration when trying to help the patients find peace of mind, the carrying out of simple social tasks, such as visiting the family at home and placating upset relatives, was also felt to be important.¹³⁴

During the early years the work of the Sisters featured prominently in the annual reports but after 1914 they received virtually no mention. Their declining importance in the Home was also apparent in the way in which the Constitution provided for their visitation. In 1911 it stipulated that there was to be a minimum of three Visiting Sisters. However, in response to the decision of the Governors in 1926 to reduce the number of Sisters, the Constitution was amended so that only two were required to visit.¹³⁵ The alteration in the status of the Visiting Sisters reflected the changing nature of the Home over the years. The progressive medicalisation of the Home, together with its separation from the West London Mission in 1911 and the advent of a less spiritually minded Medical Superintendent in 1925, resulted in religious concerns assuming a lower priority than they had done under the Barretts. Indeed, it was largely Barrett, and to a lesser extent his son, who had revered and upheld the work of the Sisters and the passing away of both men inevitably brought a change.

The ministerial provision at St Luke’s House reflected the non-sectarian basis of the Home. The most important post was the office of Chaplain which was held by a minister attached to the West London Mission. Unlike the Visiting Sisters he was

¹³³ 3rd SLHAR, taken from 8th WLMAR, 1896, p.15.

¹³⁴ Ibid., pp.16-17.

¹³⁵ 19th SLHAR, 1912, p.49 ; Minute Book of the Annual General Meeting of the Governors of St Luke’s House 16 April 1912 - 20 Dec 1946, 20/04/1926, p.119.

entitled, under the rules, to visit the patients at any time.¹³⁶ Until 1901 this position was occupied by Church of England ministers. However, in 1901 the Reverend C. Ensor Walter was appointed Chaplain after his predecessor resigned. He was not an Anglican Minister so arrangements had to be made for a Church of England clergyman to visit those patients who wished to be attended by one.¹³⁷ In addition to the Chaplain and Anglican minister, there were two honorary clerical visitors: a Jewish Rabbi and a Roman Catholic priest.

Under the Constitution of 1911 these practices became enshrined in principle. The Constitution stated that there were to be two honorary chaplains: the Superintendent of the West London Mission or his nominee and a clergyman of the Church of England. The latter was to be appointed by the Committee with the approval of the other honorary chaplain and the incumbent of the parish was to have primary claim. The Constitution also stipulated that the Home was to have two clerical visitors; a priest of the Church of Rome and a Jewish Rabbi. Both the chaplains and clerical visitors were to take charge of all the patients who declared themselves members of their respective Church and those who were not members but were willing to receive their ministrations.¹³⁸ The Anglican Chaplain and the clerical visitors were usually chosen by the committee but occasionally a minister would volunteer his services, without first being approached. For example, in 1903 the Reverend Rosedale wrote stating that since the Home was situated in his parish he would like to be appointed as Clerical Visitor to the Anglican patients.¹³⁹

The Chaplain's official role was two-fold: to conduct a service in the wards one afternoon a week and to administer Holy Communion to those patients who desired it.¹⁴⁰ However, these duties were only of secondary importance compared to what he saw as his principal task: "to inspire the sufferers with a belief in the love of God."¹⁴¹ Barrett wrote that in his services the Chaplain addressed alike Anglican, Catholic,

¹³⁶ 3rd SLHAR, taken from 9th WLMAR, 1896, p.24.

¹³⁷ 9th SLHAR, 1902, p.6.

¹³⁸ 19th SLHAR, 1912, p.49.

¹³⁹ Minute Book of St Luke's House Committee of Management 15 November 1895 - 19 July 1905: 11/11/1903.

¹⁴⁰ 2nd SLHAR, from 8th WLMAR, 1895, p.8.

¹⁴¹ 11th SLHAR, 1904, p.23.

Jewish and Nonconformist patients.¹⁴² The Anglican Chaplain, the Reverend Rosedale, also came to the Home once a week. He alternated each visit between administering Holy Communion and giving a short service, making sure that on both occasions every ward was visited.¹⁴³ Like the Visiting Sisters, the role of both chaplains in the Home assumed greater prominence during the early part of the period when spiritual ministrations were considered the most important part of the care provided. In 1912 Barrett reported to the Committee on a correspondence with the two men concerning the spiritual ministrations of the Home, in which it was agreed that, in order to facilitate access by both the Chaplains and clerical visitors to patients under their respective charge, care should be taken (as had already been the practice as far as possible) to place a card above each patient's bed with details of the Church to which they had declared themselves to belong. The Committee also sanctioned a proposal that screens should be placed around the bed when desirable to secure privacy in conversation between the patient and the chaplain or clerical visitor.¹⁴⁴ After 1916, however, the spiritual work of the Chaplains received little mention in the Committee minutes and their reports were no longer included in the annual reports.

The division of spiritual care between the Visiting Sisters, the Chaplains and the Clerical Visitors at St Luke's was more egalitarian than in the other two homes because of the emphasis upon faith in God rather than belonging to a particular denomination or receiving certain Sacraments. The Constitution stated that all the religious staff enjoyed "precisely equal rights and facilities of entrance to the Home."¹⁴⁵ The importance of having faith also meant that, unlike the other two homes, the services of the Chaplain were not indispensable because salvation was not dependent upon the intercession of a clergyman.

At the Hostel of God the importance of spiritual care was interpreted slightly differently by the medical staff, the Sisters and the Chaplain. The Medical Officers tended to view medical and spiritual care as two equal but separate parts of a whole.

¹⁴² 13th SLHAR, 1906, p.21.

¹⁴³ 12th SLHAR, 1905, p.33.

¹⁴⁴ Minute Book of St Luke's House Committee of Management 11 October 1905 - 21 May 1912: 21/05/1912, p.333.

¹⁴⁵ 19th SLHAR, 1912, p.41.

In contrast, the Sisters and the Chaplain not only felt that there was a closer relationship between the two types of care but that spiritual ministrations had greater priority. However, there do not appear to have been any of the tensions between the doctors and nursing Sisters in the Hostel of God (and St Joseph's) which characterised relations in some of the large voluntary hospitals in the mid- and late Victorian era where nursing Sisterhoods were recruited and which were largely caused by conflicting imperatives.¹⁴⁶ There are two possible reasons which may help to explain this. Firstly, the Sisters at the Hostel of God were responsible for both setting up the Home and for carrying out its internal management, whereas the sisterhoods working in voluntary hospitals were simply employees of these institutions. Secondly, in view of the fact that the patients in the Hostel were dying, the doctors, most of whom were probably Christians, would have recognised that their own role was limited and that issues of a more spiritual nature were likely to be of concern to many patients.

Caring for the patient's spiritual needs took a very different format to that at St Luke's. It was divided up between the Sisters who ran the Home and a single Chaplain. The latter was an Anglican minister whose appointment, although officially authorised by a special committee, was ultimately decided by the Reverend Mother and the Sisters whose wishes "were to be met in every possible respect."¹⁴⁷ He was paid an annual stipend for his services. In 1894 he earned £129 but by 1925 his salary had risen to £200.¹⁴⁸

The Anglican basis of the Hostel of God and the fact that the Chaplain was the only minister with an official appointment meant that he exerted considerable influence within the Home. In 1904 he put forward a suggestion to the committee (which was subsequently sanctioned) that, in light of the frequent opportunities afforded the patients for receiving Holy Communion, he thought it well to refuse permission to outsiders to celebrate the Holy Eucharist for their particular friends or parishioners except under very special circumstances. His justification was:

¹⁴⁶ Abel-Smith, *A History of the Nursing Profession*, p.19 ; Smith, F.B. (1979) *The Peoples Health*. London: Croom Helm, p.261.

¹⁴⁷ Hostel of God Annual Council Minutes February 1918 - 1977: 09/02/1925 ; 03/03/1925.

¹⁴⁸ HOGAR, 1893 - 1894, p.9 ; Hostel of God Annual Council Minutes February 1918 - 1977: 03/03/1925.

“In an institution where everything must be done to the moment, and where the services of a Chaplain are provided, it seems quite unnecessary to interfere with the ordinary routine of the day - a request which has been of frequent occurrence. I feel sure that my brother clergy will understand my reason for this.”¹⁴⁹

Furthermore, in 1933, it was the Chaplain himself who requested a £100 salary raise because his work had increased so greatly since his appointment that he could no longer augment his stipend with other work. Although he did not actually receive a pay rise, he was given occupation of a neighbouring house free of rent and rates which had the effect of decreasing his expenses by £106 per annum.¹⁵⁰

Unlike his counterpart at St Luke's House, the Chaplain at the Hostel of God seemed to retain a position of importance in the Home throughout the period. He continued to contribute to the Annual Report each year and regularly inform the Committee of the number of patients and Communicants under his charge. In 1938 he reported that ward services were still being held in the three main wards every Sunday.¹⁵¹ Although other ministers were permitted to attend to non-Anglican patients, they only had a minimal presence in the home and were not in a position to influence either policy or practice.

The Chaplain regarded spiritual preparation for death as the highest objective of the Home; the nursing and medical work were felt to be second in importance to the task of ministering to patients' souls, but at the same time he acknowledged the role they played in facilitating his own work:

“good nursing, skilful treatment, and the quiet comfort of the home are not merely good for the bodily needs of the patients; but they make a religious preparation for death more possible.”¹⁵²

His role, as described in the annual reports, was primarily based around the provision of three main services: instruction, worship and the reception of Sacraments. Daily services were held in the chapel for the workers and frequent ones in the wards for the

¹⁴⁹ Minute Book. Free Home for the Dying. Council Meetings April 1897 - February 17th 1914: 22/02/1904.

¹⁵⁰ Hostel of God Annual Council Minutes, February 1918 - 1977: 14/02/1933.

¹⁵¹ HOGAR, 1938, p.8.

¹⁵² HOGAR, 1897, p.10.

patients.¹⁵³ Holy Communion was usually administered once a month in each ward, but it could be given at other times and at any hour of the day when a patient was 'in extremis' and desired to receive the Viaticum. It was also the Chaplain's duty to give individual instruction as and when it was required and to prepare the sick and dying for the sacrament of Confirmation.¹⁵⁴ The significance attached to these duties reflected their importance in the Anglo-Catholic Church which placed great emphasis upon receipt of the Sacraments. Unlike the Chaplain at St Luke's, who only visited the patients one afternoon a week, the Chaplain at the Hostel of God attended the Home more frequently. A Charity Organisation Society representative, visiting the home in 1896, reported that the Chaplain "attends daily when necessary at the Home."¹⁵⁵

Unfortunately, the records contain very little direct information on the type of spiritual care given to the patients by the Sisters. In contrast, the more formal delineation of the Chaplains' responsibilities and the allocation of a section of the annual report each year in which to write about his work, suggest that perhaps he was considered to be primarily responsible for providing spiritual ministrations. The fact that the Sisters were not authorised to carry out many of the services provided by the Chaplain, such as administering the Sacraments, necessarily limited their role. The way in which the Chaplain wrote about the relationship between his own work and that of the Sisters helps to provide some insight into what he perceived was their task. The Reverend G.T. Evans, Chaplain at the Home from 1929, clearly differentiated between his duties and those of the Sisters and nurses. He believed that their task was essentially preparatory; by nursing the patients and saying prayers for them the Sisters and nurses were able to "prepare the way" for his own work:

"The spirit with which most, if not all, of the nursing is done and the prayer which goes with the labour all help to create just the support that the souls of the sick need so much. Sisters and Nurses prepare the way, and the Chaplain steps in aided by the power of Sacramental Grace."¹⁵⁶

One or two of the reports by the Sisters in the *St Margaret's Magazine and Half-Yearly Chronicle* provide additional glimpses into their role. Part of their work was to

¹⁵³ HOGAR, 1896, p.9.

¹⁵⁴ HOGAR, 1906, p.7 ; 1912, p.6 ; 1935, p.8 ; 1937, p.7.

¹⁵⁵ COS Report, 6 June 1896, [LMA].

¹⁵⁶ HOGAR, 1931, p.7.

tell patients about God's salvation and promise of eternal life; to share with them "the joy of the life beyond, and of the certainty of pardon through the Precious Blood." As death became imminent it changed to that of comforting patients as they passed into the next life:

"Sister holds his hand as he enters the dark valley, holding it closer and tighter as the darkness deepens, and only loosening its grasp when Another hand - stronger and more tender and pierced with nail prints, takes it from her."¹⁵⁷

At St Joseph's Hospice spiritual care was also considered the most important part of the work. The only information available on this is contained in the Annals but given that these were not intended for a public audience they are, in fact, probably more representative of how the Sisters perceived their role. The task of caring spiritually for the patients was similar to that at the Hostel of God in that it was divided between the Sisters and the minister, in this case a Catholic priest. However, the role of both was different because of the Catholic basis of the Hospice.

The Sisters felt that they made the best type of nurses for the dying because they could combine ministration to the "poor wasting body" with "care for the soul."¹⁵⁸ However, like their counterparts at the Hostel of God, this latter role was essentially preparatory in nature because it was limited by certain boundaries. The Sisters were expected to provide the patients with spiritual ministration and guidance and to prepare them spiritually for death but they could not hear Confession, receive a person into the Church or administer any of the Sacraments. The authority to perform these rites belonged exclusively to the priest with whom ultimate spiritual power rested because of the fundamental requirement that the patient become a *member* of the *Catholic* Church. The Sisters were permitted to provide Instruction (explanation of the Catholic faith) and could offer spiritual comfort through such acts as prayers, Bible reading and the administration of holy water, but their role did not extend any further. Their spiritual objective was therefore essentially two-fold: to identify potential or lapsed converts and to prepare them for reception into the Catholic Church by the priest or to minister to those already strong in the Faith. The Sisters also had to defer to the

¹⁵⁷ *St Margaret's Magazine and Half-Yearly Chronicle* (1913), Vol. III, Part 8, pp.277-278.

¹⁵⁸ Author unknown, 'At least let them die in peace', *The Tablet* July c1913.

broader hierarchical authority of the Catholic Church in certain spiritual matters, such as the occasion in 1923 when the Cardinal granted permission for a second Mass to be said each Sunday for the patients. Subsequently, this authorisation had to be renewed each year.¹⁵⁹

The importance of the Chaplain's position in the Hospice was also demonstrated by the fact that he was the only salaried minister employed by the Sisters. One of the two trust funds set up by Miss Grace Goldsmid, the Congregation's benefactor, was specifically for the purposes of employing a Catholic chaplain.¹⁶⁰ Each year a substantive sum was expended on the chaplain and chaplaincy. In 1905, the opening year, it amounted to £93. By 1916 it had risen to £152 and in 1938 it totalled £256.¹⁶¹

It was, however, the nuns' responsibility to attend to the death bed during the final moments. Sometimes the priest would be present, if he happened to be in the Hospice, or if he had been summoned by the Sisters or relatives to administer a particular rite. Once the patient entered the final stages, every attention was given to the spiritual. The bed was screened off and the Sisters began the Prayers for the Dying and the Prayers Recommending the Departing Soul. Sometimes items such as a crucifix were given to the patient to provide additional spiritual comfort.¹⁶²

Even the Sisters of Charity, who had taken a vow of service to the poor, did not act from purely altruistic motives. The Catholic Church placed significant emphasis upon the importance of good works and the benefits these conferred upon the individual's (as well as the recipient's) own spiritual development and eternal status after death. The author of an article on the Sisters' work in north-east London highlighted this added motive: "In the performance of their duties they regard the salvation of their souls as the end to be kept in view."¹⁶³

¹⁵⁹ SJHA, 1923.

¹⁶⁰ SJHA, 1900-1905.

¹⁶¹ 'St Joseph's Hospice for the Dying Poor Report 1907', p.9 ; 'Report of St Joseph's Hospice for the Dying 1916', p.14 ; 'Report of St Joseph's Hospice for the Dying 1935', p.15.

¹⁶² SJHA, 1923.

¹⁶³ Author unknown, 'The Sisters of Charity: their work in North-East London', newspaper unknown, c1904, St Joseph's Hospice Archive.

At St Joseph's, despite a regular turnover of Sisters, the daily life and routine of the Hospice continued uninterrupted. In 1924, for example, there were six changes in Sisters and between 1929 and March 1935 eleven Sisters left the Convent, two from the Hospice itself, and eleven new Sisters joined.¹⁶⁴ The continuity in the routine of the Hospice was without doubt the result of the rule and order which underpinned the life of the Congregation. However, there are also indications that from time to time the nature of convent life could have adverse effects upon those expected to adhere to its demands. Over the years the annals record several instances of Sisters who suffered nervous breakdowns and had to leave Hackney. Although the nature and pressure of their work - long hours spent ministering to the poor and destitute, the sick and the dying, in the East End - would have contributed greatly to these breakdowns, the strictly disciplined environment in which they lived would not have been conducive to relieving the stress and strain which necessarily accompanied such work. Under the Rules of the Congregation the Sisters were expected to "renounce the world" and "devote themselves to Divine Service" and were not permitted to have "intercourse with friends and family unless the Superior considered it expedient."¹⁶⁵ The Sisterhood did, however, recognise that the Sisters needed occasional periods of rest and a change of scene and provision was made for this in the form of a retreat home at St Leonard's-on-the-Sea.

v. Telling the truth to patients

Despite the advice of certain leading members of the medical profession that patients should be told the truth about their prognosis, it appears that in the homes this was not always translated into practice. At the Hostel of God many of the patients were admitted in ignorance of their condition and of the nature of the Home. As chapter four showed, it seems that many of the doctors who made referrals to the Hostel of God did not inform patients of their condition. The Medical Officer blamed deficiency in apprising patients of the true nature of their illness upon hospital almoners who, he wrote, encouraged patients to hope that, in leaving the hospital and going to the

¹⁶⁴ SJHA, 1924, p.2 ; *Hackney Annals*, 1928-1935, p.11.

¹⁶⁵ *Rules and Constitution of the Congregation of the Sisters of Charity*. Roma Tippografia (1912).

Hostel, they were entering a Convalescent home to be nursed back to health.¹⁶⁶ Such behaviour appears to have been part of wider medical practice; in her study of Victorian and Edwardian middle and upper class families Jalland also found that, after the 1880s, doctors increasingly concealed the truth from patients and, to a lesser extent, from their families.¹⁶⁷

The medical staff at the Hostel of God could not tolerate this situation but did not take upon themselves the responsibility for telling patients; instead the onus of informing them was placed upon the Sisters. Unlike Munk, who believed it was primarily the duty of relatives, or in their absence the doctor, to acquaint patients with the nature of their illness and Browne who saw it as the doctor's responsibility, the medical personnel did not feel that it was part of the physician's role. Dr Ryan wrote that in such instances it was the responsibility of the Sisters to convey the "fatal news" to the patient.¹⁶⁸ Advising patients on the true nature of their condition was probably considered important because it allowed them sufficient time to prepare spiritually for death and letting the Sisters undertake this task meant that they would be immediately on hand to offer spiritual comfort and support.

At St Luke's House, it is not entirely clear whether patients actually knew the true nature of their condition before admission, but once there every effort was made to minimise the fact that they were in a home for the dying.

"We take the greatest care to suppress the actual purpose of the Home in the wards, but the indiscretion of the patients' friends, and once or twice, I am sorry to say of a Visitor, neutralises our best efforts."¹⁶⁹

However, given that some inmates were under the impression that they had been sent to a convalescent or nursing home and that after admission the staff tried to conceal the true purpose of the home, it seems likely they too had not been informed of their prognosis by doctors. Several inmates, on eventually discovering the object of the Home, were greatly upset and asked to leave.

¹⁶⁶ Hostel Of God Annual Council Minutes February 1918 - 1977: 19/02/1925.

¹⁶⁷ Jalland, *Death in the Victorian Family*, p.117.

¹⁶⁸ HOGAR, 1923, p.7.

¹⁶⁹ 11th SLHAR, 1904, p.10.

vi. Patients

Within the source material for each of the homes, the patients' voice is very much a silent one because, aside from one letter, there are no records written directly by the inmates or through which they are allowed to speak. Although patient histories are included in the annual reports and annals, they are reproduced both selectively and in part and, unfortunately, there are no original case notes with which to compare them. At St Luke's House, under Howard Barrett's superintendency, extracts from both individual patient case histories and individual 'reasons for discharge' were recorded in the annual reports. Obviously these are not true accounts of patients' experiences because they were written from the perspective of Barrett himself and for a very specific set of purposes.

Many patients' case histories were chosen to demonstrate to subscribers that the Home was fulfilling its function as a refuge for dying members of the respectable poor who, because of the nature of their disease and their domestic and financial situations, were unable to care for themselves at home. The more painful and disagreeable aspects of patients' ailments were often described as a way to elicit the readers' sympathy: one patient suffering from stomach cancer was described as "wasted to a skeleton, with a waxen pallor."¹⁷⁰ Occasionally Barrett would attempt to lighten the tone a little by including case histories which were simply designed to provide amusement for the reader, such as the man, "one of those in the most miserable condition, intently reading Sir John Lubbock's *Pleasures of Life*. Was he sanguine of the future, or merely fond of vivid contrasts?"¹⁷¹

Many of the 'reasons for discharge' were purposefully selected to highlight patients who were unsuitable, both pathologically and morally, for admission into, and retention within, the Home. Patients suffering from mental disorders, incurable or chronic conditions were not permitted to remain. Both the histories and reasons for discharge reveal the highly moralistic and patronising elements of Barrett's disposition which served as the framework within which all patients were judged. One

¹⁷⁰ Ibid., p.15.

¹⁷¹ 4th SLHAR, taken from the 10th WLMAR, 1897, p.9.

male patient was sent away because of bad conduct. Barrett wrote that he had been a gentleman's servant and did "no great honour to his calling."¹⁷² Such moralising was part of wider social attitudes and would have appealed to many of the subscribers.

Occasionally a reason for discharge was cited to draw the attention of the reader to, what the Medical Superintendent perceived to be, a deficiency within the Home. As chapter four showed, the medical staff were concerned about a particular "class of patient who discharges himself" after being forced to witness the death of other inmates in the ward. Edmund Barrett attributed this to a fault in the management of the Home because there were no private rooms to which they could be removed. Although this may appear to indicate sensitivity to patient needs on the part of Barrett, the context in which he made this claim - the argument was used in conjunction with an appeal to readers for a new home - qualifies the purity of his motives to some extent.¹⁷³

The accounts of patients related by the Visiting Sisters in the annual reports were chosen even more selectively and were also designed for very specific purposes: firstly to emphasise the importance of having faith in Jesus Christ and the difference it made in the approach to death and, secondly, to provide evidence of, and justification for, their own role in the Home. One of the Visiting Sisters introduced her report for 1904 with the following statement: "This report is to speak about the effect of the Home upon patients' spiritual life and to refer very reverently to the inner life of those we have had the privilege to minister to."¹⁷⁴

In the same way, patient histories by the Sisters of Charity at St Joseph's were also chosen purposefully but in a different way and for a different set of reasons. They were not written to satisfy the curiosity of subscribers and patrons and to provide justification for their past, and hopefully future, financial investment, but to demonstrate to the Mother House that they were fulfilling their spiritual duties as a Catholic sisterhood working among the dying poor in the East End of London. Their

¹⁷² 7th SLHAR, 1900, pp.11-12.

¹⁷³ 21st SLHAR, 1914, pp. 15, 17.

¹⁷⁴ 11th SLHAR, 1904, p.24.

accounts were less preoccupied with moral concerns, concentrating instead upon the spiritual history of patients and the Sisters' own particular role within this. As such only patients who were reconciled to, or became members of, the Catholic faith were included. References to the severe pain experienced by patients were used to emphasise how the Catholic faith fortified them for death and enabled them to accept their suffering with resignation. No histories were provided in the official annals of patients who chose to remain outside the Catholic Church.

Even the one letter composed by a patient must be treated with a degree of circumspection. It was written by one of the male patients (RJ) at St Joseph's Hospice and was included in the annals for 1927. However, it was not the original letter - it had been copied by one of nuns - and its very position within the annals was itself a strategic manoeuvre. The letter, together with a copy of a letter from RJ's mother thanking the Sisters for their care, followed on from an account of his conversion to the Catholic faith. As such it epitomised the most important part of the Sisters' work in the Hospice and provided an unequivocal illustration of it for the Mother House. RJ was a non-Catholic when admitted and had been a particularly difficult case to convert, not least because of his influence over the other patients who had been afraid to speak to the priest when he was near. Initially he resisted the efforts of the Sisters and the priest to persuade him to change his faith, but eventually he relented. The following is a transcription of the letter sent by RJ to his mother describing his conversion:

"A wonderful thing has happened to me. I have received the Divine Truth through the R. Catholic Church. A great light came to me when unable to sleep on Easter morning, and since making my resolutions I have felt spiritually happy. I cannot describe my feeling, but it is magnificent, and perhaps all this illness has been sent in order that the final grace may be given me. I was baptised on Monday and received Holy Communion this morning. Certain relations will no doubt have queer things to say, but what is that when the destiny of one's soul is in the balance? Influence has had nothing whatever to do with this step. I hope you will not be grieved yourself, but pleased that a departing soul has found what it believes to be the true way. Finally I can only hope for a similar grace to all persons in a religion which appears to be of a deeper character, and more sincere than any I have had experience with. Sneering persons should investigate, and

they will find that things are not what they appear to be, and the kindness of the R. Catholic heart surpasses all belief.”¹⁷⁵

RJ's conversion experience not only contained and demonstrated all the main features of a “holy and happy death” but also exonerated the Sisters from any possible suspicion of coercion. His letter was also felt to be important because it influenced the conversion of one of the other patients; the Annalist recorded that RJ's letter was read out in the ward where it “touched” another inmate greatly, who then in turn asked for Instruction and to be received into the Church.¹⁷⁶

Within the patient histories for St Joseph's and St Luke's the physical causes of patients' conditions were both recognised and acknowledged; however, they were ultimately interpreted and given meaning in terms of the opportunity they afforded for the sufferer to demonstrate grace. Unlike earlier centuries, disease was not attributed solely to divine causes. Environmental and bacteriological causes were accepted but they were still primarily viewed within the context of God's work and as spiritually beneficial to the patient.

The annual reports for the Hostel of God contain only a few accounts of patients. Most of these were written by the Chaplain and were included for the same purposes as some of the case histories at St Luke's: to show the subscribers and patrons that the Home was discharging its duties. The stories, by recounting the financial, domestic and pathological background of the two patients, were designed primarily to illustrate the type of inmate using the home and to demonstrate the need for such an institution:

“An old lady who had known better days; all her relations were dead, her money was lost, her health failed, she became blind, and she had literally no one to care for her; she came to the Home and had all done for her that skill could to make the last weeks of her life easier, and when she died, her funeral was made a little less lonely than it otherwise would have been.”¹⁷⁷

Likewise, the few accounts of patients contained within the Sisters' reports in *St Margaret's Magazine and Half-Yearly Chronicle* had a similar purpose to those in the annals at St Joseph's. They too were written for a private readership - the Mother

¹⁷⁵ SJHA, 1926, pp.5-7.

¹⁷⁶ Ibid.

¹⁷⁷ HOGAR, 1897, p.10.

House and other branches of the Sisterhood - and were intended to both illustrate the primarily spiritual nature of their work with the dying poor and to justify its need.

There is no way of knowing how accurate the portrayals of patients were or how representative they were of their experiences in general, but they do provide insight into some aspects of the patients' time in the homes, which are corroborated either by evidence in other records, or by their occurrence in all three homes. At St Luke's House a few patients requested to be discharged because they were bored by the monotony of life in the home and the "unchanging and rather dull surroundings."¹⁷⁸ Several of the early reports included a timetable of the daily routine of the Home and it is easy to see how patients might tire from its tedium. Breakfast was regularly administered at 7:30 and followed by general prayers. During the morning the patients were washed and had their dressings renewed. Lunch was given at 11 am and then dinner at 1:15pm. The afternoons, between 2:00 and 4:00pm, were taken up by various visitors: the Visiting Sisters came two afternoons a week and the Chaplain once a week. At 4:30 the patients had tea and then they were washed again and their dressings changed. Prayers were said at 8 o'clock before the lights were turned down for the night.¹⁷⁹

Patients' families and friends were welcomed as visitors to the homes, although the timing of their visits, unless the patient was actually dying, was regulated quite strictly. At St Luke's they were permitted to visit any afternoon between 3 and 5pm, except Thursday and Sunday.¹⁸⁰ In the early years of the Hostel of God patients were allowed visitors everyday at 2:00 p.m. but, by 1908, their visits had been reduced to two afternoons a week unless the patient was gravely ill.¹⁸¹ The records for both St Luke's and St Joseph's contain instances where members of the same family were inmates of the home, either simultaneously or at different times.¹⁸² At St Joseph's the nuns also made provisions for children who were orphaned by the death of a parent or

¹⁷⁸ 7th SLHAR, 1900, p.11.

¹⁷⁹ 1st SLHAR, taken from 7th WLMAR, 1894, p.11.

¹⁸⁰ Minute Book of St Luke's House Committee of Management 15 Nov. 1895 - 19 July 1905: 15/03/1905.

¹⁸¹ 30 March 1894 'Report on the Hostel of God' by E. Farish ; 27 October 1908 'Report of a Visit to the Hostel of God (Free home for the Dying) Clapham Common' by H. Kelly, [LMA].

¹⁸² SJHA May 1915 - May 1921 ; 6th SLHAR, 1899, p.24.

for those whose father did not feel capable of looking after them after his wife died. The children were usually sent either to other Sister of Charity homes or to similar institutions run by Catholic religious orders in order to ensure a continuation of Catholic influences. Family members at St Joseph's often continued to visit the Hospice after a relative died.¹⁸³

Although the accounts of patients focus primarily upon their spiritual well-being, it is possible to gain some insight into their physical state. The records for each of the Homes all draw attention to the extreme, and often protracted, pain experienced by many patients, particularly those suffering from cancer. The annual reports at St Luke's contain frequent references to the "agonising mutilations" by disease or surgery to which patients were subjected.¹⁸⁴ Some of the entries in the Patient Register suggest that such accounts were not an exaggeration. One female patient with malignant disease of the larynx in 1910 was described as suffering a "terrible death." She was unable to breath through her tracheotomy tube and died almost in full strength, quite conscious and unable to breathe.¹⁸⁵ Similarly, the Sisters of Charity annals describe a female patient with advanced cancer of the throat who was admitted in a "deplorable state": the cancer had burst and was most offensive and causing her immense suffering. Another patient with cancer of the front of the head and eye who suffered severe headaches was recorded as saying his head felt as if "rats were gnawing at it."¹⁸⁶

Phthisis too was an extremely painful disease in the end stages: Howard Barrett wrote in his report for 1898 that "consumption is not an easy form of death."¹⁸⁷ Late nineteenth century medical texts on the pathology and treatment of phthisis, including its advanced stages, provide some clues as to what patients had to suffer. Symptoms during the final stages included thromboses in the veins of the extremities, oedema (swollen tissue) of feet and ankles, bed sores, ulceration of the mouth and pharynx. Towards the end the patient experienced profuse sweats after the swallowing of all

¹⁸³ SJHA May 1905 - May 1909 ; May 1909 - May 1915.

¹⁸⁴ 11th SLHAR, 1904, p.15.

¹⁸⁵ St Luke's House Patient Case Book 7 January 1909 - 16 October 1911, No. 311.

¹⁸⁶ SJHA, May 1909 - May 1915 ; SJHA, 1927, p.5.

¹⁸⁷ 5th SLHAR, 1898, p.9.

fluids; diarrhoea (which could often prove fatal); breathing became quicker; and expectoration was increasingly difficult. Death itself could occur in several ways: apnoea (cessation of breathing) from inability to expectorate the accumulating secretion; thrombosis of the pulmonary artery; pneumothorax (the presence of air in the pleural cavity); exhaustion resulting from gradual heart failure caused by the wasting course of the disease or attendant diarrhoea; or haemoptysis, either by collapse from blood loss or suffocation through blood rapidly filling the air cells.¹⁸⁸

However, in some instances, the simple act of being removed from their own homes to the peaceful atmosphere of the Home and the regular supply of good nourishment enabled patients to recover temporarily. Many improved after admission into the home, some long enough to allow them to be discharged. One of the entries in the Patient Registers at St Luke's noted that a patient suffering from tuberculosis "responded to good food, rest and treatment" with "marked improvement each month until sufficiently well to return home."¹⁸⁹ In certain cases of phthisis where the disease progressed more slowly the patient often went into remission. It appears that at St Luke's some form of after-care was offered to patients discharged from the home. One of the objectives of the St Luke's Aid Society, set up in 1898, was to provide this service, although no mention was made of what form it took.¹⁹⁰

Whilst some patients were optimistic about the possibility of recovery, such as those patients at St Joseph's who went on a pilgrimage to Lourdes, others were unable to cope with the fatality of their condition. Several patients each year left once they found out their prognosis or discovered they were in a home for the dying. The most extreme example was the case of a patient at St Luke's who committed suicide by throwing himself out of a window. At the following committee meeting the Matron reported that he had been very conscious that he only had a short time left to live and had given way to sudden impulse.¹⁹¹

¹⁸⁸ Williams, C.J.B. (1887) *Pulmonary Consumption: Its Etiology, Pathology and Treatment*. London: Longmans, Green and Co., pp.95-96

¹⁸⁹ St Luke's House Patient Case Book 7 January 1909 - 16 October 1911, No. 147.

¹⁹⁰ 5th SLHAR, 1898, p.14.

¹⁹¹ SJHA, 1923 ; Minute Book of St Luke's Hospital For Advanced Cases Committee of Management, 25 March 1931 - 26 April 1939: 26/10/1938, p.297.

vii. Conclusion

The homes for the dying were very much part of a wider interest in care of the dying that developed among some members of the medical profession during the latter half of the Victorian era. This interest slowly began to be recognised, by certain leading individuals, as a separate and distinct area of practice in which patients required a more caring and supportive environment. Although Jalland has shown how these ideas were put into practice among the middle and upper classes, little interest has been shown in their impact upon the poor working-classes. It was only through the establishment of these homes in London, whose sole objective was the provision of care for the dying poor, that certain members of the latter - the respectable poor - were able to come under their influence.

By the late nineteenth century spiritual care of all types of patients was beginning to be both separated out from, and subordinated to, medical and nursing care, both privately and in many of the voluntary hospitals. As Jalland has demonstrated in the case of middle and upper class private patients, even care of the dying was not immune to these influences. The homes, like many of the other religious based philanthropic institutions founded during this period, were set up to try and counter these trends. They not only intended to re-establish the primacy of spiritual care but also to reforge the relationship between care of the body and care of the soul.

At the same time as resisting certain trends within the broader medical profession, there is also evidence that the doctors, in one of the homes at least (St Luke's House), were influenced by wider changes in medical opinion during this period; for example, the increasing acceptance among doctors that it was morally permissible to curtail the life of patients suffering from extreme pain. Like most of their medical brethren, however, they came down very strongly against the arguments of the advocates of Euthanasia. Although the doctors in the homes did everything within their power to minimise patients' sufferings, the religious underpinnings of the institutions meant that the presence of pain was ultimately accepted because it had a role to play in the patient's spiritual life.

St Luke's was less able to dissociate itself from the wider changes that occurred. Unlike the other two homes, which were run by religious orders, it was managed by a Committee of lay personnel and each of the staff were given clearly designated roles. The medical staff had a significant presence in the Home and were able to influence policy and practice more than their counterparts at the Hostel of God and St Joseph's. Although spiritual care assumed precedence during the early years, the Home became progressively medicalised and spiritual concerns gradually came to assume a lower priority within its broader mandate (although this is not to say that it occurred at the level of individual patients). The Medical Superintendent's Report continued to dominate the annual reports each year while those of the Visiting Sisters and the Chaplains were no longer included after 1914. Unlike the reports of Howard Barrett and his son, their successors made no reference to spiritual care. The Home was also less able to resist the influence and pressure of what were perceived as wider public attitudes, such as the popular tendency to conceal from patients the truth of their prognosis and public aversion to the title 'home for the dying'.

Both St Joseph's and the Hostel of God demonstrated a stronger resistance to prevailing trends: spiritual care continued to be the most important and strongly emphasised part of the work. The fact that the Homes were run by religious orders meant that spiritual matters predominated and that care of the soul was both a full time and permanent feature of the programme. In contrast, spiritual ministration at St Luke's was only provided on a part-time visitation basis which may help to account for its gradual demise, especially after formal ties with the West London Mission were severed in 1912. Although the medical personnel and the chaplain in the Hostel of God and St Joseph's had discrete roles, the former caring for patients' bodily needs and the latter tending to their spiritual wants, the two were closely linked and worked in tandem. The work of the religious orders was less rigidly defined and demonstrated the relationship between bodily and spiritual care. The Sisters combined their nursing skills with spiritual ministering and used the former as a means to expedite the latter. As such the Sisters provided a bridge between the doctors and the chaplain by facilitating the transition from physical to spiritual care.

CHAPTER 6

Power, Control and the Institutionalisation of Death

The creation of special institutions for the purpose of caring for the dying poor during their remaining months, weeks or days raises a number of questions about the sort of influences to which patients were exposed once inside, particularly in light of the overtly religious nature of the homes. Earlier discussion in this thesis, especially in chapter three, has suggested the possibility that they were subjected to various forms of control in which both their bodies and the manner of their deaths were carefully managed in order to achieve the more important goal of conversion. Social control has been used extensively by social historians within the last twenty years as a tool for analysing the activities of those in positions of power. It is primarily used to signify the imposition of the attitudes and habits of one class upon another, the object of which was to preserve social order and stability. For historians looking at social control within the context of nineteenth century Britain it has become a means of interpreting relations between the middle and working classes.¹

The social control concept has been a particularly popular theory among historians looking at the development of religion, philanthropy and nursing in the nineteenth century.² These areas of Victorian history lend themselves readily to this form of interpretation, and as such provide a further reason why issues surrounding control are such an important consideration for this thesis. Victorian churches had traditionally played an important role in the preservation of social stability. The belief that social order was intimately connected to morality meant that the church was a crucial agency of social control. Those in positions of power supported religious institutions, while religious authority was used to legitimate existing power and class structures.³ The decline in middle class participation in churches from the 1880s onwards, however, led to a corresponding demise in paternalism and church-led charitable work which

¹ See, for example, the collection of essays in A.P. Donajrodski (1977) (ed) *Social Control in Nineteenth Century Britain*. London: Croom Helm.

² See Morris, R.J. (1983) Voluntary societies and British urban elites, 1780-1850: an analysis, *Historical Journal*, Vol.26, No.1, pp.96-113 ; Summers, A. (1979) A home from home - women's philanthropic work in the nineteenth century, in S. Burman (ed) *Fit Work for Women*. London: Croom Helm, pp. 33-63 ; Hart, J. (1977) Religion and social control in the mid-nineteenth century, in A.P. Donajrodski (ed) *Social Control in Nineteenth Century Britain*. London: Croom Helm, pp.108-130 ; Luddy, M. (1995) *Women and Philanthropy in Nineteenth Century Ireland*. Cambridge University Press, pp.2, 216 ; Mitchell, D. and Bolton, G. (1980) The administration of poverty and the development of nursing practice in nineteenth century England, in C. Davies (ed) *Rewriting Nursing History*. London: Croom Helm, pp.76-101.

³ McLeod, H. (1996) *Religion and Society in England, 1850-1914*. London: Macmillan, pp.110-11 ; Hart, 'Religion and social control', pp.108-130.

resulted in less contact with non-church goers.⁴ Some historians have argued that the fall in middle class church attendance reduced the effectiveness of churches as agents of social control⁵ and there is scope to argue that the growing reliance on religious orders may have been part of the churches' efforts to counter these developments.

One of the principal arguments used to justify the establishment of religious orders was the work they could achieve among the poor, together with the moral and spiritual influence they could exert upon them. The social make-up of religious orders (nuns and sisters came predominantly from middle and upper middle classes), like all Victorian charitable endeavours, was based upon the conviction that moral influence could only be exerted successfully if 'respectable' men and women were involved. Class barriers were also felt to be an important means of protecting women against working class vice.⁶ The social vision and philanthropic work of nuns and sisters formed part of the wider role of the Church. They were motivated primarily by religious considerations and felt that improvements in the moral condition of the lower classes were contingent upon their spiritual reformation.⁷

Organised philanthropy played an important role in the regulation of relationships and activities because it provided a means for controlling sections of the population without recourse to more overtly coercive forms of state power. It also enabled philanthropists to determine the moral conditions which could be attached to their charity rather than applying the state's definition.⁸ Disease and illness were seen as potentially disruptive forces in social relationships because the sick were unable to perform those roles upon which others might depend. As well as caring for sick bodies, nurses were thought to play an important role in the moral health of patients. The involvement of so many religious orders in nursing, however, was primarily

⁴ Obelkevich, J. (1990) Religion, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol. 3. Cambridge University Press, p.224.

⁵ Ward, W.R. (1990) Faith and fallacy: English and German perspectives in the nineteenth century, in R.J. Helmstadter and B. Lightman (eds) *Victorian Faith in Crisis*. London: Macmillan, p.40.

⁶ Hill, M (1973) *The Religious Order*. London: Heinemann Educational Books, pp.280-3 ; Gill, S. (1993) The power of Christian ladyhood: Priscilla Lydia Sellon and the creation of Anglican sisterhoods, in S. Mews (ed) *Modern Religious Rebels*. London: Epworth Press, p.149 ; Norman, E.R. (1976) *Church and Society in England 1770-1970: a Historical Study*. Oxford: Clarendon Press, p.166.

⁷ Gill, 'The power of Christian ladyhood', p.149.

⁸ Dingwall, R., Rafferty, A.M. and Webster, C. (1988) *An Introduction to the Social History of Nursing*. London: Routledge, pp.24-26.

motivated by the opportunity it provided for spiritual ministry. Given the relatively minimal chances for cure in the Victorian era, the sickbed provided a crucial opportunity for pastoral work because it could be the last chance to bring patients to an awareness of both the need for, and the means of, salvation. The role of nurses was particularly significant because they provided access to groups otherwise isolated from the moral and Christian influence of the higher social classes and, unlike the clergy, they could provide constant attendance in the sick room.⁹ Anne Summers has argued that nursing sisterhoods were key figures in a movement to reclaim both the poor and medicine from advancing secularisation.¹⁰ The growing involvement of religious orders in institutional forms of care for the poor also afforded a new opportunity to bring these groups under the sisters' influence and control. As C. Clear states:

“The tendency to ‘gather’ in certain sections of the poor, to separate them in groups according to need and to control and manage them in a formalised setting took root in many congregations at this time.”¹¹

Michel Foucault's work offers an alternative approach to that adopted by traditional historians of social control. As both historian and philosopher his primary interest is in the development of discourses and the relationship between power and knowledge which form them. He views history as a means for thinking about the way in which different forms of knowledge and power are located in particular historical situations. Thus, Foucault is concerned about the way in which power operates at the sites of its action. He acknowledges the traditional view of power as a repressive and coercive force exercised by sovereign bodies, but argues that it is accompanied by a more subtle and pervasive system of disciplinary power in which power does not belong to a dominant class or group but to ‘everybody’. The inquisition of truth, and therefore knowledge, is as much a form of power as force.¹²

⁹ Ibid., p.29 ; Rafferty, A.M. (1996) *The Politics of Nursing Knowledge*. London: Routledge, p.21 ; Bullough, V.L. and Bullough, B. (1979) *The Care of the Sick: The Emergence of Modern Nursing*. London: Croom Helm, p.84 ; Summers, A. (1988) *Angels and Citizens*. London: Routledge and Keegan Paul, pp.21-22 ; Summers, A. (1989) Ministering angels, *History Today*, Vol. 39, p.34.

¹⁰ Ibid., p.34.

¹¹ Clear, C. (1987) *Nuns in Nineteenth Century Ireland*. Dublin: Gill and Macmillan, p.106.

¹² Jones, C. and Porter, R. (1994) (eds) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge, pp.2 ; Fox, N. (1993) *Postmodernism, Sociology and Health*. Buckingham: Open University Press, p.31 ; Arney, W.R. and Bergen, B.J. (1983) The anomaly, the chronic patient and the play of medical power, *Sociology of Health and Illness*, Vol.5, No.1, p.2.

The panopticon came to symbolise the new configuration of power. It was founded on the principle of surveillance, the observation and classification of individuals, as a corrective for deviant bodies. Within the panopticon self-surveillance characterised the operation of power because the subjects were never sure when they were being observed and thus had to behave as if the surveillance were perpetual. This state of permanent and conscious visibility assured the automatic functioning of power.¹³ The operation of disciplinary power in the panopticon was particularly applicable to institutional settings, such as hospitals, schools and prisons. For Foucault the body represented the site of power. Space was seen as central to any exercise of power because it allowed for the control of bodies. When he wrote about spaces he often focused on particular institutions because it was here that space could be manipulated and arranged in such a way as to allow for the inscription of various forms of knowledge and power on bodies. In hospitals, prisons etc. bodies were constantly made visible through continuous observation and analysis. The aim was to create a malleable and passive body which could then be reformed, but the process of 'disciplination' also allowed bodies to be established as individual and discrete. Foucault argues that disciplinary power acts as a mechanism for creating and shaping subjects and subjectivity rather than as a means for repression. It is within this context that he formulates the idea of the 'gaze', a technology of power for rendering visible the individual. Through surveillance and objectification it serves to construct the body in relation to general categories of knowledge about bodies. The disciplinary techniques also harness the power of writing. Individual subjects are captured and fixed in a mass of documents so that each becomes a 'case'; an object for the acquisition of both knowledge and power.¹⁴

¹³ Foucault, M. (1977) *Discipline and Punish: the birth of the prison*. Middlesex: Penguin Books (translated by Alan Sheridan), pp.172, 199-212.

¹⁴ Jones and Porter, *Reassessing Foucault*, p.10 ; Foucault, *Discipline and Punish*, pp.141, 172, 187-212 ; Fox, *Postmodernism*, p.24 ; Armstrong, D. (1994) Bodies of knowledge / knowledge of bodies, in C. Jones and R. Porter (eds) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge, p.20 ; Rose, N. (1994) Medicine, history and the present, in C. Jones and R. Porter (eds) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge, p.60 ; Osborne, T. (1994) On anti-medicine and clinical reason, in C. Jones and R. Porter (eds) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge, pp. 34-35 ; May, C. (1992) Individual care? power and subjectivity in therapeutic relationships, *Sociology*, Vol.26, No.4, p.591.

Foucault's ideas and methodology have been taken up in recent years by a number of different historians and sociologists who wish to explore power relations and the emergence and development of 'discourses'. The relationship between health care practitioners and their patients has been the focus of several sociological studies in this vein. A number of these have adopted a broadly Foucauldian perspective for looking at the issues of power and subjectivity in therapeutic relationships. Some of them have examined these issues within the specific context of nursing care of the terminally ill.¹⁵

As historians are beginning to acknowledge, social control is only one way of looking at the interactions between different social groups. More recent research has sought to get away from this "rather murky and reductionist"¹⁶ concept, particularly historians investigating nineteenth century philanthropy. Some have reacted by going to the other extreme and endorsing the primarily altruistic motives of donors¹⁷ whilst others, such as Alan Kidd, in an attempt to escape the whole social control vs altruism debate, have adopted a very different way of looking at philanthropic relationships.

Kidd argues that motive is not the only starting point for discussing philanthropy and feels that there are other important aspects to consider in the study of social processes and interrelationships. He is concerned to emphasise the notion of reciprocity which, he says, was crucial to giving because without it the gift had no meaning. There was no such thing as a free gift and so reciprocity had to be represented in some way. The charity relationship was fundamentally unequal which meant that the potential for reciprocity was very small. The recipient was therefore dependent on the donor which left the charitable in control of the gift as a social mechanism and provided them with the power to define its meaning. In an attempt to overcome its one way character, the gift was made conditional on status rather than need. By limiting the gift to the

¹⁵ May, 'Individual care?', pp. 589-602 ; Lupton, D. (1995) Perspectives on power, communication and the medical encounter: implications for nursing theory and practice, *Nursing Inquiry*, Vol.2, pp.157-163 ; Armstrong, D. (1987) Silence and truth in death and dying, *Social Science of Medicine*, Vol. 24, No. 8, pp.651-657.

¹⁶ Prochaska, F. (1990) Philanthropy, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol.3. Cambridge University Press, pp.370-371.

¹⁷ Most notable is Frank Prochaska. See especially, Prochaska, F. (1990) Philanthropy, in F.M.L. Thompson (ed) *Cambridge Social History of Britain 1750-1950*, Vol.3. Cambridge University Press, pp.357-393.

'deserving poor', it was made dependent on the recipient who had to occupy the status of being deserving.¹⁸ Kidd goes on to argue that the individual donor's relationship with the recipient was not the central element in the charitable gift but, rather, it was more likely to have been the internal relationship with the self (internalised norms, self-image, fulfilment of an obligation) and/or the external relationship with the community (issues of legitimacy and reputability).¹⁹

Other historians of Victorian Britain have been concerned to look at social relationships from the point of view of the recipient and have found that it often offers a substantially different perspective to the social control argument.²⁰ Historical investigations which view past events only from a social control perspective tend to produce a very one-sided view, namely by implying that the objects of control were simply passive recipients, unable to exert their own influence or cultivate their own values and opinions. These historians, in their concern to redress the balance, have stressed that social control does not provide the only, or even the principal, explanation for nineteenth century class relations. They emphasise that without examining the responses of recipients it is impossible to gauge the exact role and significance of social control agencies in the development of Victorian society.

In the Victorian era working class responses to middle class efforts to make them conform to their expectations encompassed a variety of behaviours. Depending on the balance of power relations, these could range from outright defiance and resistance through to adaptation, modification, appropriation, absorption and acceptance. F.M.L. Thompson has conducted a broad analysis of some of the traditional arguments used by the advocates of social control in nineteenth century Britain and found that they are somewhat lacking in their ability to provide a full explanation for social transformations during this period, mainly because they do not account adequately for

¹⁸ Kidd, A. (1996) Philanthropy and the 'social history paradigm', *Social History of Medicine*, Vol.21, No.2, pp.184-187.

¹⁹ *Ibid.*, p.188.

²⁰ Thompson, F.M.L. (1981) Social control in Victorian Britain, *The Economic History Review*, 2nd series, Vol.34, No.2, pp.189-208 ; Prochaska, 'Philanthropy', pp.357-393 ; Cavallo, S. (1994) The motivations of benefactors: an overview of approaches to the study of charity, in J. Barry and C. Jones (eds) *Medicine and Charity Before the Welfare State*. London: Routledge, pp.46-60 ; Cherry, S. (1996) Accountability, entitlement, and control issues and voluntary hospital funding c1860-1939, *Social History of Medicine*, Vol. 9, No. 2, pp.215-233.

recipient responses. He argues that one of the dangers of the social control argument is that it always places the working classes at the receiving end and does not allow them to have any form of autonomy. Physical and material changes often had a direct impact on behaviour regardless of any attempted mediation by social superiors. He goes on to state that that the poor were not only successful in retaining and generating their own customs and beliefs but were often able to impose them, albeit in a somewhat modified form, on the middle classes.²¹

Other historians have also argued that recipients were able to select what they wanted from what was offered by their social superiors and reject any elements which they disliked. In a study of seventeenth and eighteenth century Turin, Sandra Cavallo found that although the poor played very little part in the formation of philanthropic policies, which were primarily determined by the benefactors, an examination of the actual practise of philanthropy suggests that they had much more scope; it was the recipients who “utilised, reformulated and manipulated” the language and models of relief defined by the middle classes.²²

The homes for the dying offer an important context in which to analyse issues of power and control. The relationship between the patients and providers of care was an unequal one: power and control rested primarily with those who ran the homes. However, an examination of the source material for the homes reveals that the recipients of care were sometimes able to respond in ways different to those intended by the donors. Social control arguments, whilst affording considerable scope for helping to explain social developments in the late nineteenth century, particularly, religious, philanthropic and institutional changes, by no means tell the whole story. Likewise, Foucault’s theories largely ignore the role of the recipient. Although the nature of the evidence for the homes is necessarily biased towards the donors and the information it contains is entirely from their perspective, it is still possible to see indications of patients responding in a variety of different manners, from defiance through to appropriation, accommodation and acceptance. This thesis argues that a more suitable model for understanding power relationships in the homes is to see

²¹ Thompson, ‘Social control’, pp. 189-193.

²² Cavallo, ‘The motivations of benefactors’, p.60.

them as a form of negotiation and accommodation operating within a framework of control and management.

The first section of this chapter analyses in more detail the extent to which the homes tried to take control of each patient's death, particularly their spiritual destiny, and the specific forms that this took. It begins by examining the broader framework within which the homes operated and looks at how their work related to the wider agenda of the organisation or order to which they belonged. It then moves on to focus upon the way in which power operated in the homes themselves, especially the importance of the institution as a medium for control. An examination of the forms in which power and control were manifested is as insightful as an analysis of the motives which lay behind them. In the second section the role of patients is considered and the various ways in which they responded to the work of the homes.

As well as viewing the homes as individual repositories of power, it is also possible to see them as representing a more collective form of power. Although this was never an intended or acknowledged objective - relatively little collaboration took place between them - they did share many of the same aims, even though these were tempered considerably by the denominational frameworks within which they operated. The third part of this chapter examines the grounds for viewing the homes as representing small, but isolated, pockets of response to some of the wider changes that were going on around them, particularly the ways in which the dying were cared for (or not cared for) in Poor Law infirmaries, the voluntary hospitals and in their own homes. The fourth and final section addresses a claim by one historian that the beginnings of the institutionalisation of death began during the second half of the nineteenth century and considers the question of whether or not the homes can be seen as part of this process.²³

²³ Crowther, M.A. (1981) *The Workhouse System 1834-1929*. Batsford Academic and Educational Ltd, pp.57-58.

i. Spiritual control

As earlier discussion has shown, the way in which care was provided in the homes needs to be set firmly within its broader context. All three homes considered here were run as part of a larger order, or organisation, whose aims and objectives had a profound influence upon how they perceived and conducted their individual work. One of the most important of these wider organisational objectives was to provide spiritual ministrations to the poor of all ages and in all conditions through wide-ranging programmes of social welfare. Although the ostensible aim of much of this work was to administer material and physical assistance to the poor, it served essentially as a vehicle for addressing their spiritual needs. The Sisters of Charity statement on the 'Mission in London' is particularly illuminating about the way in which they perceived their ministry. It reveals a highly ambitious programme of outreach that was all-encompassing in its nature, and its date of entry in the annals shows clearly that the Sisters believed it to be as relevant in the late 1920s and early 1930s as it was when they first came to London in 1900.

"The Mission in London....consists largely in seeking out lapsed or careless Catholics, securing Catholic marriages, seeing that children have Catholic Baptism, getting them to a Catholic day school and trying to secure the practice of their religious duties after leaving school."²⁴

The Sisters also held Mothers Meetings, ran Sunday Schools, orphanages, clubs and sodalities for children and young persons, visited the sick and elderly in their homes and infirmaries and provided a lending library, specially intended for young people in the hope that it would "provide an antidote to the flood of Literature so fatal to their minds."²⁵ The all embracing nature of the Sisters' Mission was characteristic of the techniques employed by the Catholic Church as a whole and gave considerable cause for comment among contemporary observers. Charles Booth made the following remark:

"In London the Roman Catholic Church meets us at many points, and in very different shapes, and in watching its methods we become conscious of the persistency and concentration displayed, and of the remarkable powers of adaptation characteristic of this body. Their exercise extends from high statecraft, through the whole range of appeal to intellect and

²⁴ *Hoxton Mission, 1929 - 1935*, p.2.

²⁵ 'First Annual Report of St Joseph's Convent, 1901', p.3.

emotion which constitutes 'the propaganda' in England, down to every form of guidance and control that can be exercised in the interest of religion upon men and women of all conditions, the whole system being carried to a degree of perfection and stamped with a thoroughness which make all the Protestant methods seem pinchbeck in comparison."²⁶

Both the West London Mission and the Sisters of East Grinstead provided as wide-ranging a network of social welfare provisions as that run by the Sisters of Charity. The extent and diversity of the services organised by all three religious groups reflected their concern to convert the poor, whatever their stage in life. The creation of homes for the dying was essentially a continuation of this but the fact that they represented the final opportunity for its achievement lent a new sense of urgency to the task. The management of patients' deaths provided a means for controlling the end of their lives in a way that had either not been possible, or not been successful, during their earlier years. The Sisters at the Hostel of God wrote that the Hostel afforded "opportunities which have never been found outside."²⁷

Although those running the homes did believe in the importance of addressing social problems and providing material aid to the poor, their principal objective was the salvation of souls. The daughter of Hugh Price Hughes, the Superintendent of the West London Mission, wrote: "Methodism has always been primarily the conversion of their fellow men.....when the power of reclaiming the lost dies out of the Church, it ceases to be the Church."²⁸ Heywood Smith, Howard Barrett's successor as Medical Superintendent at the West London Mission, described how this objective related to the overall work of the Medical Department, a philosophy which, as one of its branch institutions, was shared by St Luke's House: "I consider a Medical department attached to such a Mission as the West London Mission to be a factor of the highest importance in obtaining access to and winning souls for God."²⁹ The Sisters of Charity and the Sisters of East Grinstead viewed the work of their respective homes in the same way; the Hospice annalist for 1905 noted that it was "destined to bear a rich

²⁶ Booth, C. (1902) *Life and Labour of the People in London*. London: Macmillan and Co. Ltd, 3rd series: Religious Influences - Summary, p.16.

²⁷ *St Margaret's Magazine and Half-Yearly Chronicle* (1925), Vol. VI, Part 8, p.304.

²⁸ *The Life of Hugh Price Hughes* (1904) by his Daughter. London: Hodder and Stroughton, p.70.

²⁹ 6th West London Mission Annual Report (hereafter WLMAR), 1893, p.4.

harvest of fruit for the souls,”³⁰ while a Charity Organisation Society representative who visited the Hostel of God in 1896 wrote that the Sisters’ “sole anxiety” was “that all may die trusting for pardon through the death of Christ.”³¹

As well as a central preoccupation with patients’ spiritual needs, the staff in the homes were even more anxious to impart a particular *form* of Christianity to the patients. Barrett wrote that at St Luke’s House “*Our* [my italics] Christianity, imperfect though it be, is the very *raison d’être* of the Home, without which it would be comparatively unmeaning.” He was far more concerned that patients possessed a belief in the Christian faith than professed themselves members of a particular denomination.³² However, conversely, the relative importance of faith over denominational affiliation was in fact highly redolent of the thinking of a particular denomination of Christianity; the form of Wesleyan Methodism preached by Hugh Price Hughes, the leader of the West London Mission.³³ Likewise, the Sisters and priest at St Joseph’s Hospice would only provide patients with Catholic ministrations, while their counterparts at the Hostel of God focused their efforts on an Anglo-Catholic style of ministry.

The Anglican basis of the Hostel of God was given formal expression from the outset and it was made a condition that all the staff be members of the Anglican Church. A ‘Memorandum and Declaration’ stated that the Home had been founded “with the express object and intention that it should be continued by Members of and in accordance with the principles of the Church of England.”³⁴ This requirement was made legally binding when the Statutes were drawn up in 1917. They stipulated that all persons holding office, including the Council, had to be members of the Church of England and that anybody who ceased to do so forfeited their right to hold office and to be associated with the institution.³⁵ The fact that no alteration in the internal management of the Home could be made without the Mother Superior’s approval and

³⁰ St Joseph’s Hospice Annals (hereafter SJHA), May 1905 to May 1909.

³¹ ‘The Free Home for the Dying’ 1896, Charity Organisation Society (hereafter COS) records, London Metropolitan Archives (hereafter LMA).

³² ‘The Report of St Luke’s House’ taken from 6th WLMAR, 1893, pp.19-20.

³³ *The Life of Hugh Price Hughes*, p.205.

³⁴ ‘Hostel of God Memorandum and Declaration’, c1917.

³⁵ ‘The Hostel of God Statutes 1917’, pp.4-5.

that the appointment and removal of the chaplain required her sanction further reinforced its denominational exclusivity.³⁶ The advantage of maintaining such a restrictive policy was that it ensured all the staff shared the same objectives and collaborated towards the same end. The Chaplain felt that “without the co-operation of the Staff the spiritual work of the Hostel could not go on.”³⁷

As well as staff exclusivity, there is evidence that the Home was also tending towards ministerial exclusivity. The Council’s acceptance of the proposal by the Chaplain in 1904 that outsiders should be refused permission to celebrate the Holy Eucharist for their particular friends or parishioners except under very special circumstances (see chapter 5)³⁸ was just one of a series of manoeuvres whereby the Chaplain was able to enhance his position and influence within the Home and ensure that his services were indispensable. The figures provided in the annual reports and Council minutes detailing the number of patients who came under his charge suggests that this quickly became established practice and that very few were attended by their own minister.

When publicising their work in non-religious circles or among audiences of a different denomination the homes tended to play down some of the specifically religious dimensions of their work. For example, at one of the first meetings of the Committee of Management at St Luke’s House Howard Barrett submitted new three-fold cards to be distributed among friends in order to make the work of the Home more widely known. The cards were of two kinds: one mentioned the West London Mission on whose promised aid they could rely in times of need and the other did not make any reference to a religious community. Barrett argued that the reason for having the two different kinds of card was that he wanted to circulate the work of the Home as widely as possible and to ensure that its unsectarian nature was fully understood. He instructed the Committee that effective distribution of the cards would depend on the discrimination of the distributors.³⁹

³⁶ ‘The Free Home for the Dying Bye-laws to the Deed’, c1896.

³⁷ Hostel of God Annual Report (hereafter HOGAR), 1933, p.7.

³⁸ Minute Book of the Free Home for the Dying Council Meetings April 1897 - 17 February 1914: 22/02/1904.

³⁹ Minute Book of St Luke’s House Committee of Management 15 November 1895 - 19 July 1905: 31/01/1896.

In the same way, an article in *The Philanthropist* stated that religion in the Home was not “obtrusive” or “thrust on a hopeless dying patient” but rather acted as an “influence” which, “underlying everything, makes itself unconsciously felt and realised.”⁴⁰ The annual reports, however, reveal another side to the spiritual work which suggest that the former aspect was as much in operation as the latter. Although Barrett stated that the patients would not be “pestered with spiritual exhortations,” he admitted that this did not preclude their being “encouraged to ask for the visits of any minister of his own Church, if he has one whom he may desire, from whom he can receive the Holy Communion and such religious teaching as he needs.”⁴¹ He also wrote that “everyone strives alike to render all the influences of the place conducive to spiritual collectedness and to bring a confident looking forward to the City of God.”⁴² The agreement reached between the two Chaplains and Howard Barrett to place a card above each patient’s bed detailing which church they had declared themselves to be a member of so that each minister would be able to get in contact with those patients under his respective charge (discussed in the previous chapter) was a particularly telling example.⁴³

The Visiting Sisters were even less discrete about their real intentions. As chapter 3 showed, Sister Lily felt that it was the “duty” of the Visiting Sisters to minister to the “inner life” of the patients and to “try and reach that which makes the man *himself*, and does not belong to another.”⁴⁴ To support this claim one of the Sisters recounted the story of her ministry to a male patient who refused to believe that he had cancer. “As he was becoming physically worse, I asked him how it was he never referred to that other life, of which he could not be entirely ignorant. We had often discussed the things which affected the body and mind, but surely in the inner recesses of his being God had some place, or had he ignored that life?”⁴⁵

⁴⁰ ‘St Luke’s House’, *The Philanthropist*, November 1906, in ‘Presscuttings Concerning St Luke’s House: a home for the Dying Poor, 1901 - 12 January 1929, p.8.

⁴¹ 5th St Luke’s House Annual Report (hereafter SLHAR), 1898, p.7.

⁴² 6th SLHAR, 1899, pp.21-22.

⁴³ Minute Book of St Luke’s House Committee of Management 11 October 1905 - 21 May 1912: 21/05/1912, p.333.

⁴⁴ 11th SLHAR, 1904, p.24 ; 13th SLHAR, 1906, p.32.

⁴⁵ 11th SLHAR, 1904, p.25.

Other accounts of patients give an insight into how spiritual pressure might have been brought to bear upon the patients. Both the Visiting Sisters and Howard Barrett made frequent references to the “influences of the Home”⁴⁶ that were cast upon the patients. Barrett attributed the conversion of one patient to the “various influences acting upon him” which included the “conversation and teaching of Mr Pearse [the Chaplain] and the Sisters.”⁴⁷ He felt that the work of the Visiting Sisters was particularly important because they “guided the conversation” towards spiritual subjects⁴⁸ and their “gentle influence and delicate directness” was hard for patients to resist.⁴⁹

The Sisters of Charity also exercised a certain level of discretion in the way in which they publicised their work. An article written in *The Daily Graphic* about the Hospice stated that no effort was “made by those in authority to convert the guests to their own way of thinking” and that the initiative for conversion had to come from the sufferer; “it will never come from the Sisters of Charity.”⁵⁰ However, the Sisters showed less reticence about the way in which the nature of their work was advertised in Catholic newspapers where they knew they would find a sympathetic and more supportive audience. The author of an article in *The Catholic Fireside*, after a visit to the Hospice, wrote that “every expedient [is] employed to calm and strengthen the traveller for his last journey, and with constant frequent reminders of the glorious Kingdom beyond, the dread valley of Death is approached with courage and faith.”⁵¹

The stories in the annals were also far more open about the way in which the Sisters conducted their spiritual ministry, but given that these accounts were only intended for internal consumption this does not come as any great surprise. One account told the story of a German patient, a professed unbeliever, who the Sisters visited at Bethnal Green Infirmary before his admission into the Hospice. He was given a German Bible by one of the lady visitors and “rejoiced to get a book written in his own language.” The Sister took advantage of “this softened mood” and “prevailed on him to think of

⁴⁶ 6th SLHAR, 1899, p.26.

⁴⁷ 4th SLHAR, taken from 10th WLMAR, 1897, p.14.

⁴⁸ 8th SLHAR, 1901, p.29.

⁴⁹ 1st SLHAR, taken from 7th WLMAR, 1894, p7.

⁵⁰ Author and title unknown, *The Daily Graphic*, 4 October 1913, in St Joseph Hospice Archive.

⁵¹ Stenson, M.D. (c1913) ‘Waiting for the last summons. A work of God’s love’, *The Catholic Fireside*, pp.344-345.

going to Confession.”⁵² Another Sister, in ministering to a more recalcitrant patient, adopted a slightly more forceful approach. The annalist wrote that she “insisted” that conversation with the priest might be beneficial, despite the patient already having said that the latter could not help him.⁵³

The Sisters of Charity were especially attentive in bringing patients to an awareness of their sin. Any wickedness on earth was seen to be the work of the devil and thus supreme importance was attached to ensuring that patients recognised the need for confession and priestly absolution. The annalist recorded the story of one patient who had not been long in the Hospice “when the religious atmosphere had its effect, the thought of the past, his early graces and opportunities and his abuse of them and the infinite goodness of God in rescuing him before it was too late overwhelmed him with gratitude and also with contrition.”⁵⁴

The accounts of patients are important because they provide insight into the expectations placed upon those coming into the homes. Both the annals at St Joseph’s and the stories contained in the St Luke’s House annual reports show that the staff at each home had very definite ideas about the ‘good death’ which it was hoped all patients would aspire to and come as close as possible to achieving. Both the ‘holy and happy death’ and the ‘respectable Christian death’ were dependent upon the patient undergoing spiritual preparation and help to explain why this aspect of the homes’ work was so fundamentally important. In the early annual reports for St Luke’s no secret was made about the attempts that would be made to facilitate this: in 1898 Barrett wrote that no question was ever asked about an applicant’s religious views but “when he is admitted careful and diligent pains are taken to prepare him for the great and solemn change he has soon to pass through.”⁵⁵ Catholics in particular felt that preparation for death was essential. Father Gallwey, the founder of St Joseph’s Hospice, wrote that it was “absolutely necessary to make ready for death” and “that the more we prepare for a happy death, the more we shall taste of that true

⁵² SJHA May 1915 - May 1921.

⁵³ SJHA 1926, pp.4-5!

⁵⁴ SJHA, May 1909 to May 1915.

⁵⁵ 5th SLHAR, 1898, p.7.

peace which Christ came to bring to this earth.⁵⁶ The pressure on patients at St Joseph's would have been particularly great because, as Charles Booth remarked, "the Catholic standard as to the performance of religious duty is high."⁵⁷

One of the accounts in the annals that stands out as particularly illustrative of the Sisters' desire to take control of the patients' death and manner of dying was the case of a Freemason, nicknamed 'Daddy', who was admitted into the Hospice in the early 1930s. His conversion was extolled by the annalist as "a miracle of grace" and contrasted strongly to his decision to become a Freemason, which was attributed to "the lure of ambition for a high social position," especially as he subsequently rose up through the ranks to become Master of a Lodge in Sudbury.⁵⁸ The Roman Catholic Church did not look favourably upon the practice of Freemasonry, viewing it with a sense of hostility and suspicion. A Papal Bull, issued in 1738, condemning Freemasonry gave official sanction to this disapproval. It was followed by a second Bull in 1751 and a series of Encyclical letters which set out clearly the Church's objections. Broadly, these were two-fold: firstly, the secrecy surrounding the work of the Freemasons interfered with proper submission to the Holy Church, and secondly, its acceptance of naturalist principles produced a tendency towards anti-Christianity.⁵⁹ The Sisters of Charity's strict adherence to the principles of Roman Catholicism would have meant that they shared in its disapprobation of Freemasonry, and would have been most anxious to save Daddy from its sinful grasp.

An accident with a fire had burnt both of Daddy's legs and they had to be amputated after gangrene set in. He then suffered a stroke which left him unable to speak, apart from one word, "Penny." Daddy refused to respond to any of the efforts by the Sisters and the priest to make his peace with God. Instead he sat and smoked all day and his hand which "flourished a ring with Masonic emblems on it" served as a constant reminder to them that his loyalties lay elsewhere. However, the Sisters did not lose

⁵⁶ Gallwey, P. Father, SJ (1877) 'Funeral Discourse in Memory of Cecil Marchioness of Lothian'. London: Burns, Lambert and Oates, pp.11, 31, in bound volume of Father Peter Gallwey Sermons, Jesuit Archives, ref. CPJ 61.

⁵⁷ Booth, *Life and Labour*, p.245.

⁵⁸ SJHA 1929 - 1934, pp.11-12.

⁵⁹ Clarke, The Very Reverend H.G.M. (1967) Freemasonry and religion, in *Grand Lodge 1717-1967*. Oxford University Press, pp.207-208.

hope and about a fortnight before Daddy's death they noticed that his eyes were often fixed on the crucifix. His gangrene returned "this time to herald his death." The Sister spoke to the old man and "gently insinuated that the Lord would soon call him. She then asked him if he loved God. Daddy said nothing and Sister taking the crucifix from her neck asked him to show his love by kissing the image. Daddy looked at the outstretched arms of Jesus on His Cross and then slowly and reverently bowed his head and kissed the figure. The sign was given." The patient's confession was then heard by the priest with the aid of a slate and pencil after which he was anointed and the ring removed from his finger. The annalist wrote that "The anointing which followed had a dramatic turn when it came to the removing of the ring. A hard scrutiny of the old man's face showed he had no regrets....The appearance of Daddy's face was from that moment altered."⁶⁰ The removal of the ring and the kissing of the crucifix had tremendous symbolic significance, partly because of the patient's inability to speak and partly because they epitomised the surrender of his old set of beliefs and his willingness to accept the Catholic Faith.

In contrast to the fear and hostility which characterised dealings between the Freemasons and the Catholic Church, St Luke's House and the Hostel of God both enjoyed an amicable and beneficial relationship with them. Official Masonry was piously Christian and vaguely Protestant, and was therefore not perceived as a threat to either the Established Church or the State.⁶¹ The fact that it welcomed all Christians regardless of denominational affiliation would particularly have appealed to the Methodist-run St Luke's. In 1909, Barrett's son, Edmund, established the Misericordia Lodge, a Freemason lodge, which became affiliated to St Luke's.⁶² The new honorary consulting surgeon appointed in 1923 was also the Master of this Lodge.⁶³ At the Hostel of God the charitable generosity of the Freemasons helped to provide a continuing and important source of income, with many different lodges, both in England and overseas, donating gifts and money to the Home each year.

⁶⁰ SJHA 1929 - 1934, pp.11-14.

⁶¹ Jacob, M.C. (1981) *The Radical Enlightenment: Pantheists, Freemasons and Republicans*. London: George Allen and Unwin, p.113.

⁶² 16th SLHAR, 1909, p.34.

⁶³ 30th SLHAR, 1923, p.7.

In their efforts to secure the salvation of patients who came under their care, the staff in the homes were not motivated entirely by altruistic concerns. As Michael Hill argues, one of the most important goals of religious orders was for members to seek personal perfection, whether this was defined in terms of individual or social goals or an active or contemplative life.⁶⁴ Catholics believed that works of mercy were as beneficial to the dispenser as they were to the recipient. Father Gallwey wrote that the fate of Catholics at the Judgement seat depended on works of mercy.⁶⁵ The Constitution and rules of the Sisters of Charity also postulated that, as well as labouring for the souls of others, they should attend to the salvation of their own souls.⁶⁶

The Sisters of Charity, particularly in the early years, were active in going out to the homes of the poor and into the local infirmaries to bring back dying individuals to the Hospice. Many of these were cases whose salvation the Sisters felt was dependent upon removal to the Hospice. At St Luke's House the admission of patients was not motivated by the same sense of urgency regarding their spiritual concerns as it was at St Joseph's; moral considerations appear to have been at least as important. Several patients were discharged each year because they were morally unsuitable for the home and the infirmary was felt to be a more appropriate place for them. The patient register for 1900 recorded how one patient, a semi-unconscious blind man, was sent out because Howard Barrett decided "it made no difference to him where he was. It was a pity he should keep the bed from someone who could appreciate the comforts of the House."⁶⁷

In contrast, the Sisters at St Joseph's gave greater priority to patients' spiritual needs and were often prepared to overlook their moral shortcomings. One woman who had been convicted for murder and sentenced to imprisonment in Aylesbury Gaol was admitted because the Mother Rectress, although concerned about bringing in any

⁶⁴ Hill, *The Religious Order*, p.262.

⁶⁵ Gallwey, Father P., SJ (1865) 'A Discourse Preached at the Funeral of Sir C. Tempest'. London: Burns, Lambert and Oates, p.16, in bound volume of Father Peter Gallwey Sermons, Jesuit Archives, ref. CPJ 61.

⁶⁶ *Rules and Constitutions of the Congregation of the Sisters of Charity*. Roma Tippografia (1912), p.19.

⁶⁷ St Luke's House Case Book 25 September 1896 - 8 September 1904, No.187.

“rough or wicked element” into the Hospice, “wished that the poor soul might die in Catholic surroundings.” She resolved her moral dilemma by stipulating that no-one but herself, the Sister-in-charge and the Chaplain should be informed about her past history.⁶⁸ A similar concern motivated the Sisters’ attempts to persuade a patient who had spent much of her life in a “beer shop” exposed to the “infectious air of depravity in Hoxton”⁶⁹ to come into the Hospice, while another was admitted twice “for the purpose of making her Easter duty” because it “would be alas otherwise omitted.”⁷⁰

It appears that members of the lay staff who threatened in any way to undermine the Sisters’ work were immediately told to leave. One of the stories in the annals recounts how a nurse in the Private Home was dismissed because, although a convert, she still retained some free-thinking notions and was a member of the Suffragettes. Her principal crime, however, was that she tried to persuade one of the female patients to leave and go into a Protestant institution. The Sisters believed that the devil was working through her and it was her attempt to subvert the religious work of the Home that ultimately led to her dismissal.⁷¹

Unfortunately, there is very little direct information contained in the annual reports for the Hostel of God on the more prescriptive qualities of the spiritual ministrations, although certain remarks by the Chaplain and other features of the Home do offer some suggestions. The Statutes stated that the Sister Superior did not have the authority to reject or remove patients on the grounds of, or default for, religious belief.⁷² However, the tendency towards denominational and ministerial exclusivity suggests that patients were expected to respond to the ministrations of the Sisters and the Chaplain and to conform to the beliefs of the Anglo-Catholic Church. Patients who did not respond to this ministrations, “who fail to answer to our efforts,” were labelled as “disappointments.”⁷³

⁶⁸ SJHA May 1915 - May 1921.

⁶⁹ ‘Notes for the Annals of St Joseph’s Hospice’ 1904 - c1909, pp.13-15, Religious Sisters of Charity Generalate (hereafter RSCG).

⁷⁰ *Ibid.*, pp.29-30.

⁷¹ SJHA, May 1905 - May 1909.

⁷² ‘The Hostel of God Statutes 1917’, pp.10-11.

⁷³ HOGAR, 1902, p.7.

Charles Booth also commented upon the monopolistic tendency of the Anglo-Catholic Church in his survey of religious influences in London: "Since its exponents believe that theirs is the only road, this faith is by its nature very exclusive and upon those who accept it all the temporal benefits the Church can offer are lavished."⁷⁴ He also remarked, rather scathingly, that "as a general rule the Sisters' action appears to be lacking both in religious tolerance and in social insight" and "the temptation to win souls by whatever means becomes great and the unscrupulous spirit which is evinced obtains the more license from the fact that the Sisters feel themselves to be working not for their own community but for the Church and God."⁷⁵

The inclusion, by the Chaplain, of the annual figures for Communion, Baptism and Confirmation in the annual reports provides a further indication of the extent and prevalence of Anglo-Catholic influences to which patients in the Home would have been subjected. There is a danger, however, of reading too much into these figures and it is important to remember the purposes for which they were given. Although the numbers in the reports do correspond to those provided by the Chaplain at the Council meetings, they do not show how many patients actually responded to, or accepted, his ministrations. In his reports the Chaplain also tried to give the reasons why not all of the patients responded to his ministry. For example, in 1908, he wrote that out of the hundred or so patients in the Home, 71 had been communicants. The rest, he said, had been in the home for too short a time or were too ill to either prepare sufficiently or to enter into any ministrations except the shortest possible prayers.⁷⁶ There is a sense here that he was almost abdicating responsibility for these patients by implying that they were somehow beyond his control, otherwise they too would have welcomed his ministrations.

The transferral of the dying poor into institutional care also offered enormous potential for managing patient activity. As Anne Summers argues:

"The advantage of institutional care was that it removed patients from the distraction and noise of the family and placed them in more solemn and peaceful surroundings where they could receive continuous care and

⁷⁴ Booth, *Life and Labour*, p.280.

⁷⁵ *Ibid.*, pp.352-353.

⁷⁶ HOGAR, 1908, p.7.

attention and which was felt to be more conducive to spiritual reflection.”⁷⁷

Within the homes for the dying, time and space were manipulated in such a way as to maximise patient exposure to spiritual influences.

The staff in all three homes felt that the spiritual atmosphere they created was invaluable to the patients. The Chaplain at the Hostel of God wrote that despite intense bodily suffering, “with such surroundings as are found in this home, it is marvellous how readily they turn their thoughts to God and seek their peace with Him.”⁷⁸ The stories of patients at St Joseph’s are peppered with remarks about the effect of the “religious atmosphere” upon patients; the frequent prayers and ward services and public sayings of the Rosary were believed to inspire spiritual thoughts in many of them.⁷⁹ At St Luke’s House Howard Barrett, the Chaplain and the Visiting Sisters all spoke about the “influences”⁸⁰ of the Home upon patients: “The refinement of the Home, the stillness and peace of the wards, help so much to maintain that quietness of soul which alone can prepare for the abiding of the ‘peace which passeth understanding’.”⁸¹

The physical layout of the homes too was instrumental in stimulating patient awareness of spiritual factors. The male wards at St Joseph’s were arranged in such a way that patients were able to follow Mass and Benediction when the doors were open.⁸² Similarly, a connecting passage between the chapel and the Hospice enabled patients to access the former as often as they wished.⁸³ At both the Hostel of God and St Joseph’s the presence of the chapel was felt to play a significant role in rousing patients’ religious sensibilities. The Chaplain at the Hostel of God described it as the “Power House” of all the work.⁸⁴ The importance of the chapel reflected the wider teaching of the Catholic and Anglo-Catholic Churches which placed great emphasis

⁷⁷ Summers, *Angels and Citizens*, pp.18-19.

⁷⁸ HOGAR, 1898, p.10.

⁷⁹ SJHA May 1915 - May 1921.

⁸⁰ 6th SLHAR, 1899, p.26.

⁸¹ 4th SLHAR, taken from 10th WLMAR, 1897, p.16.

⁸² Stenson, ‘Waiting for the last summons’, pp.344-345.

⁸³ SJHA, May 1909 - May 1915.

⁸⁴ HOGAR, 1931, p.7.

upon ceremony, worship and the sacraments. Pusey, a leading proponent of Anglo-Catholicism, believed that one of its principle characteristics was a strong regard for the visible part of devotion, such as the decoration of churches, which act insensibly on the mind.⁸⁵

Other visual stimuli in the two homes took the form of “sacred pictures and appropriate texts” hung on the walls.⁸⁶ St Joseph’s also made extensive use of other religious objects, such as statues, holy water and Bibles, as a means of encouraging patients to focus upon spiritual matters. A visitor to the Hospice commented on the “many lovely pictures, all spiritual or sacred subjects, a boon for the sick, to lift their thoughts above their present sufferings and gladden them with images of the beautiful home to which they are journeying.”⁸⁷ In addition, each of the Sisters wore a crucifix around her neck which, it was noted, one patient was particularly “drawn” to.⁸⁸ The daily prayers in the wards for all three homes and the regular administration of Holy Communion helped to serve as a further catalyst for spiritual contemplation.⁸⁹

The institutional aspects of the Hospice also impacted upon patients in more subtle ways. The regular attendance of the priest to the Catholic patients was felt to be particularly instrumental in helping to revive or inspire faith in some patients. The annalist for the years 1929 - 1934 wrote: “Example is all powerful but the devotion of Catholic priests to their flock has often been the means of fanning the flickering light of faith in a wavering soul to a burning fire.”⁹⁰ The fact of being in a Catholic institution had a particularly isolating effect on non-Catholic patients. A story published in *The Tablet* in 1913 described how one of the female patients had asked “why the prayers were not said for her as for the other Catholic patients,”⁹¹ while another was recorded as saying she felt like the “only black sheep” as she watched all

⁸⁵ Chadwick, O. (1960) (ed) *The Mind of the Oxford Movement*. London: Adam and Charles Black, p.200.

⁸⁶ HOGAR, 1896, pp.7-8.

⁸⁷ Stenson, ‘Waiting for the last summons’, pp.344-345.

⁸⁸ SJHA, 1935.

⁸⁹ SJHA, 1929 - 1934 ; 1st SLHAR, taken from 7th WLMAR, 1894, p11 ; HOGAR, 1937, p.7.

⁹⁰ SJHA, 1929 - 1934, p.2.

⁹¹ ‘Some cases we have helped to save at St Joseph’s Hospice for the Dying: III The Woman who Returned to the Faith of her Baptism’, *The Tablet*, 8 November 1913.

the other patients receive Holy Communion on Christmas Day.⁹² In the same way, the presence of dying persons in the same ward and having to witness the death of other patients could also have a spiritual impact upon some inmates. One young girl, on seeing the death of a ward companion only the day after her admission, received “a great shock” but, as the annalist noted, it succeeded in “filling her soul with grace.”⁹³

At St Luke’s House religious influences were not present in the same ubiquitous way in which they were at St Joseph’s and the Hostel of God. The patients in these two homes encountered continual spiritual reminders in the form of the full time presence of the Sisters and the Chaplain. In contrast, the spiritual staff at St Luke’s only visited the Home on a part-time basis. It also appears that not all of the pictures were confined to religious texts or illustrations. Sister Lily wrote that some depicted scenes from the country and village life.⁹⁴ Similarly, the library not only contained a selection of “simple, suitable, and readable works of devotion and spiritual instruction” but also poetry, biographies, travel, adventure and classical novels, “mostly of action and incident, and not mere character analysis and unwholesome moral pathology.”⁹⁵ This is not to say that the staff did not maximise the time and opportunity for spiritual ministrations once they were there. The two Chaplains and the Visiting Sisters came to the Home regularly each week. Services took place in the wards which meant that all patients were exposed to them, whether they wanted to be or not, and every effort was made to include all the inmates. Prayers were printed on a card for patients to hold and were followed by the Lesson and a brief exposition. The Chaplain firmly believed that “it is certainly a great gain to them all to be able to take place in the service.”⁹⁶ Ward services were also thought to serve as an important way to reach non-Christian patients. The Anglican Chaplain at St Luke’s House wrote:

“At first he is shy, he will only listen to service as if he were not even interested; then he grows more eager, and at last comes request that he, too, may receive the Holy Communion. That is the opportunity we wanted. An earnest talk makes all the difference to his comfort and happiness. That

⁹² Hospice Annals 1929-1934, p.15.

⁹³ ‘Notes for the Annals of St Joseph’s Hospice’ 1904 - c1909, pp.20-21, [RSCG].

⁹⁴ 7th SLHAR, 1900, p.7.

⁹⁵ 10th SLHAR, 1903, p.12.

⁹⁶ 2nd SLHAR, taken from 8th WLMAR, 1895, p.13.

man can now meet his Maker and face his Saviour with the assurance of pardon.”⁹⁷

The provision of care through an institutional medium had important repercussions for the patients’ ability to retain a sense of ‘individuality’ after admission into the home. At one level they were treated as individuals, in the sense that they were approached by the staff on an individual basis and a rigorous attempt was made to get at their individual histories, that “which makes each man himself.”⁹⁸ However, at the same time, those ministering to the inmates were motivated by a very specific set of objectives: the identification of patients’ particular spiritual needs so that a decision could be made on the best course of action to meet these. All patients were subjected to the same scrutiny, held up against the same standards and expected to conform, as closely as possible, to the same outcome, albeit differently in each home. The staff had very clear ideas about death and the manner for which it should be prepared, to which all patients were expected to submit. Conversely, the Visiting Sisters at St Luke’s interpreted a patient’s failure to respond to the spiritual work of the home as indicating an absence of “marked individuality” and an incapacity for “any perceptible depth of feeling.”⁹⁹ The loss of individuality was particularly pronounced at St Joseph’s where considerable pressure was brought to bear upon the patients to achieve a ‘holy and happy death’. The Catholic Church was noted by contemporaries as being run by a highly organised and powerful hierarchy which repressed individualism.¹⁰⁰

Howard Barrett, as both founder and Medical Superintendent of St Luke’s House, occupied a unique position and as such stands out as a very strong individual male voice which is absent from the other two homes. Not only was he the inspiration behind the creation of the Home, but he was also primarily responsible for constructing its ideology and defining the scope and nature of its work. After the Committee was formed in 1897 he continued to remain the dominant influence until his resignation as Medical Superintendent in 1913. He exercised supreme authority in all questions regarding patient eligibility.¹⁰¹ As this thesis has shown, little tolerance

⁹⁷ 12th SLHAR, 1905, p.33.

⁹⁸ 13th SLHAR, 1906, p.32.

⁹⁹ 20th SLHAR, 1913, p.16.

¹⁰⁰ Booth, *Life and Labour*, pp.252-253.

¹⁰¹ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p.24.

was shown to patients who did not conform to his expectations of their moral character. Deference was clearly shown towards patients of a higher social standing, such as a gentleman with a university education whose presence was described as having “graced” the Home.¹⁰² Unsuitable patients, whom Barrett felt belonged to the infirmary class, were discharged. One of the fundamental objects of the Home was that it was intended for those for whom the workhouse would be an “unbearable degradation” and neither Barrett or his son were prepared to compromise on this.¹⁰³ In the same way, the Visiting Sisters looked disparagingly upon patients whose spiritual performance did not meet their standards. “Inconsistent or disagreeable Christians” were not viewed favourably; the Sisters wanted each patient to become a “real” Christian.¹⁰⁴

Barrett also disliked patients who could not be managed easily. Badly behaved patients, those who “would not keep our rules,” were sent out.¹⁰⁵ Others, who refused to settle, were given frequent doses of drugs, such as morphia, to keep them docile. In the latter case the administration of morphine would have had implications for their state of consciousness and probably meant that in such instances spiritual ministrations assumed a lower priority because it would have been largely ineffectual. Patients with particularly “disfiguring maladies” were usually kept in strict seclusion.¹⁰⁶ During the early years Barrett was able to ensure that much went his way because several of his family members occupied prominent positions within the Home. The declining spiritual dimension of the work after his death suggests that attempts by the staff to convert patients would not have been so rigorous or relentless, although conversion would have remained the primary objective of those directly responsible for the inmates’ spiritual welfare. The separation of St Luke’s from the West London Mission in 1912 would also have freed it from its former obligation to conform to the wider religious objectives of this organisation.

¹⁰² 1st SLHAR, taken from 7th WLMAR, 1894, p8.

¹⁰³ 21st SLHAR, 1914, p.16.

¹⁰⁴ 3rd SLHAR, taken from 9th WLMAR, 1896, p.15.

¹⁰⁵ 13th SLHAR, 1906, p.9.

¹⁰⁶ 1st SLHAR, taken from 7th WLMAR, 1894, p8.

To avoid the danger of seeing the religious work of the homes as in any sense unique or simply as an exercise in the spiritual control of inmates through the management of their deathbeds, the historian needs to take a few steps back and examine the previous arguments within the much broader context of late Victorian and Edwardian philanthropy and attitudes towards death and religion. The impulse to religious indoctrination was characteristic of most Victorian charitable work. F.K. Prochaska has argued that Victorian philanthropists, particularly women, were preoccupied with sin and the need to secure an inmate's confession.

“As with their own children, they believed that severity was needed to produce good effects, to pluck good from evil. Severity went hand in glove with their conception of love. By instilling a sense of shame, or criminality, in their charges, they prepared the ground for conversion and reformation.....And as ‘physicians of the soul’, as interpreters of the sacred mysteries, they added greatly to their own power over others and thereby to their self-regard.”¹⁰⁷

The homes were, to a large extent, typical of other charitable institutions set up during the Victorian era, particularly those run by religious orders. Many of these had religious underpinnings and, despite aiming ostensibly to provide physical and material care, were primarily concerned with the moral and spiritual lives of inmates. Religious sisterhoods in particular were influenced by their denominational basis and allegiance to the wider objectives of their order. The methods and objectives of those who ran the homes for the dying would not have shocked the majority of their middle and upper class contemporaries, who shared a similar moral outlook and would have expected the homes to have had some form of religious basis and at least one member of staff entrusted with the provision of spiritual ministrations. Even the lower middle and working class patients who were inmates in the home would not have been wholly averse to receiving some form of spiritual ministrations. Historians who have looked at working class attitudes towards death and religion have argued that, although many of the poor evaluated and understood their daily lives in secular terms, religious feeling

¹⁰⁷ Prochaska, F.K. (1980) *Women and Philanthropy in Nineteenth-Century England*. Oxford: Clarendon Press, pp.156-157.

was not completely absent, and when death approached many turned to religion for explanation and solace.¹⁰⁸

ii. The patients' response

In spite of the persistent and diligent efforts of the staff in each of the homes to subject patients to their spiritual ministrations and to make them conform to their particular ideas about death and the appropriate manner in which to die, there was scope for patients to respond to these pressures in various ways. Ultimately patients were free to leave the homes, although considerable attempts were often made to persuade them to stay. The Patient Registers at St Luke's contain a record of one patient who was able to walk out unnoticed.¹⁰⁹ Others left because they were under misapprehensions about the purpose of the particular home they were in. As chapter 4 showed, several thought it was a convalescent home and after discovering that this was not its function, immediately requested to go home. Patients were also able to use the homes as a temporary form of respite care while arrangements were made for them to be taken elsewhere. On rare occasions patients who were known *not* to be dying were admitted, such as the case, in 1938, at the Hostel of God of a soldier's invalid daughter who had about two years left to live. According to the Sisters, the military authorities thought it was too much for a father to have to move from place to place with her. It was also felt that her sister was suffering because too much of their mother's time was taken up by the invalid daughter and so the nuns agreed to care for her in the Hostel.¹¹⁰

Several patients at St Luke's House discharged themselves because they were bored with the tedium of life in the Home. Inmates were subjected to a fairly monotonous daily routine; the only varying feature was the afternoon visitor, either the chaplain, a Visiting Sister, the doctor, or the patient's own family and friends.¹¹¹ As chapter 4 showed, Barrett wrote that the reason one patient discharged himself was that he was

¹⁰⁸ Kent, J. (1973) Feelings and festivals: an interpretation of some working class religious attitudes, in H.J. Dyos and M. Wolff (eds) *The Victorian City: Images and Realities*. London: Routledge and Kegan Paul, p.867 ; Vincent, D. (1980) Love and death and the nineteenth century working class, *Social History*, Vol. 5 (2): 223 - 247.

¹⁰⁹ St Luke's House Case Register 7 January 1909 - 16 October 1911, No.200.

¹¹⁰ *St Margaret's Magazine and Half-Yearly Chronicle* (1938), Vol. X, Part 1, p.13.

¹¹¹ 1st SLHAR, taken from 7th WLMAR, 1894, p11.

“intensely bored and tired of his unchanging and rather dull surroundings.” Although careful enquiry was made for alternative accommodation, he was unable to find any other place suitable for a young man in his condition except the infirmary. The patient was recorded as being sent there with his own full approbation, but with the promise of readmission and Barrett reported that he had since heard that the patient was quite happy there.¹¹² He also cited the case of another discharged patient who actually left St Luke’s because he wanted to *return* to the Infirmary.¹¹³ Although these accounts of discharged patients are Barrett’s interpretation of events and their inclusion in the annual reports is part of his efforts to reinforce the ideology of the Home, they do suggest that some patients threatened to undermine the way in which it worked.

The role of family could also play an important and influential part in shaping patients’ assumptions of charity, particularly in determining how and why they wanted to use it. Barry and Jones have argued that a growing body of evidence shows that shifting household circumstances meant that the poor often used charity in ways not intended by the donors.¹¹⁴ One patient at St Joseph’s, despite great attachment to his family and the distance of their home from London, decided to go into the Hospice because he realised that if he continued to remain at home he would be a health risk to his family.¹¹⁵ A number of patients left the homes because they missed their families and wanted to be at home with them,¹¹⁶ while others discharged themselves because of domestic problems at home.¹¹⁷

There is also considerable evidence among the records for St Luke’s and St Joseph’s to suggest that not all patients responded to the spiritual work of the homes. The ‘Notes’ written for the compiling of the annals in the early years at St Joseph’s contain two examples of patients who resisted all efforts to induce them to convert to Catholicism. One inmate had been admitted to the Hospice three times but on each

¹¹² 7th SLHAR, 1900, p.11.

¹¹³ 16th SLHAR, 1909, p.15.

¹¹⁴ Barry, J. and Jones, C. (1994) (eds) *Medicine and Charity Before the Welfare State*. London: Routledge, p.11.

¹¹⁵ SJHA, 1921.

¹¹⁶ 4th SLHAR, taken from 10th WLMAR, 1897, p.6.

¹¹⁷ 11th SLHAR, 1904, p.10.

occasion failed to show any sign of religious inclination.¹¹⁸ Needless to say, neither of these two stories were included in the formal copy of the annals sent to the Mother House in Dublin. However, even the annals themselves contain evidence that patients were able to defy the Sisters' ministrations. One patient, it was very briefly noted, died whilst still a member of the Church of England; however, the annalist quickly moved on to the fact that her daughter, also a patient, was successfully converted.¹¹⁹ There is little way of knowing about the many patients who did not feature in the stories in the annals but no doubt there were others who did not surrender to the Hospice's influences. In the cases of juvenile patients the Sisters had to defer to the wishes of the parents. Several of the stories in the annals concerned children who wished to become members of the Catholic Church but this was only permissible if the parents gave their consent.¹²⁰

The stories in the annual reports at St Luke's also featured a number of patients who failed to respond in the desired way to the spiritual ministrations of the Home. Barrett wrote that many patients "keep silence" on spiritual matters.¹²¹ Specific examples included an account by the Matron of a man who proved "quite inaccessible to religious influences"¹²² and the case of a male patient who Barrett said "refused to resign himself to death."¹²³ The Visiting Sisters also acknowledged that the lack of response by some patients was due to their inability to think of anything but their suffering,¹²⁴ suggesting that attempts to use the body as a means to reach the soul were not always effective. Again, nothing is known about the patients who did not feature in the annual reports.

It was not only the Sisters at St Joseph's who resorted to methods of subterfuge;¹²⁵ it was also possible for the patients to deceive the nuns. One of the stories in the annals describes the case of EJ, a female patient who managed to get into the Hospice on two

¹¹⁸ 'Notes for the Annals of St Joseph's Hospice', 1904 - c1909, pp.29-30, 68-69, [RSCG].

¹¹⁹ SJHA, 1929-1934, p.4.

¹²⁰ SJHA 1921, 1923.

¹²¹ 19th SLHAR, 1912, p.28.

¹²² 20th SLHAR, 1913, p.18.

¹²³ 17th SLHAR, 1910, pp.34-35.

¹²⁴ 20th SLHAR, 1913, p.16.

¹²⁵ See chapter 3.

separate occasions by pretending to be a different person each time. After her second admission some of the other patients identified her as an old patient, although she “emphatically denied” it and, because the Sisters on the ward had been changed since she was last there, they believed her. Although the Register did have a record of a patient EJ, who had been a nursery maid, the occupations did not agree. The sisters only discovered EJ’s deception because on the night before her death she suddenly decided to own up to the priest and the Sister in Charge that she had been in the Hospice before as a patient and had obtained the money from the Nursing Mission under false pretences.¹²⁶

At St Luke’s House patients, or those applying on their behalf, were also, on occasion, able to subvert the purposes of the Home. However, once the duplicity was discovered, such cases were not allowed to remain. For example, in 1903 five patients had to be discharged because they were noisy or suffering from uncontrollable delirium. Barrett wrote that in four of the cases the patient had been delirious before admission and the fact had been suppressed.¹²⁷ He also described the case of a “merry little fraud of an urchin of nine, with a back as arched as that of an angry cat” who was sent to the Home and “how after a happy time of gross favouritism and petting, we unwillingly discovered him to be perfectly well and able to jump downstairs, and so had to send him out.”¹²⁸ The high number of discharges in the early years at St Luke’s, so deplored by Barrett, suggests that a considerable number of patients, or those who they were sent by, tried to use the Home for purposes other than which it was intended. As shown in chapter 4, Barrett was particularly averse to relatives and friends ‘dumping’ feeble or invalid persons on the Home¹²⁹ and the discovery that the patients’ condition did not correspond to that which was written on their certificate.¹³⁰

The Sisters at St Joseph’s were, on occasion, more willing to relax the rules concerning the patient’s medical status. One patient was described as being sent by the London County Council to the Hospice by mistake but was permitted to remain,

¹²⁶ SJHA, 1921.

¹²⁷ 11th SLHAR, 1904, p.10.

¹²⁸ ‘St Luke’s House: A Home of Peace’, taken from 7th WLMAR, 1894, p.110.

¹²⁹ 12th SLHAR, 1905, p.8.

¹³⁰ 14th SLHAR, 1907, p.17.

despite the fact that “he was really too well.”¹³¹ Cases of epilepsy and paralysis, although ineligible for admission, sometimes found their way into the Hospice, either because the Sisters were prepared to show further flexibility or because the patients concealed the fact prior to their admission. It was also possible for patients to decide not to accept any medical assistance. A female patient was recorded in the annals as refusing to take any medicine for the last three days of her life because “she wanted no relief from pain.”¹³² However, it should be noted that this was commended by the Sisters because the patient had undergone full spiritual preparation and her abstinence was looked upon as further confirmation of the strength of her religious conviction.

Patient needs at St Luke’s could also be heard through the comments and requests written by Lady Visitors to the Home in the special ‘Report’ book. This book was used by them to record their opinions as to the condition of the Home at the time of their visit.¹³³ Although most of the entries were complimentary in nature, they did occasionally contain suggestions for improvement. The contents of this book were obviously read by the Medical Superintendent and, on occasion, acted upon. A proposal by Howard Barrett at a committee meeting in 1910 for the purchase of an ear trumpet for deaf patients¹³⁴ was made in response to an entry in the Report Book earlier that month by one of the Lady Visitors to the Home who, after speaking to a deaf female patient in one of the wards, had suggested that such an instrument might be provided for patients too poor to possess one.¹³⁵

Although patients were able, in small ways, to make their needs known and responded in various ways to the pressure that was brought to bear upon them, their admission into the homes and the time spent in them ultimately had a disempowering effect because the relationship between themselves and those providing the care was fundamentally unequal. Each home admitted people who emotionally, psychologically, spiritually, materially and physically were in a very vulnerable state,

¹³¹ SJHA, 1925.

¹³² SJHA, 1923.

¹³³ Minute Book of St Luke’s House Committee of Management 11 October 1905 - 21 May 1912: 16/11/1910, p.246.

¹³⁴ Minute Book of St Luke’s House Committee of Management 18 June 1912 - 27 May 1918: 22/04/1913, p.47.

¹³⁵ ‘Report of House Visitors’, 18 November 1910 to 27 March 1923.

most of whom, for lack of better alternatives, were dependent upon these homes to provide shelter for them during their remaining time on earth. This placed the staff in a position of power and as such offered considerable potential for the control and management of patients. Once inside patients were under constant supervision and at the mercy of religious influences that assumed a variety of different forms, from the very subtle to the very obvious, many of which would not have been easy to resist. They were also subject to the authority of those who ran the homes and to the knowledge that their ability to remain in the home was dependent upon the good will of these same people. Attempts not to conform to the demands placed upon them by those in authority would have incurred disapprobation, however muted or disguised a form it took, and an ability to remain impervious to the influences that came at them from all sides and in many different shapes would have been the preserve of the few rather than the many. Spiritual opportunities and resources within the homes, particularly at St Joseph's and the Hostel of God, were maximised by those responsible for this aspect of patients' welfare. Although other philanthropic institutions, particularly those managed by religious orders, were run in a similar manner, the fact that all the patients were very close to death would have lent an urgency and intensity to their efforts not seen to the same degree in other homes.

iii. 'Pockets' of response

The end of the Victorian period has been described by Asa Briggs as a 'late Victorian revolt', in which almost all of its principal values were challenged to some degree. Contemporaries began to look at the failures as well as the successes of the earlier part of the century.¹³⁶ It is arguable that the homes, by carving out a new niche for themselves, were responding to some of the wider religious, medical and philanthropic changes in the late Victorian era. Although, the homes claimed, in the words of Howard Barrett, not to "trench upon the province of either the hospital, the parish infirmary or the home,"¹³⁷ this assertion in many ways denoted a wider

¹³⁶ Briggs, A. (1988) Victorian values, in E.M. Sigworth (ed) *In Search of Victorian Values*. Manchester University Press, p.24.

¹³⁷ 6th SLHAR, 1899, p.8.

intention on their part to supply those elements which they felt were absent from or inappropriately and inadequately provided for by these institutions.

As part of the campaign for publicising their work, the homes drew attention to the differences which they believed existed between themselves and the workhouse. Both St Luke's and St Joseph's had differing perceptions as to the relative importance of these. The Sisters of Charity were more concerned to highlight the religious shortcomings of the workhouses, especially in relation to Catholic inmates. One advert contrasted the religious provision for Catholic patients in each institution. The workhouse, "where at best the priest visits at intervals, between which religion is invisible," was felt to be considerably lacking when seen in relation to the Hospice where patients were "tended by nuns who have devoted their whole lives to the service of God's poor, to be surrounded by the symbols of religion reminding them of God's love and pity for poor suffering humanity, and, as the last great hour approaches, to be lovingly helped and encouraged as only a Catholic can possibly help and encourage."¹³⁸ The nursing provision at the Hospice was also compared with that in the infirmaries. The author of an article in *The Catholic Weekly* referred to the "difference between a paid nurse and a Religious" saying that "when love and hire are put into the balance there is not the faintest doubt which scale will weigh the heaviest."¹³⁹ M.A. Crowther has argued that a "secular intention" did underlie much of the workhouse philosophy. Although a religious element was incorporated into the discipline, the "purpose of the institution was social rather than spiritual"; souls of inmates were intended to be saved but the proof of salvation was to be seen in the reward to society.¹⁴⁰

At St Luke's House, by contrast, Howard Barrett was more preoccupied with the moral aspects of workhouse provisions and their effect upon the treatment of inmates. He described the infirmaries as having a "hard, unsympathetic atmosphere" and intended for "promiscuous" and "degraded society." He felt that the treatment there tended "not altogether unnaturally, to become rather mechanical and unsympathetic"

¹³⁸ 'At Least Let Them Die in Peace', *The Tablet*, July c1913, St Joseph's Hospice Archive.

¹³⁹ Wilberforce, W. 'St Joseph's Hospice, Mare Street, Hackney', *The Catholic Weekly*, date unknown, p.2, St Joseph Hospice Archive.

¹⁴⁰ Crowther, *The Workhouse System*, p.66.

and contrasted it with St Luke's House which was aimed at the 'respectable' poor who "through no moral fault of their own" had come down in the world and to whom the name of pauper was an "unbearable stigma."¹⁴¹ Although the staff at the Hostel of God made far fewer references to workhouse provision, they too seem to have been primarily concerned about its moral underpinnings.

The homes also stressed the advantages they felt they offered in relation to those found in the homes of the poor, where the conditions of extreme hardship and deprivation endured by the inhabitants were thought to be deleterious to spiritual reflection and to their ability to achieve a 'good death'. Victorian social observers, such as the Congregationalist minister Andrew Mearns and Charles Booth, had helped to expose the horrific conditions which prevailed in the homes of the poor and the sisters' own visits to the local neighbourhoods served to further reinforce this. The Chaplain at the Hostel of God believed that:

"a death of protracted suffering or of lingering weakness, terrible as it always must be, is, in the homes of the poor, greatly aggravated by the limited room, the absence of quiet, the difficulty of surrounding the patient with those little comforts and alleviations which richer folk can obtain to ease the last sufferings."¹⁴²

His counterpart at St Luke's was of the same opinion. He wrote that very often in the homes of the poor "death is robbed of all its beauty, and is terrible to witness."¹⁴³

An advertisement produced by the Sisters at St Joseph's challenged its readers to think about the appalling conditions in which the patients would have to die if they did not have recourse to the Hospice:

"Have you any idea of the sordid privations and the extreme misery which results from the dire poverty, overcrowding, lack of sympathy and honour, lack of honesty and morals?...They die in conditions worse than the most savage of savages have ever yet had to face."¹⁴⁴

Many of the inmates at St Joseph's had been actively removed from their homes by the Sisters and taken to the Hospice. The annals recorded one story of an old lady who

¹⁴¹ 4th WLMAR, 1891, p.12 ; 5th SLHAR, 1898, p.6.

¹⁴² HOGAR, 1896, p.9.

¹⁴³ 9th SLHAR, 1902, p.10.

¹⁴⁴ 'St Joseph's Hospice for the Dying Christmas - First and Last', c1913, St Joseph's Hospice Archive.

was admitted into the Hospice because “she lived in dire poverty and dirt. Her children numbered about 21 but were all typical of the locality. They slept on a heap of rags which covered a filthy old wooden bedstead. The place was literally alive with insects. Some of her children and grandchildren slept in the room, and alcohol was no stranger there.” The Sisters felt these “surroundings were not conducive to the peace of a prayerful, happy death” and persuaded her to come to the Hospice.¹⁴⁵ Another patient living in a “filthy house in Bermondsey” was admitted in “such a state of neglect” that it took a whole day to get her clean and comfortable.¹⁴⁶

As this thesis has shown, the medical staff at St Luke’s were also concerned about the health risk posed to other family members by allowing consumptive and cancer patients to die at home. The infectious nature of consumption, especially in the last stages, was felt to be a danger to others, while cancer was thought to be both a physical offence and a cause of ill-health to others because it could become unsanitary unless properly nursed.¹⁴⁷

At the same time as removing patients from their own dwellings, the homes sought to recreate a ‘home-like’ atmosphere within their respective institutions. This was typical of many of the small charitable institutions set up during this period. The home was a central feature of Victorian life and the efforts of those who ran the homes to transpose certain elements of it were hardly surprising. Inevitably, their perceptions of what form these should take was shaped by their own ideas of what constituted a ‘home’ and their desire to render everything conducive to spiritual reflection. The Sisters of Charity felt that that the home-like atmosphere of the Hospice was more effective because it was wedded to Catholic surroundings and thus, as well as reviving patients’ religious sensibilities, was also able to influence their moral attributes. One story in particular illustrates the two-fold effect which these influences could have:

“The homelike atmosphere united with the religious surroundings had a softening effect on him reminded him of his early days and his nice refined home in Germany.....By degrees the faith that was dormant revived, he

¹⁴⁵ ‘Notes for the Annals of St Joseph’s Hospice’, 1904 - c1909, pp.8-9, [RSCG].

¹⁴⁶ *Ibid.*, pp.21-22.

¹⁴⁷ 6th SLHAR, 1899, p.8 ; 20th SLHAR, 1912, p.11.

went to Confession and Holy Communion and began to say his prayers again.”¹⁴⁸

Howard Barrett wrote that their aim at St Luke’s was to be as “home-like as possible.” The rationale which underlay this had a medical, as well as a spiritual, dimension. Barrett felt that, unlike the hospitals, they did not have to concern themselves with the need to secure as microbe-free an environment as possible because the patients had no hope of recovery. He did not think that “a few stray bacilli” from stair carpets, wallpapers and curtains would affect their comfort or well-being.¹⁴⁹ The annual reports for 1893 and 1900 gave a description of some of the more home-like aspects of St Luke’s. Each room had basket chairs, “soft muslin window hangings,” window boxes and plants, while each bedside had a small table with a linen cover, a vase of flowers and a dish of fruit resting on it. Sister Lily felt that such surroundings “help to soothe the spirit...to uplift those who have been toiling in the heat of the day.”¹⁵⁰ Barrett also spoke about the “cosy-corners with palms and ferns and easy chairs” and bedrooms that had the “*soigné* look which speaks of home.”¹⁵¹ Each room also contained a piano and music featured large in the entertainments provided for the patients.¹⁵²

Pictures of the wards in the early annual reports for the Hostel of God were also very home-like in appearance, each one possessing a fireplace, tables, armchairs, pictures on the wall and lots of flowers and plants.¹⁵³ These photographs, like those at St Luke’s, were characteristic of the images used by many other small, specialised hospitals and institutions in the four decades before the First World War. The large voluntary hospitals also sought to recreate a domestic environment, but one that was reflective of the domesticity of a great upper class Victorian house. The domestic images used by smaller homes and hospitals resembled more of a ‘cottage’ appearance. D.M. Fox and Chris Lawrence argue that such pictures were an attempt to portray the hospital as a benevolent, caring and pious institution where medical

¹⁴⁸ SJHA, May 1915 - May 1921.

¹⁴⁹ 5th SLHAR, 1898, p.7.

¹⁵⁰ ‘The Report of St Luke’s House’, taken from 6th WLMAR, 1893, p. 23 ; 7th SLHAR, 1900, p.22.

¹⁵¹ ‘The Report Of St Luke’s House’, taken from 6th WLMAR, 1893, p.22.

¹⁵² H.K. ‘St Luke’, *Methodist Recorder*, June 1904, in ‘Presscuttings Concerning St Luke’s House: a home for the Dying Poor, 1901 - 12 Jan 1929, p.4.

¹⁵³ HOGAR, 1898 ; 1911.

intervention was subordinated to domestic order.¹⁵⁴ In spite of efforts by the staff in the homes for the dying to recreate a home-like atmosphere and surroundings, many patients obviously felt the difference keenly; as chapter 4 showed, a number of them each year opted to leave because they were homesick and wanted to die at home.

It is also possible to see the homes for the dying as a response to some of the major developments that occurred in the voluntary hospitals in the nineteenth century. Scientific and medical advancements during this period had resulted in the deliberate exclusion of the dying by a medicine which was becoming progressively more secularised in character and was concerned to focus primarily on the body and the restoration of health. The voluntary hospitals had originally been conceived within a framework of Anglican charity. Each one appointed a chaplain and patients were expected to submit to moral and spiritual improvement in return for their admission. Bibles and other improving literature were regularly donated for these purposes.¹⁵⁵ However, as Roy Porter has argued, the hospitals were rarely connected to any specific religious denomination because their funding was dependent upon their ability to transcend religious and political barriers and to be as ecumenical in character as possible. One of their most important functions was to try and heal religious and political divisions among the elite.¹⁵⁶

During the nineteenth century, however, hospitals were gradually medicalised through their establishment as centres of training and clinical research and as the workplace of the elite of the medical profession.¹⁵⁷ The emphasis within hospitals on acute patients helped to ensure a larger turnover of patients for treatment and enabled a higher success rate.¹⁵⁸ By the late nineteenth century, in response to growing numbers of

¹⁵⁴ Fox, D.M. and Lawrence, C. (1988) *Photographing Medicine: Images and Power in Britain and America Since 1840*. London: Greenwood Press, pp.41-42.

¹⁵⁵ Pickstone, J.V. (1982) Establishment and dissent in nineteenth century medicine: an exploration of some correspondence and connections between religious and medical belief systems in early industrial England, in W.J. Sheils (ed) *The Church and Healing*. Oxford: Basil Blackwell, p.187 ; Porter, R. (1989) The gift relation: philanthropy and provincial hospitals in eighteenth century England, in L. Granshaw and R. Porter (eds) *The Hospital in History*. London: Routledge, pp.149-178.

¹⁵⁶ Porter, 'The gift relation', p.153.

¹⁵⁷ Granshaw, L. (1989) 'Fame and fortune by means of brick and mortar': the medical profession and specialist hospitals in Britain 1800-1948, in *The Hospital in History*. London: Routledge, p.201.

¹⁵⁸ Lawrence, C. (1994) *Medicine in the Making of Modern Britain 1700-1920*. London: Routledge, pp.55-82 ; Abel-Smith, B (1964) *The Hospitals 1800 - 1948*. Cambridge, Massachusetts: Harvard University Press, p.39.

patients and an increase in teaching functions, pastoral care had declined in importance.¹⁵⁹

In the second half of the nineteenth century, particularly post-Nightingale reforms, nursing, especially hospital-based nursing, also became increasingly secularised. Florence Nightingale was responsible for introducing the first secular-based training programme; her experiences of working with religious orders in the Crimea and their interdenominational rivalries had left her wary as to their priorities, especially those who were evangelically inclined. She was afraid that their religious loyalties would conflict with the responsibility of the nurse to the medical and lay authorities.¹⁶⁰ As nursing interests focused increasingly on issues of training and professionalisation, their former religious responsibilities gradually assumed less importance.

The homes for the dying not only sought to re-establish the primacy of spiritual care but to reforge the relationship between care of the body and care of the soul which, as the nineteenth century progressed, had been increasingly neglected by hospital-based medicine. At St Joseph's the Sisters believed that the opening of the new Hospice would be of immense importance to Catholic patients who were unable to obtain the religious ministrations they required in the public hospitals governed by non-Catholics:

“Everyone who has had the experience of public hospitals controlled by Non-Catholics knows how difficult it is, even with the very best and kindest intentions on the part of the staff of nurses and officials, for Catholic patients to obtain those religious ministrations at the hands of their own clergy which are such a consolation to them in the time of sickness.”¹⁶¹

Although St Luke's House was founded in response to certain deficiencies within existing hospital provision, the staff there found themselves unable to run against the

¹⁵⁹ Summers, A. (1994) The costs and benefits of caring, nursing charities, c1830 - c1860, in J. Barry and C. Jones (eds) *Medicine and Charity Before the Welfare State*. London: Routledge, p.138.

¹⁶⁰ Rafferty, *The Politics of Nursing Knowledge*, p.36 ; Summers, *Angels and Citizens*, p.23 ; Abel-Smith, B. (1960) *A History of the Nursing Profession*. London: Heinemann, p.19 ; Summers, 'Ministering Angels', pp.31-37 ; Maggs, C. (1993) A general history of nursing: 1800-1900, in W.F. Bynum and R. Porter (eds) *Companion Encyclopaedia of the History of Medicine*. London: Routledge, p.1319.

¹⁶¹ Author unknown, 'New Hospice for the Dying in Hackney', newspaper unknown, 1904, St Joseph's Hospice Archive.

tide of modernity. By the second decade of the twentieth century tensions had begun to develop between their desire to keep it as home-like as possible for the benefit of the patients and their need to upgrade its status to that of a hospital in order to generate desperately needed public and financial support. After a suggestion by Edmund Barrett in 1914 that a name modification might be necessary in the near future, the Committee was increasingly of the persuasion that the term home was looked upon unfavourably by the general public. It was felt that the word hospital commanded a far higher degree of respect and would stimulate greater public benevolence. Barrett believed that patients preferred the idea of going into a hospital because they associated it with the idea of treatment, nursing and possible recovery. In contrast the word 'home' only engendered feelings of reluctance and suspicion and such institutions were, on the whole, thought to be less efficient.¹⁶²

After the adoption of the title 'St Luke's Hospital for Advanced Cases' in 1917, St Luke's began to find itself prey to some of the developments which affected the voluntary hospitals during this period. Over the next two decades the Hospital became progressively medicalised: not only were the services of a growing number and diversity of doctors utilised, but, as the previous chapter showed, their power was further enhanced and given formal acknowledgement in 1936 through the creation of a medical committee authorised to deal with all medical matters.¹⁶³ By 1925 St Luke's was described in the annual report as a "modern and fully equipped hospital."¹⁶⁴ A picture of one of the wards in the Hospital in the 1924 annual report bore a much closer resemblance to a voluntary hospital ward than those depicted in earlier reports, with iron beds down two of the walls, no curtains, bare walls and wooden floors.¹⁶⁵ This imagery formed part of the changing focus of hospital photography during the interwar period. According to Lawrence and Fox, hospital wards after 1918 were no longer depicted as domestic but as long, empty, clean, spacious, symmetrical and functional. Medicine became the central focus of the hospital and was portrayed as

¹⁶² Minute Book of St Luke's House Committee of Management 18 June 1912 - 27 May 1918: 26/06/1917, pp.278-283.

¹⁶³ Minute Book of St Luke's Hospital for Advanced Cases 25 March 1931 - 26 April 1939: 04/05/1936, p.196.

¹⁶⁴ 32nd SLHAR, 1925, p.12.

¹⁶⁵ 31st SLHAR, 1924.

vigorous, scientific and a powerful agent of progress. The origins of this changing imagery are complex, but they included the supplanting of lay control of hospitals by medical men.¹⁶⁶ By contrast, many smaller homes and institutions continued to emphasise domesticity. Both the Hostel of God and St Joseph's Hospice adhered to the use of this traditional imagery; pictures of wards at the Hostel of God in 1930 still contained mantelpieces, pictures, plants and flowers, while the accounts in the annals for St Joseph's continued to stress the importance of the Hospice's home-like atmosphere.¹⁶⁷

Like the voluntary hospitals, St Luke's found itself subject to deepening financial insecurities and became increasingly reliant upon patient payments as a source of income. As well as pecuniary difficulties, the very status of general and special hospitals as voluntary institutions was under threat from state encroachment. During the 1930s St Luke's, because of its status as a 'non-localised special hospital', became involved in efforts to try and counter this trend. It sent representatives to the London Voluntary Hospitals Committee, set up to safeguard the interests of the voluntary hospitals after the passing of the Local Government Act in 1929, which aimed at closer association of the state with the voluntary hospitals.¹⁶⁸

The staff at St Luke's also began to perceive their work as part of the wider hospital system. Even Howard Barrett was not immune to these influences. His reflections in the 1916 annual report on 'What Does St Luke's House Stand For?' were indicative of the direction in which the thinking of those who ran the Home was moving. He wrote that St Luke's was a "natural successor" to the hospitals and took on much of their "least successful work." He also said that the dying poor were a class whom the hospitals "*must* not care for" [his italics].¹⁶⁹ The extent to which this attitude had come to dominate thinking at St Luke's was revealed in the 1922 report which

¹⁶⁶ Fox and Lawrence, *Photographing Medicine*, pp.42, 181.

¹⁶⁷ HOGAR, 1930 ; SJHA, 1929-1935.

¹⁶⁸ Minute Book of St Luke's Hospital for Advanced Cases Committee of Management 25 March 1931 to 26 April 1939: 23/02/1938, p.86.

¹⁶⁹ 23rd SLHAR, 1916, pp.9, 11.

referred to the Hospital as a “sort of ‘Clearing House’ for the general hospitals by releasing their beds for patients who can recover.”¹⁷⁰

At the same time as ensuring that St Luke’s was recognised as a hospital, the staff were anxious to reassure the public that, although they insisted upon the efficiency of a hospital, they maintained, as far as possible, the “appearance and atmosphere and elastic administration of a Nursing Home.”¹⁷¹ The annual report for 1930 included an excerpt from a letter written by the Secretary after a visit to the Home:

“It is so different to the big London Hospitals where everything, although naturally, beautifully, organised, is, one feels, rather mechanically done, coming under the ‘regular’ routine work of a big Institution. But at St Luke’s House, where everything is so much smaller and intimate, one gets that personal touch.”¹⁷²

However, this was evidently a matter of personal interpretation, and therefore open to question. A remark made by one of the representatives of the Charity Organisation Society after a visit to the Home in 1916 on the “unhome-like and institutional atmosphere” suggests that the image portrayed in the reports was somewhat different in reality.¹⁷³

As well as seeing the homes as representing a form of response to methods of care within domiciliary, workhouse and hospital settings, it is also possible to interpret their emphasis upon spiritual care as a reaction to broader secularising trends, particularly the impact of the latter upon attitudes towards death. Pat Jalland has argued that from the 1870s concern for spiritual welfare was gradually superseded by a concern to minimise physical suffering, while attitudes towards death were characterised by a growing sense of uneasiness and uncertainty.¹⁷⁴

A. Gilbert has also identified a new form of dying emerging in the late nineteenth century: ‘the secular way of death’. Although religion was still important for

¹⁷⁰ 29th SLHAR, 1922, p.5.

¹⁷¹ 29th SLHAR, 1921, p.16 ; 35th SLHAR, 1927, p.16.

¹⁷² 37th SLHAR, 1930, p.6.

¹⁷³ Minute Book of the St Luke’s House Committee of Management 18 June 1912 - 27 May 1918: 11/04/1916, p.216.

¹⁷⁴ Jalland, P. (1996) *Death in the Victorian Family*. Oxford University Press, pp.52-54.

comprehending the future world, understanding of the present world became increasingly secularised.¹⁷⁵ In pre-industrial society death was a normal occurrence and disease and pain were little understood and virtually uncontrollable. Christian belief and ritual had played a major role in pre-modern coping mechanisms. However, by the late nineteenth century advances in medicine and improvements in sanitation and diet had resulted in increasing longevity and more effective controls over illness and pain and consequently death became a more peripheral concern.¹⁷⁶

The degree to which each of the homes was able to control their response to secularisation and other modernising trends differed significantly. St Joseph's Hospice and the Hostel of God were more successful in their efforts to oppose the forces of secularisation, and this continued to be a primary motivating factor in their work. One particularly telling example was a decision by the Sisters of Charity in 1937 to purchase, for £3,000, the Congregational Church which adjoined their property to prevent it being used for "secular purposes."¹⁷⁷ Within both homes spiritual care continued to be the most important and influential aspect of their work. In other respects, however, the two homes followed more contemporary developments. Institutional care of the dying reflected one of the prominent features of nineteenth century medical history: the growing trend towards institutionalisation. The homes also emphasised the importance of retaining the services of fully trained doctors and nurses and utilising the latest technological developments such as lifts, oil heating, refrigerators, incinerators and wirelesses to ease their own work and to enhance the comfort of the patients. It can thus be argued that the development of St Joseph's Hospice and the Hostel of God embodied a fundamental paradox: the persistence of tradition within modernity.

By contrast, St Luke's House was less successful in countering the influences of secularisation and modernisation and increasingly found itself in the position of having to accommodate to them in order to survive. Not only did the Home become progressively medicalised but, in response to perceptions concerning medical, nursing

¹⁷⁵ Gilbert, A. (1980) *The Making of Post-Christian Britain: a History of the Secularisation of Modern Society*. London: Macmillan, p.10.

¹⁷⁶ *Ibid.*, p.61.

¹⁷⁷ *Hackney Annals*, 1936 ; 1937.

and popular attitudes towards homes for the dying, the Committee was compelled to change its status to that of a hospital. Although the annual reports continued to impress upon supporters that it still retained a home-like atmosphere, all the signs point to it becoming increasingly institutionalised over the years and adopting many of the characteristics of the voluntary hospitals. One possible reason for this was that spiritual care was only ever provided on a part-time basis and was not so deeply entrenched in the life of the Home as it was in the other two institutions. The priority given to spiritual care in the early years had depended largely upon the commitment and drive of Howard Barrett and his son, and after their deaths it could no longer be sustained. The precarious nature of its funding over the years also meant that the Committee needed to be extra sensitive to wider medical and public opinion.

The work of the Sisters of Charity at St Joseph's Hospice represented another more peculiar and individual response which stemmed from their status as a religious and ethnic minority. Throughout the nineteenth century Catholicism remained a separatist, minority religion, ostracised from the mainstream of English life.¹⁷⁸ Faced with widespread hostility, an atmosphere of intense religious competition and the perceived threat of widespread indifference, the Catholic Church was forced to renew its efforts to preserve its own identity and retain the allegiance of its members, particularly those who had lapsed from the faith. After 1850 a new zeal characterised the work of the Church as it sought to emphasise and reinforce its distinctiveness. Much of its time and a large proportion of its resources were channelled into trying to protect its flock from unedifying external influences.¹⁷⁹ The Church aimed to shield Catholics from all Protestant and secular influences by keeping them in self-enclosed communities where the church served as the focus of social and religious identity.¹⁸⁰ The services of religious sisters in schools and other institutions was seen, from the outset, as vital in this process.¹⁸¹

¹⁷⁸ Gilbert, A.D. (1976) *Religion and Society in Industrial England: Church, Chapel and Social Change, 1740-1914*. London: Longman, p.173.

¹⁷⁹ Heimann, M. (1995) *Catholic Devotion in Victorian England*. Oxford: Clarendon Press, p.124.

¹⁸⁰ Kitson Clark, G. (1973) *Churchman and the Condition of England 1832-1885*. London: Methuen and Co. Ltd, p.336.

¹⁸¹ O'Brien, S. (1988) Terra incognita: the nuns in nineteenth century England, *Past and Present*, Vol. 121, p.115.

The position of Irish Catholics in London was doubly precarious because of rampant anti-Irish sentiment, greatly exacerbated by Anglo-Irish relations during this period. The Church was particularly active in its mission to Irish Catholics, partly because of their presence in such large numbers in London and partly because of their greater vulnerability to racial prejudice. Sheridan Gilley has argued that the ethnocentric element in Irish religion in London was very strong and was reinforced by their tendency to congregate in ghettos and the celebration of major Irish religious festivals, such as the St Patrick's Day service in St Patrick's, Soho. As a result, Catholics were able to use the whole body of inherited Irish loyalties in bringing to bear upon the Irish.¹⁸² The decision by Father Gallwey to invite a group of Irish sisters to start a ministry to Irish Catholics in the East End of London would have been particularly instrumental in this:

“An appeal from the Irish Sisters of Charity is always sure to reach the hearts of the exiled Irish in London. When it is an appeal from a band of the good Sisters in exile with them it comes with double force.”¹⁸³

Many of the stories in the annals concerning Irish patients suggest that the Sisters were of a similar mindset: there are frequent references to the “Irish heart”¹⁸⁴ and the “strong Irish faith”¹⁸⁵ which the Sisters believed would soon revive with the right means of encouragement.

The Sisters' mission work was intended primarily for Catholics, many of whom were Irish. During the early years of their work in London they encountered considerable racial and religious prejudice from non-Catholics in the locality.¹⁸⁶ Irish names predominated in the patient registers for the early years and Catholics were given priority of admission. Most of the lay nurses who worked in the Hospice were also Irish, as were some of the doctors, and they would have helped to further reinforce a sense of Catholic Irish identity.¹⁸⁷

¹⁸² Gilley, S. (1969) *The Roman Catholic mission to the Irish in London, 1840-1860, Recusant History*, Vol.10, p.141 ; Gilley, S. (1972) *Papists, Protestants and the Irish in London, 1835-70*, in G.J. Cuming and D. Baker (eds) *Popular Belief and Practice*. Cambridge University Press, p.261.

¹⁸³ Author unknown, title unknown, newspaper unknown, 1905, St Joseph's Hospice Archive.

¹⁸⁴ 'Notes for the Annals of St Joseph's Hospice', 1904 - c1909, p.9, [RSCG].

¹⁸⁵ *Ibid.*, p.13.

¹⁸⁶ SJHA, 1900-1905.

¹⁸⁷ 'A London Gate to Heaven', reprinted c1919 from the *Ave Maria*, p.8, [RSCG].

The Sisters of Charity were particularly vigilant in their efforts to protect their flock from non-Catholic influences. The stories in the annals contain several examples of the Sisters trying to ward off Christian Science and Protestant missionaries. One account of a visit to a dying patient at her home recorded how “annoyed” the Sister had been at finding that a Protestant lady had also called round. The latter individual almost succeeded in persuading the patient not to go to the Hospice and the annalist described the effect of this upon the Sister as “feeling the devil had got in.”¹⁸⁸ The Sisters’ work in the Hospice can therefore be seen to have played a very important role in helping to maintain the identity of the Catholic Church as a whole and in preserving the religious and ethnic integrity of its Irish members. By appealing to their shared ethnic roots the Sisters not only succeeded in using death to celebrate patients’ Catholicity but also their ‘Irishness’.

iv. The institutionalisation of death

M.A. Crowther has argued that the growing number of deaths which occurred in institutions in the late nineteenth century signified the beginning of a process whereby death became institutionalised.¹⁸⁹ This section will consider to what extent this process was taking place in the homes for the dying and the implications it had for more traditional deathbed rituals. The homes signified both a displacement of the site of death and a fundamental change in the role and position of the family. The family was a much venerated pillar of Victorian society and virtually all of life’s activities, including death, occurred within its sphere. The traditional Victorian deathbed scene took place in the home with family and friends present throughout and playing an active role in caring for the patient. While this continued to remain the norm for middle and upper class families, growing numbers of working class deaths were occurring outside of the home and away from the family, in poor law institutions, hospitals, sanatoria, asylums and the multitude of other homes and hospitals set up to care for the sick poor who were ineligible for the voluntary hospitals. Institutions had a divisive effect upon families. They were supposed to offer a substitute for family

¹⁸⁸ SJHA, May 1905 - May 1909.

¹⁸⁹ Crowther, *The Workhouse System*, pp.57-58.

care but they also separated its members who were forced into the position of having to defer to the institution's staff.¹⁹⁰

The shift in attitudes regarding the role of the family was also reflected among late nineteenth century medical opinion. Both William Munk and Oswald Browne, the two Victorian doctors most responsible for heightening awareness of care of the dying among the medical and nursing professions, envisaged a fairly limited role for relatives; only the immediate family were to be present at the deathbed. Although it was permissible for doctors to make suggestions about little things that they could do to ease the patients comfort, it was ultimately felt that "the occasion mainly calls for self-effacement."¹⁹¹

The gradual shift in the place of death from the home to the institution has been linked by historians to another phenomenon whose roots have been traced back to the late Victorian era: the concealment and denial of death. This process, according to the historian Philippe Ariès, originated in the desire of relatives and friends to spare the dying and to hide from them the gravity of their condition. This motivation, however, soon became subsumed within the desire to protect those close to the dying person from having to confront the reality of their loved one's death. The dying were removed to institutions where families and friends no longer had to deal with their immediate presence.¹⁹²

As chapter three showed, this view of death has been challenged by David Cannadine and Jay Winter who argue that people wanted to remember as much as they wanted to forget. Ariès' views have also been questioned by the sociologist David Armstrong who has contended that Ariès' interpretation of events is a fallacy. He disputes Ariès' thesis that death in the late nineteenth and early twentieth century became a silent discourse, maintaining that there was more thought, spoken, written and discussed on the subject of death than ever before. Instead, he offers an alternative explanation for

¹⁹⁰ Ibid., p.64.

¹⁹¹ Munk, W. (1887) *Euthanasia: or Medical Treatment In Aid of an Easy Death*. London: Longmans, Green, and Co., p.90 ; Browne, O. (1894) *On the Care of the Dying: a Lecture to Nurses*. London: George Allen, p.32.

¹⁹² Ariès, P. (1981) *The Hour of Our Death*. London: Allen Lane, pp.561-577.

what was happening by claiming a more subtle distinction in social responses to death during this period; rather than death being silenced there was a fundamental shift in the way in which it was spoken about. Until the mid-Victorian period the central preoccupation had been with the *dying* in the context of the private domestic setting in which great significance was attached to the words of the dying and their attendants. However, from the 1850s onwards the focus was increasingly upon the *dead* person as manifested in the new rituals of certification and registration and the great medical, legislative and public interest shown in the proper management of the corpse.¹⁹³ In the context of Armstrong's argument it is possible to argue that the late nineteenth and early twentieth century saw the beginnings of the concealment of the *dying* as opposed to death *per se*.

The creation of homes specifically for the dying not only represented part of a process whereby death became institutionalised but also signified a new phenomenon; institutionalisation of the dying stage. Although Crowther argues that growing numbers of deaths were occurring inside institutions, by and large this was not an intentional process. The deliberate removal of the dying respectable poor into institutions specially designed for this purpose, however, denoted the beginnings of the intentional institutionalisation of death and dying for members of this group. It can also be argued that the gradual displacement of these patients from their homes into institutions and the growing number of deaths that occurred in them, in which death was managed by others, formed part of the process whereby the former importance attached to the dying person and their family was increasingly undermined.

Evidence from St Joseph's Hospice and the Hostel of God also adds a new dimension to Ariès' argument that by the late nineteenth century there was a growing tendency to conceal from patients the true nature of their prognosis. The staff in both homes believed that patients should be informed of their condition. The Catholic Church, in particular, felt that people should "be under no illusion when death is near" and that

¹⁹³ Armstrong, D. (1987) Silence and truth in death and dying, *Social Science of Medicine*, Vol. 24, No. 8, pp.651-657.

friends and relatives should not try to deceive them.¹⁹⁴ Inevitably, this thinking, like every other aspect of their work, was motivated primarily by spiritual considerations. Knowledge of impending death, that “the moment when they stand face to face with their Lord and Creator is fast approaching,”¹⁹⁵ was particularly important if patients were to “be prepared for that inevitable summons.”¹⁹⁶

However, in adopting this practice, both homes did think that they were going against a recently developed but growing penchant among both the medical profession and the public in general not to inform patients of their true condition. As chapter 5 has shown, the Medical Officer at the Hostel of God spoke to the Council in 1925 about the increasing tendency for hospital almoners to encourage cancer patients to believe they were entering a convalescent home to be nursed back to health and it was only after their arrival at the Hostel that the truth was revealed to them.¹⁹⁷ The Sisters of Charity also felt that “in this twentieth century.....so many, acting from philanthropic motives in their great desire to alleviate the sufferings of their fellow creatures, shrink from the *true* kindness of making known to the sufferers that their end is nearing.”¹⁹⁸

In contrast, concerted efforts were made by the staff at St Luke’s not to inform patients that they were in a home for dying persons. There is, however, some ambivalence here because several of the accounts of patients, particularly those written by the Visiting Sisters, talk about patients who refused to accept their prognosis. One possible explanation for this ambiguity is that it was left up to the staff, particularly the Chaplains and Visiting Sisters, to only discuss the matter with patients when they felt the time was right. The overall willingness of the homes to confront death and dying, even though it was used as part of their ‘higher’ mission to reach the spiritually impoverished masses, could be seen as an attempt to resist the growing tendency to avoid death which characterised wider social attitudes among the

¹⁹⁴ Gallwey, Father P., SJ (1889) ‘A Funeral Discourse by Father Gallwey, SJ, Over the Remains of Eliza Mary Katharine Devas’. London: Burns, Lambert and Oates, p.14, in bound volume of Father Peter Gallwey Sermons, Jesuit Archives, ref. CPJ 61 ; Hostel of God Annual Council Minutes February 1918 - 1977: 14/02/1922.

¹⁹⁵ ‘St Joseph’s Hospice for the Dying Report 1907’, p.5.

¹⁹⁶ Author unknown, ‘Hackney bazaar in aid of the Hospice for the Dying Father Bernard Vaughan on life and death’, newspaper unknown, c1913, St Joseph’s Hospice Archive.

¹⁹⁷ Hostel of God Annual Council Minutes February 1918 - 1977: 09/02/1925.

¹⁹⁸ ‘St Joseph’s Hospice for the Dying Report 1907’, p.5.

middle and upper classes. At the same time, there is scope to argue that the numerous applications made on the behalf of patients by family and friends was evidence of a more widespread desire not to have to take on the responsibility of the dying person themselves.

Institutionalisation also had important implications for the role which the family could play in the patient's death. Whereas previously relatives had played a central part in caring for the patient, they suddenly found themselves having to surrender control to a whole host of strangers in the form of nuns, doctors, nurses and chaplains. As a consequence, the family was forced into what was essentially a passive role. This reduced influence may have been the reason why some families requested to have patients discharged and return home.

At St Joseph's Hospice the Sisters envisaged a largely spiritual role for the family. Some of the features of the "holy and happy death," particularly its more didactic elements, were akin to the Evangelical death of the early and mid-Victorian era.¹⁹⁹ Although general visiting hours were restricted, the Sisters appear to have been fairly flexible about allowing the immediate family to visit outside of these times. It was fervently hoped that patients' relatives, particularly those who had lapsed from the faith, would gain inspiration from the manner in which their loved one approached death and find consolation and comfort in the Catholic faith. The annals describe the effect of one patient's death upon his wife:

"His wife who was a badly instructed convert always remained in the room and she too profited and it all made a great impression on her whenever the children were present. She began to send them to Mass and Catechism and had them all Baptised Catholics.....His death made a very great impression on his wife. She had never made her first Communion and had been badly instructed and seemed to have very little religion in her. But from her husband's death she got great grace and about a fortnight after came of her own accord and asked to be prepared for her first Communion."²⁰⁰

For those relatives who failed to find religious consolation while their loved one was still in the Hospice, it was hoped that the decorations in the mortuary would provide a

¹⁹⁹ Cecil, R. (1982) Holy dying: Evangelical attitudes to death, *History Today*, Vol. 32, pp.30-34.

²⁰⁰ SJHA, May 1905 - May 1909.

final means of inspiration. The annual report for 1907 stated that it was “furnished with marble slabs, altar, candles and holy pictures, calculated to revive the Faith of friends and relatives, to inspire the Catholic spirit of reverence for the dead so salutary to the Living.”²⁰¹

Visitors whose moral integrity was open to question were subjected to much closer scrutinisation by the Sisters. Although they were prepared to be more flexible about the moral character of potential inmates, they were less tolerant about patients being exposed to corruptive influences from visitors once in the Hospice. One story recounted how the visit of a “painted powdered lady” to one of the male patients had “greatly distressed” the Sister in Charge. Her fears were compounded by the knowledge that the patient had “lost his faith” after he left the Hospice the first time through “drinking and bad company.” The Mother Rectress therefore told him that he ought not to have any visitors for a while and the annalist noted that the lady visitor did not come to the Hospice again.²⁰²

At St Luke’s House the ability of the family to participate in the death of a patient was deliberately kept to a minimum and the opportunity for relatives and friends to play a role was limited by the creation of a set of ‘rules’ which visitors were expected to abide by. Barrett clearly felt that priority should be given to medical, nursing and spiritual care of the patients. Ministers were permitted to visit the patients at any hour but family visiting time was strictly regulated.²⁰³

“We accordingly welcome all visitors but, on account of feebleness of most of our patients and the large amount of each day that is taken up by special nursing attendance on them and visits by doctors, the chaplain, the clergy and the Sisters, it is necessary to confine ordinary visiting hours to following days and hours.”

Every afternoon, except Thursday and Sunday from 3-5, except by special appointment with Matron. (signed) Howard Barrett, Honorary Medical Superintendent.²⁰⁴

²⁰¹ ‘St Joseph’s Hospice for the Dying Report 1907’, p.6.

²⁰² SJHA, May 1927 - Jan 1929, p.240.

²⁰³ 3rd SLHAR, taken from 9th WLMAR, 1896, p.24.

²⁰⁴ Minute Book of St Luke’s House Committee of Management 15 Nov. 1895 - 19 July 1905: 15/03/1905.

At one level it is possible to see the homes as part of the process identified by Crowther whereby death gradually became institutionalised. However, for the first time the process of *dying* was also being deliberately institutionalised; the last few days, weeks and months of patients' lives were played out in an institutional setting, the place of death occurred away from the home and the role played by the family in attending to the dying patient assumed less importance and was less deterministic. At the same time, there is scope to view the homes as a response, in part at least, to the shift in attitudes identified by Armstrong and to claim that they represented an attempt to reassert the importance of the dying process. The argument also needs to be qualified in one other respect. The homes were only intended for a specific section of the population - the 'respectable poor' and the impoverished middle classes - and thus it was only for these groups that dying away from home in an institution became a more accepted practice in the late nineteenth and early twentieth century. It can be argued that for paupers, the 'undeserving' poor, this process had begun over a century earlier, namely with the creation of the workhouse and later the Poor Law infirmaries. However, these institutions differed fundamentally from the homes in that they were not specifically set up with the single objective of caring for the dying.

v. Conclusion

The above discussion has shown that the foundation of homes for the dying with a solid religious basis and a primarily spiritual purpose represented an attempt by small, disparate groups of people to hold on to a tradition of pastoral care, which they felt was being progressively undermined by wider social, medical and religious changes. Underpinning the foundation of the homes was the belief that death was an important and pivotal event in a person's life because it was the final step before encountering God and undergoing divine judgement. The significance of this was two-fold: firstly, it meant that careful spiritual preparation was essential if the dead were to stand confidently before God and, secondly, it represented the last chance for those who had not yet accepted the gift of salvation. Neither the hospitals, the infirmaries nor the homes of the poor could provide the type of care or opportunities that the staff of the homes envisaged for their patients. Although their individual aims and methods varied

according to their particular denominational affiliation, they each showed a considerable capacity for resourcefulness in the range of techniques they enlisted to help them achieve these. Space and time were carefully controlled and the atmosphere and influences of the homes made as conducive as possible to inspiring a particular form of spiritual reflection in the patients.

However, as this thesis has shown it was possible, in small ways, for patients to resist the pressures that were brought to bear upon them. Their responses ranged from outright defiance, as in the case of those who chose to leave, to an acceptance of some of the things on offer (food, medical care etc.) and a rejection of others, such as spiritual ministrations. It was also possible for patients to use the homes in ways not intended by those who ran them, for example as a temporary means of care before transferral to another institution. Patients too had their own particular reasons for using the homes which were often far removed from the more spiritually-driven reasons of those who ran them. One such example was the patient at St Joseph's who wanted to protect his family from risk of infection. Although patients were subjected to various forms of management within the homes, the latter cannot be viewed simply as an exercise in social control, because to do so would be to ignore the impact which the patients themselves could sometimes have and the various ways in which they could respond to the attempts at control by those who ran them.

It is important to remember that the emphasis upon tending to patients' spiritual needs characterised many other philanthropic endeavours during the late Victorian and Edwardian eras. Institutions with a specific denominational allegiance were particularly vigilant in converting patients to their particular branch of Christianity. The fundamental factor which made the homes for the dying different was that for the first time dying patients, through their transferral to an institutional setting, were being singled out as the special objects of conversion. The fact that these patients were so close to death gave an added sense of urgency to the work of those who ran them.

The preoccupation with ensuring all aspects of the work were rendered conducive to spiritual reflection was only a feature of the early years of the history of St Luke's

House. Unlike the other two homes it found itself powerless to resist wider secularising influences, particularly once it achieved hospital status in 1917, and it became more vulnerable to those factors which were influencing the development of the voluntary hospitals during the 1920s and 1930s. In contrast, St Joseph's and the Hostel of God, despite modernising the facilities they could offer to patients, did not compromise on their overall objective of saving souls and were successfully able to retain this as their primary focus.

Finally, the homes constituted part of a wider process that occurred during the late nineteenth and early twentieth centuries: institutionalisation. More specifically they were part of a growing trend towards the institutionalisation of death. By deliberately singling out the dying, those who ran the homes sought to re-establish the importance of the dying process, particularly within a spiritual context, and to ensure that death would act as the gateway to eternal life. At St Joseph's and the Hostel of God the dying process continued to be looked upon primarily from a spiritual perspective, but at St Luke's it gradually lost this emphasis and became more medical in focus.

CONCLUSION

The Impact of the Homes for the
Dying

The creation of homes for the dying in the late nineteenth century signified both a new approach to, and a change in attitudes towards, care of the dying respectable poor. For the first time this group was looked upon as requiring special medical, nursing and, most importantly of all, spiritual care within an institutional setting. The homes also represented the beginnings of a recognition of dying as a process for the respectable poor, from the time of diagnosis as 'dying' until the moment of death. This study has demonstrated that while the establishment of these three homes in the late Victorian and early Edwardian era represented a new awareness of, and a new way of looking at, care of the dying poor, their creation at this particular time was very much a product of broader social, medical, philanthropic and religious developments. It has also shown that, despite having similar founding philosophies, their development up until 1938 differed in significant ways and was characterised by marked continuities and changes.

All three homes targeted a very specific section of the population: the dying respectable poor who were medically ineligible for retention in the voluntary hospitals and 'morally' unsuitable for admission to the poor law infirmaries. Many of these, it was felt, had been spiritually neglected and lived in squalid, overcrowded houses in which it was very difficult to provide adequate care, either medical or religious. Those who ran the homes aimed to provide the patients with bodily and spiritual care, the emphasis upon the latter, within a home-like atmosphere. The same moral and religious thinking underpinned many other philanthropic enterprises during the late Victorian period and thus the homes can be viewed as part of a much broader network of charities. Their novelty lay in the fact that for the first time certain individuals and groups were beginning to single out the dying respectable poor as persons requiring special institutional care from trained medical, nursing and religious staff. At the same time the homes, particularly St Joseph's and the Hostel of God, challenged some of the wider religious and medical changes that were occurring during this period. The different denominational basis of each institution meant that the way in which care, particularly spiritual care, was administered varied significantly, while their individual management structures had implications for the way in which they developed later.

Like all charitable endeavours during this period, the foundation of the homes was both influenced by, and helped to shape, prevailing social attitudes. They were only intended for specific section of the poor - the 'respectable poor' - and, as such, suggested a desire, on the part of those running them, to both care for and manage this group right up to the end of life. Moral preoccupations were particularly apparent at St Luke's House during the years when Howard Barrett was Medical Superintendent. Barrett was emphatic that only members of the deserving poor could be admitted to the Home and showed no compunction in discharging dying patients whom he felt were morally suited for the Poor Law infirmaries. By contrast, in keeping with Catholic notions of 'holy poverty', the moral character of patients at St Joseph's was looked upon as less important than their spiritual condition. Patients from the lower end of the social scale, such as thieves and prostitutes, were accepted if it was felt that they would benefit spiritually from being in the Hospice. By the 1930s, social attitudes towards the poor had begun to change; the term 'pauper' no longer existed as a legal social category and poorer social groups were subject to less moral discrimination and segregation. As a result, the moral status of patients in the homes no longer held the same importance, although they were still intended primarily for the reception of the dying poor.

Patient populations within the homes also changed markedly during this period. The epidemiological basis of each institution altered from a high intake of phthisis patients to a predominance of cancer sufferers. Although this transition was a characteristic of all three homes, it occurred at a different time in each. At St Luke's House and the Hostel of God it took place much earlier, between the years 1905 and 1910, but at St Joseph's it did not happen until around 1925 and proportionately was not as big a change as that in the other two homes. The larger number of cancer patients at the Hostel of God and St Luke's was due to the high percentage of hospital referrals which they received. The religious affiliation of patients in these two homes remained relatively stable over the years, both showing a majority of Church of England patients; but at St Joseph's the almost predominantly Catholic population during the early years gave way, after 1925, to a significantly higher number of Church of England inmates. The epidemiological and religious changes at the Hospice coincided

with its expansion in 1925 to a 75-bed institution and the increased admission of patients recommended by the public authorities.

All three homes experienced difficulties in the early years in maintaining their status as institutions for the 'dying'. The number of discharges and chronic, long-term patients was generally higher than it was in the 1920s and 1930s. At St Luke's the average length of stay of patients shortened gradually over the years suggesting that they were more successful in overcoming this problem. Certain biases in the data for the Hostel of God, as noted in chapter 4, meant it was difficult to tell if the staff there were able to overturn the problem of chronic patients, although the purchase of an adjacent property for more long-term patients in 1931 may have gone some way to achieving this. By contrast, the average length of stay of patients at St Joseph's remained significantly longer and suggests that the Hospice was not as fastidious about only accepting patients with short prognoses.

Between their foundation and 1938 all three places evolved from small, independent, community based homes into institutions that were both recognised as providing a special form of care and were part of much wider medical networks in London. St Luke's and the Hostel of God both became integrated into the London hospital system. St Joseph's, which during the early years had centred its work upon the local, predominantly Irish Catholic population in the East End, had, by the 1920s and 1930s, expanded its patient catchment area and been brought into a closer alliance with the state through its incorporation into local government networks of medical and nursing provision. During the interwar years both St Joseph's and St Luke's accepted local authority funding, but the Hostel of God appears to have continued to rely primarily on voluntary contributions. Although St Joseph's Hospice and the Hostel of God continued to be looked upon and portray themselves as homes, St Luke's House, after 1917, assumed both the status and appearance of a small, special voluntary hospital.

The history of the homes during the period 1878 to 1938 illuminates some of the tensions that arise between the introduction of modern developments and the persistence of more traditional attitudes and beliefs. Institutional care represented an

innovative approach to caring for the dying and reflected modern developments such as the growing trend towards institutionalisation and the importance of providing medical care from trained physicians and nurses. At the same time, the founding philosophies of the homes were deeply entrenched in some of the more traditional aspects of care of the dying, particularly the pre-eminence given to the soul. As such it can be argued that they embodied a fundamental paradox: the persistence of tradition within modernity.

The stronger religious basis of the Hostel of God and St Joseph's Hospice and their management by a sisterhood provided a bulwark against the influences of secularisation and meant that they were able to avoid many of the tensions which this inevitably created and also to retain most of their traditional beliefs. In contrast, the staff at St Luke's were unable to resolve these tensions. The absence of any formal religious links after 1912 and the resignation of its spiritually-driven founder in 1914 meant that religion occupied an increasingly tenuous position within the Home and, as a result, it gradually lost many of its more traditional elements. The modernisation and medicalisation of St Luke's - symbolised by its change to hospital status after 1917 - gathered momentum from then on and its outlook came gradually to reflect that of the voluntary hospitals as issues of finance and state encroachment took up more and more of its time.

The principal traditional feature of care of the dying to which the homes paid homage was the "soul cure." One of the principal reasons they were founded was to provide salvation for those whose souls were in danger of being condemned to an eternity in hell. During the early years every other aspect of their work was subordinated to this objective. The deathbed was carefully managed so that spiritual care received precedence. Patients' status as both the dying and the destitute and their dependence upon the refuge offered by the homes were also subtly integrated into this work. Attending to patients' bodily and mental needs was believed to facilitate the transition to the "soul-cure." As chapter 3 has shown, such thinking formed part of a broader change in attitudes; Victorian philanthropists increasingly felt that spiritual responses would only be evoked if they were preceded by, or accompanied with, material aid. At

St Joseph's Hospice and the Hostel of God "soul cures" remained the primary objective suggesting that, unlike care of the living, spiritual issues in care of the dying were still important to certain groups. The continued religious emphasis of these two homes has implications for Jalland's argument that during the late Victorian and Edwardian period middle and upper class concerns about spiritual issues in care of the dying gave way to heightened anxieties about the patient's physical suffering. The work of the two homes suggests that not all members of these social groups followed wider trends; by adhering to more traditional beliefs and practices the staff were able to both resist and challenge the changing attitudes of some of their contemporaries.¹

By contrast, the personnel at St Luke's House were, after 1914, more vulnerable to wider religious, medical and social changes, so that over the years spiritual preparation for death became less of a priority. In chapter 3 it was shown that the changing emphasis of the annual reports was particularly indicative of this shift. The absence of any full time religious staff was, in part, responsible for this alteration in thinking, while the often precarious financial position of the Home meant that the staff were far more sensitive to public opinion or, more precisely, to their particular interpretations of it, and many of the changes implemented during this period were a direct response to this.

The denominational basis of each home had a significant impact on the way in which spiritual care was administered to the patients. Attitudes towards dying patients and the management of the deathbed were deeply entrenched in the theology of their respective churches. Vigilant efforts by the staff to convert patients to their particular branch of Christianity was a characteristic of many other late Victorian and Edwardian philanthropic endeavours which had a specific denominational allegiance. However, the fundamental factor which differentiated the homes for the dying was that, for the first time, dying patients, through their transfer to an institutional setting, were being singled out as the special objects of conversion.

¹ It should also be noted that the Friedenheim, the Home of the Compassion of Jesus and Our Lady's Hospice in Dublin retained a primarily religious focus thereby giving added strength to this argument.

At St Joseph's and the Hostel of God religious thinking and denominational affiliation continued to exert a powerful influence on the way in which each home was run. "Holy and happy deaths" remained the principal objective of the Sisters of Charity, while the work at the Hostel of God continued to centre upon the provision of an Anglo-Catholic ministry. After the First World War, however, the "respectable Christian death" at St Luke's assumed less importance as the Home began to move in a more secular direction.

The homes for the dying also constituted part of a wider interest in care of the dying that developed among some members of the medical profession during the latter half of the Victorian era. In chapter 5 it was shown that certain leading physicians were beginning to look upon it as a separate and distinct area of practice in which patients required a more caring and supportive environment. Although by the late nineteenth century spiritual care of all types of patients was beginning to be both separated out from, and subordinated to, medical and nursing care, the homes represented an attempt to try and counter these trends. They not only intended to re-establish the primacy of spiritual care but also to reforge the relationship between care of the body and care of the soul. The role of the Sisters at St Joseph's and the Hostel of God, which combined nursing skills with spiritual ministrations, was particularly instrumental in this because it helped to facilitate the transition from physical to spiritual care.

The willingness of the homes to confront death and to encourage their patients to do so, even though it was primarily motivated from spiritual concerns, has repercussions for the wider historiography of death and dying, particularly the arguments of historians, such as Ariès, that by the late nineteenth century there was a growing tendency to conceal from patients the true nature of their prognosis. Although the homes identified this tendency not to inform patients of their condition as a growing practice among the medical profession and the public in general, their acceptance of patients as 'dying' can be seen as an attempt by certain groups and individuals to resist wider changes in social attitudes among the middle and upper classes.

The homes were also part of a process in the late nineteenth and early twentieth century whereby death gradually became institutionalised. The place of death was removed from a domestic to an institutional setting in which the role played by the family in attending to the patient was less important and therefore less deterministic. At the same time, the work of the homes represented an attempt by certain members of the upper middle classes to reassert the importance of the dying process, particularly its spiritual aspects, within the specific context of the dying 'respectable poor'. As part of this process the former importance attached to the dying person was increasingly undermined as their care was taken over by institutional management. Although the individual responses of patients to the work of the homes was important - essentially shown through a personal declaration of faith - they were expected to conform to certain sets of expectations and intended outcomes.

The fundamentally unequal relationship between the patients and those who ran the homes meant that very few of the former would have been impervious to the influences to which they were exposed once inside. However, on occasion inmates were able to respond in ways not envisaged by those who provided their care. While some found themselves having to accommodate to, or accept, the values and beliefs imposed upon them, others were able to demonstrate a stronger degree of resistance, either by refusing to yield to spiritual ministrations or by exerting their own influence on the homes and using them for purposes other than those for which they were officially intended.

The Impact of the Homes

An analysis of the work of the homes for the dying would be incomplete without examining the extent of their impact upon society, collectively as well as individually, by exploring some of the possible reasons why they failed to spread either locally, throughout London, or at a national level. The first part of this section assesses briefly the individual success of each home by evaluating its position at the end of 1938. The second part looks more closely at the broader impact of the homes and considers some of the possible reasons why it was so limited.

In 1938 St Joseph's was by far the largest of the three institutions, accommodating up to 75 patients. The Hostel of God had 55 beds in constant occupation, while St Luke's House, with only 48 beds, was the smallest of the three homes but seemed to experience the most difficulty in filling them all. The location of St Luke's and its stipulation that patients have less than four months to live may have been partly responsible for its inability to maximise its accommodation. The reports and minute books contain numerous references to the low number of admissions. In 1914 Edmund Barrett wrote that the reason they did not receive more applications was because they were situated in the wrong place: "the patients come from the East End and all the poorer suburbs while we are lodgers in a West End residential square, cramped for room and totally unable to suitably advertise us." He went on to make this the basis of an appeal to the public for money to buy a new home more suitably located.² However, the new premises which was finally built ten years later, was situated only a few doors away from their old address and thus did little to remedy their problems.

As Table 10 shows, St Joseph's Hospice was also the wealthiest of the homes; in 1935 its total income amounted to £18,346, over double that taken by the Hostel of God in 1938 and over three times as much as the sum received by St Luke's.³ Unlike the other two homes, St Luke's found itself facing the threat of war with a very precarious financial situation; in 1938 it had a negative balance of £1,090.⁴ The reasons given in the annual report for this state of insolvency reflected the Home's reliance upon money received from patients and the public authorities, both of which declined considerably during this year.⁵ Despite being the smallest of the homes, St Luke's also had the highest annual expenditure on salaries.⁶ This was probably due to the fact that all its nursing staff were employed from outside the institution, compared to the Hostel of God and St Joseph's where part of the nursing was supplied by the resident sisterhood; for example, in 1938 £1,090 was spent on nursing salaries, compared to

² 21st St Luke's House Annual Report (hereafter SLHAR), 1914, p.13.

³ 'Report for St Joseph's Hospice for the Dying, 1935', pp.14-15 ; Hostel of God Annual Report (hereafter HOGAR), 1938, pp.14-17 ; 46th SLHAR, 1939, pp.24-25.

⁴ 46th SLHAR, 1939, pp.12-14.

⁵ Ibid.

⁶ Ibid., p.25.

Table 10: Income and Expenditure 1938

| | St Luke's House | Hostel of God | St Joseph's Hospice* |
|------------------------------------|-----------------|---------------|----------------------|
| Income | £5,166 | £7,306 | £18,346 |
| Subscriptions and Donations | £1,800 | £2,446 | £2,436 |
| Patient Contributions (St Luke's) | £765 | | |
| Patients in Annexe (Hostel of God) | | £791 | |
| Private Nursing Home (St Joseph's) | | | £2,552 |
| Congregational Collections | | £5 | £133 |
| King Edward Hospital Fund | £50 | | |
| Hospital Sunday Fund | £70 | | |
| Hospital Saturday Fund | £200 | £60 | |
| Hospital Savings Association | £839 | | £240 |
| Public Authorities | £297 | | £649 |
| Flag Day Appeal | | | £1,212 |
| Invested Property | £792 | £3,290 | |
| Bequests | | £570 | £3,076 |
| | | | |
| Expenditure | £6,257 | £6,278 | c£6,500 |
| Surgery and dispensary | £288 | £144 | £267 |
| Domestic | £1,466 | £1,252 | £1,788 |
| Provisions | £1,408 | £1,306 | £2,976 |
| Salaries and Wages | £1,825 | £1,179 | £1,213 |
| | | | |
| Balance | -£1090 | £57 | |

* Figures for St Joseph's apply to 1935 because no information was available for 1938.

£507 at the Hostel of God.⁷ As well as deepening financial insecurities, the very status of St Luke's as a voluntary hospital was under threat from state encroachment. After the Local Government Act of 1929 gave responsibility of the former Poor Law infirmaries to local county councils, St Luke's, which, as chapter 6 has shown, had

⁷ Ibid., p.24 ; HOGAR, 1938, p.14.

been designated a 'non-localised special hospital', became involved in efforts in the 1930s to safeguard the status of the voluntary hospitals.⁸

The more secure financial basis of the Hostel of God was due to a substantially higher income from donations and subscriptions, a large proportion of which came from the Freemasons, money provided by patients in the Annexe, generous legacies, invested property and a wealthy Endowment Fund.⁹ The relative affluence of St Joseph's was also the result of the generous sums given by donors and subscribers and the money received from patients in the Private Nursing Home. The main source of income, however, came from the substantial bequests left to the Hospice.¹⁰ The fact that St Joseph's and the Hostel of God both modified the purposes of their institution over the years, in order to admit patients with other types of condition and to enhance their income, may have contributed towards their long-term success.¹¹

After the establishment of St Joseph's Hospice in 1905 no other homes for the dying, either religious or secular, were founded in Britain until the 1950s when two hospices were set up in Scotland.¹² The question of why their impact was so limited in the early decades of the twentieth century must be examined at two levels; firstly, closer scrutiny of the records of the Homes themselves to see if they offer any insight, and secondly, an investigation of the broader social, medical, religious and philanthropic changes that were occurring during this period.

All three homes were the subject of criticism at some point during the first forty years of their history. The role of critical voices - from whom they came, why and the form taken - is particularly important in assessing the impact of an institution because it may help to reveal possible weaknesses within it and also provide some clues as to how it was received by popular opinion.

⁸ Minute Book of St Luke's Hospital for Advanced Cases Committee of Management 25 March 1931 to 26 April 1939: 23/02/1938, p.86.

⁹ HOGAR, 1938, pp.14-17.

¹⁰ 'Report for St Joseph's Hospice for the Dying, 1935', pp.14-15.

¹¹ St Luke's Hospital for Advanced Cases (renamed Hereford Lodge 1974) closed in 1985. St Joseph's Hospice and the Hostel of God (now Trinity Hospice) still exist today.

¹² St Margaret's Hospice, in Clydebank, in 1950 and St Andrew's Hospice, in Airdrie, in 1957. Both were established and run by the Irish Sisters of Charity.

Both St Luke's and St Joseph's were looked upon with disapproval by some of the local residents because of their choice of title, suggesting that certain members of the public at least did not relish the presence of a home for the dying in their neighbourhood. The decision temporarily to close St Luke's in 1901 was largely the result of a complaint lodged by a local builder that much could be seen in the front wards and on occasion men had been seen sitting at the window smoking and expectorating. He also expressed disapproval at a hearse having been seen at the door of the home at 9:15 in the evening. In an attempt to appease the builder and avert the closure of the Home, the windows were covered with muslin blinds and instructions issued that the patients should never sit in the windows at the front of the house. Arrangements were also made for the removal of the deceased between five and six in the morning before anyone else was about.¹³

Despite all the efforts at discretion, St Luke's was once again the subject of criticism in 1927 when one of the local residents complained about the coughing and vomiting noises of the patients at night. She demanded that something be done and threatened to bring the matter before Princess Margaret, one of the vice-presidents, claiming the Home as a 'public nuisance'. The Committee responded by letter saying that everything would be done that was compatible with the patients' health to mitigate the trouble.¹⁴

The Sisters at St Joseph's were also criticised over their choice of title. Only four months after opening, an article appeared in *The Mercury* denouncing the Sisters' use of the word 'dying' (written on a large board in the garden of Cambridge Lodge), and claiming that this "gloomy and disheartening announcement is very depressing to people who reside in the neighbourhood, especially those who are stricken down by illness." The author suggested that the term 'incurables' would be more suitable and "would still convey the exact meaning the Sisters desire, without the unpleasant

¹³ Minute Book of St Luke's House Committee of Management 15 Nov. 1895 - 19 July 1905: 04/07/1901.

¹⁴ Minute Book of St Luke's Hospital for Advanced Cases Committee of Management 30 April 1925 to 26 February 1931: 12/07/1927, pp.149-150.

reminder that all those who enter the Hospice are without hope.”¹⁵ However, with such popular misrepresentations of the Home’s purpose, retention of the original title remained imperative for the Sisters and, unlike St Luke’s, it was never forced to the point of having to change its name.

Not only did the staff at St Luke’s feel that the sub-title of the Home was received unfavourably by the public, but it was even, on one occasion, the subject of royal reproach. In 1908 the Queen visited the Home and expressed her dislike of the name ‘Home for the Dying Poor’. She asked for the title to be changed to ‘Home of Rest for the Weary’ because the former was “inexpressibly sad and depressing.” Barrett objected to this particular suggestion because it would be far too misleading to the public. A proposal was put forward to consider the name ‘Home of Peace’ but the Friedenheim would not consent to this because it was the same title as their own. The matter was explained to the Queen who, on hearing that as a rule the patients were kept in ignorance of the title of the Home, agreed to the retention of the original name.¹⁶

At the Hostel of God it was not the name of the Home that came up for criticism but the size of the Chaplain’s annual stipend, a substantially higher sum than that paid to the Medical Officer. An article from *Modern Society*, written around 1898, drew attention to the £135 salary received by the chaplain and contrasted it with the combined wages of the medical and nursing staff and the servants, which amounted to only £122. Although the author asserted that he in no way intended to demean the work of the Chaplain or cast aspersions upon the integrity of his motives, he obviously found this financial injustice difficult to accept; “Economic principles can hardly be exposed to a ruder shock.”¹⁷

The ward arrangements at St Luke’s also gave considerable cause for concern. At a meeting of the Committee in 1916 the observations made by a representative of the

¹⁵ Author unknown, ‘Hospice for the dying’, *The Mercury*, 8 April 1905.

¹⁶ Minute Book of St Luke’s House Committee of Management 11 October 1905 to 21 May 1912: 13/06/1908, pp.120-123 ; 14/10/1908, pp.134-135.

¹⁷ Article in *Modern Society*, c1898, no title, author unknown, in Charity Organisation Society Archive, London Metropolitan Archives, ref. A/FWA/C/D211/1.

Charity Organisation Society after a visit to the Home were discussed and then minuted. The visitor commented on the undesirability of having cancer and tuberculosis cases in the same wards, suggesting instead that the Home should have fewer admissions and confine itself to cancer patients. Nothing was done at the time about separating cancer and tuberculosis patients because Howard Barrett did not feel that these arrangements were desirable or practicable in the present premises.¹⁸ Two months later the Matron reported that the Chief Almoner at St Thomas' Hospital had said that the practice of not segregating phthisical and cancer patients was viewed with disfavour by the medical staff and patients' friends. This time the Committee agreed, upon the advice of Barrett, to separate the two types of case as far as possible.¹⁹ However, it does not seem that much effort was put into implementing this. Three years later, in 1919, Edmund Barrett informed the Committee that both St Thomass' Hospital and the Brompton Hospital had ceased sending patients to St Luke's, the latter because patients had complained of being uncomfortable there. Barrett said that he had written to both hospitals and the almoner at the Brompton had replied giving specific reasons for patient discontent; firstly, that the bodies of patients who died in the night were left in the ward until morning and secondly, the presence of cancer and tuberculosis patients in the same wards. He went on to say that definite steps would be taken to redress these which would then be communicated to the Brompton: the scheme for isolating beds with curtains, which at that time was only in operation in one of the wards, would be extended to the other wards as he saw fit and the Matron would be given the task of devising a means for separating cancer and tuberculosis patients, even if at the cost of fewer admissions.²⁰

Individually these criticisms may not appear very significant but collectively they demonstrate that the homes, particularly St Luke's, were not always viewed satisfactorily by either the public or the medical authorities. As chapter 4 has shown, the local government was beginning to make provisions for dying patients and it may be that these institutions were looked upon more favourably than the independent and

¹⁸ Minute Book of the St Luke's House Committee of Management, 18 June 1912 - 27 May 1918: 11/04/1916, pp.217-218.

¹⁹ Ibid: 20/06/1916, p.222.

²⁰ Minute Book of the St Luke's Hospital for Advanced Cases Committee of Management 23 June 1918 - 25 March 1925: 28/11/1919, pp.72-74.

somewhat idiosyncratic initiatives which the homes represented. Their tendency to be inward looking may also have influenced their ability, or inclination, to diffuse their ideas among a wider audience. St Joseph's Hospice and the Hostel of God in particular were focused on a specific style of care which was not easily transferable to non-Anglican or non-Catholic led institutions.

The inability of the homes to make any widespread impact may also relate to broader developments during the late nineteenth and early twentieth century. The homes were founded in what was essentially a transitional period - religion was increasingly challenged by secularism, voluntarism was under threat from collectivism, attitudes towards death and dying were fundamentally altering and assumptions about the poor were changing - suggesting that by the 1920s and 1930s their former relevance had somewhat declined.

The early twentieth century has been characterised by several historians as a period in which social attitudes towards death underwent significant change. The First World War forced a confrontation with death on a scale and in a manner never previously experienced. As chapter 3 has shown, the War had largely undermined the ability of Christianity to provide meaning and solace because it was unable to provide an adequate explanation for the unprecedented grief and mortality that had ensued. David Cannadine has also argued that, while the War led to a mass preoccupation with all forms of death associated with the War, "at the level of particular, domestic, individual experience death from *natural* causes [my italics], as an integral and accepted part of family life, seems to have been less significant than in the period before the first war."²¹ The inadequacy of traditional religion, taken together with Cannadine's argument, might suggest that homes for the dying, particularly ones with a strong religious emphasis, would not have appealed to a generation who had just come through the experience of World War One. It is hardly surprising that after 1918 people could no longer contend with death in their daily lives in the same way that they had a decade earlier. Within this context institutions caring for the dying would

²¹ Cannadine, D. (1981) War, death, grief and mourning in modern Britain, in J. Whaley (ed) *Mirrors of Mortality: Studies in the Social History of Death*. London: Europa Publications Limited, p.232.

perhaps have seemed largely irrelevant when held up against the recent memory of the sudden and horrific deaths of a nation of young, healthy men in the prime of life.

In the early decades of the twentieth century deliberately choosing to die away from home was still a relatively new experience for the respectable poor. Although increasing numbers of deaths were occurring in institutions and hospitals, it was by no means a recognised or common procedure - many people continued to look upon the home as the traditional site of death. As chapter 4 has shown, it was not uncommon for patients to leave because they preferred to die at home. However, as chapter 6 suggested, it was also possible that some people may have looked upon the homes as a way of avoiding direct confrontation with the death of another, especially if that death was premature.

Religious and philanthropic developments during the first decades of the twentieth century also had implications for homes founded upon a strictly religious and voluntary basis. By the early 1920s many of the areas which had formerly come under the umbrella of philanthropy were being taken over by initiatives from local governments and private, professional societies. More importantly, it was seen as their duty to provide these services. Churches were willing to cede responsibility because they realised that other bodies could do it better and they no longer had the financial resources.²² At St Luke's House there is evidence of this declining interest in charitable enterprises. By the late 1920s the Home was having considerable problems generating sufficient support, especially financial income. Unlike the other two homes, it was especially sensitive to wider economic conditions and the depression of the early 1930s gave considerable cause for concern. Throughout this period the Treasurer tried continuously to impress upon the Committee the urgent need to try and interest the younger generation in their work and entreated the governors to think about new ways of increasing subscriptions. At one of the meetings the Treasurer also touched upon another factor which may have contributed to St Luke's ongoing financial problems and to its long-term demise: the loss of earlier charismatic

²² Cox, J. (1982) *The English Churches in a Secular Society: Lambeth, 1870-1930*. Oxford University Press, p.273 ; McLeod, H. (1996) *Religion and Society in England 1850-1914*. London: Macmillan, p.221.

leadership. He contrasted the apathy of the present governors to the gifts of inspiration provided by the Barretts and Miss Don, the late Secretary, particularly when it came to methods of fund-raising.²³

After the War local government authorities even began to assume responsibility for the provision of dying patients. The Medical Superintendent at St Luke's House, in his report for 1921, remarked that, where possible, the various local authorities were finding room for advanced tuberculosis cases in their own institutions.²⁴ As chapter 4 has shown, the post-war period, in response to increased mortality rates from the disease during the war, saw renewed efforts by local authorities to provide for tuberculosis sufferers in an advanced stage of illness. The acquisition of the former Poor Law infirmaries by local authorities in 1929 also meant that there was increased institutional provision for persons suffering from other forms of advanced disease. As the London County Council Medical Officer pointed out in his report for 1925 (see chapter 4), these institutions could be run more efficiently and economically than smaller, voluntary ones because they provided a much higher number of beds and were financed by the local authorities.

By the early twentieth century religious influences no longer carried the same force or operated in the same pervasive manner that they had fifty years earlier. The authority of the Bible had been questioned thoroughly and changing views on hell, judgement and the immortality of the soul greatly undermined many of the former claims held by religion.²⁵ The growing irrelevance of religion in a secularising society meant that, while existing institutions with a primarily religious emphasis were able to survive, often only by accommodating themselves to wider changes, it was increasingly difficult to justify the establishment of new ones run along the same lines.

By the 1920s and 1930s attitudes towards the poor had also begun to change. After the War middle class anxiety about the condition of the poor in London was subsumed within the more urgent problems caused by world depression, a million unemployed

²³ Minute Book of the Annual General Meeting of the Governors of St Luke's House, 16 April 1912 - 20 December 1946; 24/04/1912, pp.143, 151 ; 26/04/1934, p.181.

²⁴ 28th SLHAR, 1921, p.7.

²⁵ Rowell, G. (1974) *Hell and the Victorians*. Oxford: Clarendon Press, pp.4, 212.

and the decay of Britain's staple provincial industries.²⁶ As discussed earlier, the middle classes, by the 1920s and 1930s, were also less disposed to cast judgement on the poor by discriminating between 'paupers' and 'respectable poor'. The improved status of, and standards of care in, the former Poor Law infirmaries, some of which were being used to care for advanced cases, meant that both the working classes and the lower middle classes were more willing to use them.

There is no single factor which explains why the homes were so limited in their impact. By the second decade of the twentieth century conditions had gradually begun to stabilise so that many of the circumstances which had given rise to the need for homes devoted to caring for the dying 'respectable' poor had largely disappeared or were no longer underpinned by the same sense of urgency. Geoffrey Rivett has suggested that one possible reason why reforms do not always succeed is that problems which were pressing at the start can become insignificant by the end and are replaced by new ones. He uses the example of infectious diseases as an illustration, arguing that at one point they were responsible for an entire hospital system but quickly waned in importance with the introduction of public health matters.²⁷ The inability of the homes to make an impact beyond London also owed much to the highly individualistic, inward-looking approach adopted by each institution, particularly the way in which spiritual care was provided. The focus of each home on a particular branch of Christianity, especially St Joseph's and the Hostel of God, would not have sat very comfortably with the more secular-oriented society of 1930s England. In light of this the homes for the dying can be seen as little more than small, isolated pockets of reaction but their very survival and the subsequent role they would come to play in the founding of the modern hospice movement in the 1950s and 1960s stands as a testimony to both the strength of that resistance and to their overall success.

²⁶ Stedman Jones, G. (1984) *Outcast London: a Study in the Relationship Between Classes in Victorian Society*. London: Penguin Books, pp.340-348.

²⁷ Rivett, G. (1986) *The Development of the London Hospital System 1823-1982*. Oxford University Press, p.347.

APPENDIX 1: Methodological Note

This thesis is part of a wider study - the Hospice History Project - which is being directed by Professor David Clark within the Department of Palliative Medicine at the University of Sheffield. The project commenced in 1994 and, until now, has mainly preoccupied itself with the emergence and development of the modern hospice movement in Britain which began in the 1960s. The various misconceptions about the origins of the first 'hospices' in Britain and the very limited understanding of their beginnings were, in part, responsible for the study described here.

As a researcher based in a specialist department of palliative medicine, I had the advantage of working in a multi-disciplinary environment. One of the principal benefits of this was being exposed to a range of different research methods and techniques, particularly those employed by social scientists and clinicians, which in turn enabled me to reflect on my own methodology and to consider where it fitted in with the approaches used by other researchers. One unforeseen, but very fortuitous, consequence of this was finding myself in a situation, regarding a set of patient registers (see the discussion in the following section on St Luke's House), in which I had to rely on a procedure which is far more common to these groups of researchers than it is to historians, and for which I was able to obtain much helpful advice.

Sources

The selection of primary material was principally determined by its availability. During the first twelve months of my PhD a detailed survey was conducted of the sources available for each of the five homes in England and the Hospice in Dublin. At one point the possibility of comparing the development of Our Lady's Hospice in Dublin and St Joseph's Hospice in London was considered. Both institutions were run by the Irish Sisters of Charity and offered potential for contrasting developments in England and Ireland. However, the greater number and variety of sources available for the Hostel of God, St Luke's House and St Joseph's Hospice, together with the fact that each had a different denominational basis, a factor which seemed to have

impacted significantly on their development, provided more scope for a comparative study of three institutions founded in the same city.

The records for St Luke's House and the Hostel of God have both been deposited in a public archive - St Mary's Hospital, Paddington and The Minet Library, Lambeth respectively - and have been well catalogued by the archivists. In contrast, the material for St Joseph's was divided between two sites; the Hospice itself and CARITAS, the central archive for the Irish Sisters of Charity in Dublin. The latter have been catalogued by the archivist but the records retained by the Hospice have not been preserved in any systematic manner. Finding them involved rooting around in a variety of rooms from the filing cabinet in Matron's office to a dusty room in the depths of the basement!

The records kept by each institution vary considerably. At St Luke's the three main collections of primary material are the annual reports, which exist for every year since the Home's foundation; the patient registers, available from 1896 onwards; and the minute books for the various committees. Financial ledgers and cash books have also been deposited in the archive at St Mary's Hospital, along with a scrap book of newspaper cuttings for the years 1901-1929. Unfortunately, gaining access to the patient registers created a few problems; they have been closed to the public for one hundred years because they contain 'sensitive' data on the patients. However, because we only wanted to examine the data in aggregate in order to establish certain trends and patterns, we felt we had a legitimate case for looking at the registers. In order to obtain permission to access them, we had to follow a route that many of the clinicians and social scientists in our department have to take when dealing with sensitive data: application to the Local Research Ethics Committee, an often difficult and lengthy procedure. In due course, however, formal approval of our application to the St Mary's Local Research Ethics Committee was granted in October 1998.

The material retained at St Joseph's Hospice consists of three main types: the convent annals, dating from 1900 onwards; the patient registers, available from 1905 onwards; and newspaper articles, dating from the early 1900s. CARITAS in Dublin also

contains copies of the annals. In addition to these, there is a small notebook entitled 'Notes for Annals of St Joseph's Hospice' which covers the years 1904 to 1909 and differs considerably in content from the annals themselves. Unfortunately, only three of the early annual reports for St Joseph's are still in existence - 1907, 1916 and 1935 - but they do at least cover three out of the four decades of its pre-1938 history. These are also kept at CARITAS together with a few other miscellaneous items such as letters and newspaper cuttings.

The records relating to the Hostel of God are less comprehensive. The two principal deposits are the annual reports and the minute books for the Council and the House Committee. The reports for the very early years are incomplete, but the correspondence records of the Charity Organisation Society concerning the Hostel which have been deposited at the London Metropolitan Archives contain some of the missing reports. This does, however, still leave the following years unaccounted for: 1899-1901, 1903-1905, 1907, 1909-1910, 1913, 1915-1916 and 1918-1919. Patient registers are available, but only from 1927 onwards. Other records include subscription and donation journals and miscellaneous documents relating to the constitution and property valuations.

Aside from conducting a survey of the primary material, the remainder of my first year was spent reading through the relevant secondary literature in order to generate a series of questions which I could use when analysing my own sources. I also wanted to see what methods and approaches have been used by historians researching into similar subjects.

The large part of my second year was taken up looking in detail at all the sources for each home and making comprehensive notes. As I read through the material certain issues and questions were necessarily raised which I then went on to explore using other primary material and secondary sources.

Implications of the nature of the sources for the thesis

The primary material available for each of the three homes was of a fairly limited nature and had certain implications for the way in which this study could be conducted and the questions that could be asked. Social historians of medicine are increasingly aware that to date much of their work provides an elitist view of medical developments and are beginning to advocate the need for a more patient-oriented perspective. However, ideal as it would have been to conduct the latter sort of study, the fact that all of the material available for the homes was compiled by those who ran them necessarily prevented this type of approach. Unfortunately, there were no documents written by the patients themselves or their families so that any glimpses we do have of these two groups are based solely upon the perceptions of those providing the care. Nevertheless, this still offers an extremely interesting insight into the homes during this period and it is not entirely impossible to gain some understanding of the patients' experience.

As mentioned above, the relatively greater variety of primary material available for the three homes was an important factor in determining their selection. Although all the sources were written by those who ran the homes and meant that it would only ever be possible to understand events from their perspective, the fact that they were compiled within a number of different contexts and for a variety of purposes helped to provide a range of viewpoints from which the homes could be examined. The very different purposes and authorship of the sources was instrumental in determining the way in which they were written and had important implications for the way in which their contents could be interpreted historically.

The annual reports were essentially written for the benefit of subscribers and patrons - both current and potential - to justify the existence of the home and to appeal for support, particularly financial aid. The reports for the Hostel of God and St Joseph's Hospice were primarily a record of their administrative work but those for St Luke's for the years 1893 to 1913 were considerably different. The latter were far more substantial compilations which included a lengthy report by the Medical

Superintendent and contributions by other key members of personnel. The reports for the Hostel of God, and in particularly those for St Luke's, played an important role in helping to construct their ideology. In contrast, the Committee minute books, which provide insight into the management and practical workings of the homes, offer a means for comparing ideology with what happened in practice. Unfortunately, the absence of any minute books and most of the annual reports for St Joseph's meant that we had little information on the more practical working of the Hospice and issues relating to its management.

Information on the Hostel of God was also found in some of the copies of *St Margaret's Magazine and Half-Yearly Chronicle* which are still kept at St Margaret's Convent in East Grinstead. The purpose of the *Magazine* was to recount the broader work of the Sisterhood for each half-year. Each edition included reports from some of the branch houses. Although the *Magazine* was published, it was intended primarily for internal readership, particularly the Mother House, although it was probably read by members of other Anglo-Catholic religious organisations. Every few years the Sisters at the Hostel would write a report which focused mainly on the Home's spiritual work and would have been intended to illustrate that it was carrying out the principal objectives for which it had been set up.

The annals for St Joseph's Hospice were written by a member of the Sisters of Charity to be sent to the General Assembly, held at the Sisters of Charity Mother House in Dublin every six years. As such they were only intended for a limited and private audience and would not have been read outside of the sisterhood. Their principal objective was to describe the main events and happenings concerning the Convent and the Hospice during that period and to demonstrate to the Mother House that they were fulfilling their spiritual duties as a Catholic sisterhood working among the dying poor in the East End of London.

The data in the patient registers contains information on each individual patient and can be used to build up an understanding of the various patterns of admission, epidemiology, mortality, length of stay and discharge in each home. Unfortunately, the

registers did not include individual case histories for the patients which meant that most of the information was of a quantitative rather than qualitative nature. Although we could not gain direct insight into the patients' experience, we were able to look at them as a group and to explore changing trends over the years. Likewise, an analysis of the statistical data provided the basis for a more qualitative analysis by allowing us to examine the social, medical, administrative, epidemiological and economic factors which determined admission and discharge policies. It also allowed us to pursue questions as to *why* and *by whom* particular facts were recorded and what they reveal about life in the homes.

The archives for both St Joseph's Hospice and St Luke's House also included a collection of most of the newspaper reports that were published about each institution during the period covered by this study. The majority of these were written by personnel who worked in the home which meant that they too served as a means for portraying their respective institutions in a particular way.

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