

***'A Sense of Mercies':***  
**End of Life Care in the**  
**Victorian Home**

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***'A Sense of Mercies'*<sup>1</sup>:**  
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**Victorian Home**

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<sup>1</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855. Papers relating to Samuel James Allen and Family Acc 100/D2 York City Archive.

## Abstract

At the dawn of the twenty-first century palliative care in England is undergoing significant change. The value of enabling the dying to be able to exercise choice over their place of death and to make death at home an available option has been recognised by hospice professionals for some years and has recently been incorporated into Government policy. To reconsider end of life care in the Victorian period, the last age before hospitals started to be widely regarded as the usual location for death, and when the majority still preferred to, and did, die at home, is therefore both timely and relevant.

This study presents evidence from diaries, letters, novels and visual art, and introduces important and previously unexplored sources. Based on this evidence, it is suggested that the family's central role in the decision making process, and in providing care, allowed them to draw on shared emotional and psychological support and derive comfort from their shared religious beliefs. The wider community of friends, neighbours, extended family and the many middle class women who undertook to visit the sick as a Christian duty, all provided further support to carers and helped to prevent the 'social death' so often experienced by the terminally ill in the twentieth century.

Throughout the nineteenth century Christianity still provided the framework within which most people understood death. Christian end of life care was focussed upon spiritual preparation and gave the dying respect and a dignity conferred by their perceived proximity to God. For carers, emphasis on preparedness provided them with a comforting role praying and reading from scripture with the dying, when otherwise they could feel impotent in the face of untreatable bodily suffering. Contrary to suggestions that Christians disapproved of pain relief, the evidence suggests that pain relief was mostly welcomed once available, but when pain was encountered Christian teachings about its purpose were drawn upon as a source of consolation and strength.

Doctors, although becoming increasingly influential in end of life care provision through an increase in their professional status and an improving ability to provide effective pain management, did not, it is argued, generally exercise the levels of authority and control over the home deathbed that they could later in a hospital setting. These limitations can be observed in the process of negotiation through which diagnosis was arrived at, frequently involving recourse to second opinions, and through the constraints imposed by the lack of effective treatments.

Finally, the persistent preconception that the Victorians were morbidly 'obsessed' with death is challenged. Instead it is suggested that the Victorian response to death was both pragmatic and rational, given its prevalence in their society. Much Victorian language, imagery and behaviour surrounding death was influenced by Romanticism and by notions of 'respectability', which, it is contested, created the false impression of an obsession with death itself.

Through focussing on these aspects this study aims to re-evaluate end of life care in the Victorian home and reveal the neglected positive aspects of such care, many of which are finding renewed relevance today.

# Contents

PREFACE AND ACKNOWLEDGEMENTS .....	i
INTRODUCTION AND LITERATURE REVIEW .....	1
Aims and objectives .....	1
The relevance of this study to contemporary palliative care.....	1
Literature review.....	3
Sources and methodological concerns .....	8
Structure .....	12
CHAPTER ONE: DEATH AND DYING IN VICTORIAN ENGLAND .....	14
Death in Victorian England.....	14
The Victorian response to poverty, filth and disease.....	18
Dirt, miasmas and change in the sickroom .....	21
CHAPTER TWO: CHRISTIANITY AND THE VICTORIAN DEATHBED .....	27
The influence of Christianity in the care of the dying .....	27
Christian philanthropy in the care of the dying .....	31
The role of the clergy in the care of the dying .....	33
The 'good death' .....	38
The 'good death' transformed .....	53
CHAPTER THREE: MEDICINE AND THE VICTORIAN DEATHBED .....	60
Medical status and authority in Victorian England .....	60
The role of doctors in the care of the dying.....	68
Negotiating diagnosis and breaking bad news.....	72
Recourse to second opinions .....	80
The limitations of treatment.....	83
Reliance on Druggists and Quacks .....	87
The role of professional nurses in the care of the dying.....	89
Transformations in the care of the dying: advances in pain relief.....	91

Transformations in the care of the dying: the role of the hospital.....	94
CHAPTER FOUR: FAMILY- LED CARE .....	100
Caring for the dying as a gendered experience .....	101
The importance of the bedside vigil.....	105
The role of absent relatives and friends .....	108
Romanticism, sentimentality and an obsession with death? .....	110
The attitude of the poor toward care of the dying .....	120
CONCLUSIONS .....	125
BIBLIOGRAPHY.....	131
Manuscript Sources.....	131
Published Sources .....	133
Secondary Sources .....	136
On-line Resources .....	145
APPENDIX A .....	i
APPENDIX B .....	iv
APPENDIX C .....	viii
APPENDIX D .....	ix
APPENDIX E.....	x

*“A place to stay untouched by death*

*Does not exist*

*It does not exist in space, it does not exist in the  
ocean,*

*Nor if you stay in the middle of a mountain”<sup>1</sup>*

Buddha

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<sup>1</sup> His Holiness the Dalai Lama *Advice on Dying and Living a Better Life*. Trans. Hopkins, J., Rider, London, 2002, p.40.

## PREFACE AND ACKNOWLEDGEMENTS

*'To conjure, even for a moment, the wistfulness which is the past is like trying to gather in one's arms the hyacinthine colour of the distance. But if it is once achieved, what sweetness! – like the gentle, fugitive fragrance of spring flowers, dried with bergamot and bay.'*<sup>1</sup>

Mary Webb

Mary Webb spoke here of the difficulties and rewards of writing historical fiction, but her words can equally be applied to historical research, for she beautifully captures the joy of those fleeting moments when historical sources can bring the past vividly alive once again. Nowhere is this truer than in the accounts of last illness and death, where alongside the minutiae of daily existence, are revealed the innermost feelings, hopes, fears and private thoughts of our predecessors in the face of personal calamity.

The Victorian age has now passed beyond any living memory, but as a child of the 1960s, in my youth it endured still as fading memories in the mind's eye of grandparents and great aunts. It was the recollections of these elderly relatives of their Victorian childhoods that first ignited my interest in nineteenth-century history, and through whom I first sensed this 'fugitive fragrance of spring flowers'.

Over the years I have discovered traces of the Victorian age remaining still in shadowed corners left behind by a century of profound change: in the decaying architecture of the old Liverpool Street station, the lingering smell of coal dust in the Stratford marshalling yards, in my grandmother's immaculately kept parlour of her red-brick Victorian terrace house, and in the faded but imposing memorials of the City of London Cemetery. Walking through its avenues lined with horse chestnut and lime, reading the names and epitaphs, conjured the imagination to dwell upon the lives of those who lay forgotten beneath the fabulously ostentatious monuments of granite and marble. The need to know better the people of this age, who brought Britain to the zenith of its splendour and global power, but whose world it seemed was one of hardship, poverty and inequality, has been an enduring quest.

Those I knew who could remember the Victorian age have themselves all gone now, as has much of the old East End of London, but the Victorians live on through the

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<sup>1</sup> Webb, M. *Precious Bane*. Jonathan Cape, London, 1939 [1924], p.11.



literature, art, correspondence and diaries they left behind, which still provide a sense of their times as they had lived them.

As to why this study has chosen death and dying as its subject, its inspiration comes from two directions: firstly, from a belief that it is in their attitudes toward death that the Victorians have been at their most misunderstood and secondly, through a belief that the Victorian way of family-led end of life care, located in the home, and supported by extended family and community networks, provides a model that is both relevant and useful to modern palliative care practice.

There are many people to thank, without whom this study would either not have been possible at all, or would have been a much diminished effort. Firstly, my grandmother Florence Edmunds and my great aunt Sarah Knapp, who unknowingly provided the inspiration, my school history teacher Peter Sillis, who nurtured my interest in history through such difficult times, my friends and the tutors at the University of Worcester, in particular Dr Darren Oldridge and Dr Frank Crompton, for their invaluable support and advice and for believing in this project at times when I did not, Paul Simmons for the kind donation of his library and his help with proof-reading, Heather Campbell at St. Richard's Hospice for the opportunity to teach my subject, to Dr Michael Harper and Reverend David Knight at St Richard's Hospice for their encouraging and insightful comments in response to this thesis, the friendly and ever helpful staff of York, Gloucestershire, Herefordshire and Worcestershire archive and record offices, Dr Julie-Marie Strange and Dr Stephanie Snow for their positive responses to my initial research proposal, my mum, without whose financial support this could never have happened, and to finally my dear Sarah, and to Rob, Martha and Nick, who have sacrificed such a lot for me to be able to do this. Thank you all.

## INTRODUCTION AND LITERATURE REVIEW

### ***Aims and objectives***

The aim of this study is to examine how the dying were cared for in the Victorian home. It will examine the objectives of care, the attitudes and beliefs that underpinned it, and the factors that determined the form it took. It will also examine how each of these factors may have changed over time and may have differed between different groups in society. The study will consider the roles played by the professionals involved in end of life care: clergymen, doctors and nurses, and also the roles of family, friends and members of the local community, exploring how they interacted and the changing influence each of them had over the deathbed.

The study has four principal objectives. Firstly, to chart the changes that occurred during the Victorian period to help create the foundations of modern palliative care. Secondly, to demonstrate the many positive aspects of Victorian end of life care that may have relevance to modern practice, such as its location in the home and the leading role of families in decision making and in providing care, drawing upon extended family, the local community and a shared Christian faith for support, direction and guidance. Thirdly, to consider the extent of, and limitations upon, medical power and authority over the deathbed with reference to the process of diagnosis, recourse to second opinions, and the limited effectiveness of treatments. Key factors will be identified that, it is argued, contributed to the increased medicalisation of end of life care by the end of the century: the increasing professional status of medicine, the ability of doctors to control pain more effectively, and the growth of hospitals. Finally, the study will draw upon accounts of last illness from the period to challenge the perception that the Victorians were 'obsessed' with death.

### ***The relevance of this study to contemporary palliative care***

The sociologist Philip Mellor has observed that 'death is one of the very small number of universal parameters within which individual and social life is constructed'.<sup>1</sup> For this reason, the different ways in which individuals in a particular society respond to death can tell us much about the prevalent beliefs and values of that society at different points in time. In 2008 most deaths in Britain occurred in hospital (58%). Only 18% of

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<sup>1</sup> Mellor, P.A. Death in High Modernity: the contemporary presence and absence of death In Clark, D. (ed.) *The Sociology of Death: theory, culture, practice*. Blackwell, Oxford, 1993, p.27.

deaths were at home.<sup>2</sup> Death in a hospital environment often means death in the company of strangers in the form of professional nurses and doctors, rather than in the company of close family members, with what are now identified as negative consequences for the dying person and for relatives. Elisabeth Kübler-Ross, a pioneer in the re-evaluation of the place of death in Western society, identified that 'dying becomes lonely and impersonal because the patient is often taken out of his familiar environment and rushed to an emergency ward'.<sup>3</sup> Furthermore, the impersonal clinical environment of many NHS hospitals appears from recent evidence to be un-conducive to enabling the terminally ill and very elderly to die with dignity and appropriate care.<sup>4</sup>

For the majority of Victorians, death occurred at home in familiar surroundings and in the company of close family and friends. The benefits of such a death for the dying and the bereaved have been understood by the hospice movement for some years. Julia Neuberger, for example, has argued that in twenty-first century Britain, the kind of death people aspire to is now one where:

'Death will happen in our homes, with us there holding the hands of our dying family members. It will happen in the presence of children. It will be considered as normal as it once was, not something one has to leave home to do. There will be expert professional help available, with Macmillan and other hospice home care nurses, with people who can give families a break, who know how to alleviate pain and discomfort, but they will come to the home...if we are to die well, we must be given the choice of dying at home'.<sup>5</sup>

This is a death that the late Victorian middle classes would have found entirely familiar, but it is only recently that its value has been recognised in government policy. The 2008 *End of Life Care Strategy* cited four components necessary for a 'good death':

'Being treated as an individual, with dignity and respect;  
Being without pain and other symptoms;  
Being in familiar surroundings; and  
Being in the company of close family and/or friends.'<sup>6</sup>

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<sup>2</sup> Department of Health *End of Life Care Strategy: Executive Summary*. Department of Health, London, 2008, p.3.

<sup>3</sup> Kübler-Ross, E. *On Death and Dying*. Routledge, London, 1973, p.7.

<sup>4</sup> Care Quality Commission *Dignity and nutrition inspection programme: National Overview*. CQC, Newcastle-upon-Tyne, 2011.

<sup>5</sup> Neuberger, J. *Dying Well: a guide to enabling a good death*. 2<sup>nd</sup> edition. Radcliffe, Oxford, 2004, p.15.

<sup>6</sup> Department of Health, *op. cit.* p.3.

Given these developments, now is perhaps a timely and important moment to look back upon the Victorian era, when home death was last the norm and these conditions last formed the basis of a 'good death', and to chart the origins of its decline in favour of the hospital alternative.

### ***Literature review***

Until relatively recently death was a neglected aspect of Victorian history. It was only when social history rose in prominence with the new historicism of the 1960s and 70s that it appeared on the historical radar as a subject of interest. It was attempts by psychologists to understand grief in bereavement and the value of mourning ritual to the grieving process that initially ignited interest. However, it is mourning and funerary practices, the most obvious area in which to demonstrate difference between the Victorians and ourselves, that have subsequently attracted the most interest from historians. In recent years though, interest in Victorian end of life care has increased and has come from fields as diverse as social and medical history, sociology, anthropology, psychology and literary studies.

The modern historiography arguably began in 1965 when anthropologist Geoffrey Gorer suggested that contemporary attitudes to death compared unfavourably with those of the previous century. Death, Gorer hypothesised, had become hidden and problematic, creating what he termed the 'pornography of death', and leaving the bereaved socially isolated. Gorer believed that 'if we dislike the modern pornography of death, then we must give back to death – natural death – its parade and publicity, readmit grief and mourning' and alluded to the Victorian age as being one where grief and mourning had been so admitted.<sup>7</sup> This analysis was supported by Philippe Ariès, who was again critical of modern attitudes that perceive death as a shameful and fearful experience, thereby isolating the dying and giving the bereaved little space and time to grieve.<sup>8</sup>

Gorer and Ariès' valuable pioneering work is widely acknowledged, but both have been criticised for viewing the Victorian period as a 'golden age' of mourning without providing substantive evidence to support their claims. David Cannadine, for example,

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<sup>7</sup> Gorer, G. *Death, Grief, and Mourning in Contemporary Britain*. Cresset Press, London, 1965, p.175.

<sup>8</sup> See Ariès, P. *Western Attitudes toward Death from the Middle Ages to the Present*. Trans. P.N. Ranum (Marion Boyars, London, 1976).

has claimed that their work 'makes assumptions about the functional and therapeutic values of the elaborate death-bed, funerary and mourning rituals which are unproven'.<sup>9</sup>

The debate took a slightly different turn in the early 1970s with the publication of John Morley's *Death, Heaven and the Victorians* (1970) and James Stevens Curl's *The Victorian Celebration of Death* (1972). Morley's primary interest was in Victorian mourning ritual, but in attempting to contextualise some of the 'more astonishing objects' associated with Victorian mourning, he started to identify the social, cultural and economic circumstances that produced the Victorians' attitudes toward death.<sup>10</sup> Curl saw the Victorian period as a halcyon age of memorial architecture and identified the importance of Romanticism to understanding Victorian mourning and funerary rituals. Curl also unashamedly compared contemporary attitudes to the dying unfavourably with those of the Victorians:

'The dignity which should be given and accorded to those who grow old or those who die has been reduced to considerations of giving the minimum physical comforts to those who are no longer economically productive, and of disposing of the refuse once life is extinct. This deprivation of dignity is a subject for sober reflection, and is expressed in institutional hospital-wards, 'old people's "homes"', municipal lawn-cemeteries with no character at all, and incinerators of the dead'.<sup>11</sup>

In focusing on the memorials to the Victorian dead Curl underplayed the negative aspects of Victorian mourning, such as its disproportionate and stifling burden upon women, the stigma attached to a pauper burial and the exploitative practices of Victorian undertakers. He did however, like Morley, identify the importance of middle class notions of respectability in understanding Victorian behaviour toward death.

In 1981 David Cannadine challenged such nostalgia for the Victorian age with a more critical examination of Victorian mourning. Cannadine claimed that 'the conventional picture of death in the nineteenth century is excessively romanticized and insufficiently nuanced'<sup>12</sup>, arguing that the Victorians were 'not particularly successful in coming to terms with death'.<sup>13</sup> Cannadine identified the Great War as a pivotal moment in

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<sup>9</sup> Cannadine, D. War and Death, Grief in Modern Britain In: Whalley, J. *Mirrors of Mortality: Studies in the Social History of Death*. Europa, London, 1981, pp.188-189.

<sup>10</sup> Morley, J. *Death, Heaven and the Victorians*. Studio Vista, London, 1971, p.6.

<sup>11</sup> Curl, J.S. *The Victorian Celebration of Death*. Sutton, Stroud, 2000 [1972], p.266.

<sup>12</sup> Cannadine, *op. cit.* p.188.

<sup>13</sup> *Ibid.* p.242.

changing attitudes to death in Britain, suggesting that the ostentatious celebration of death and prolonged periods of public mourning ceased to make sense in the face of industrialised warfare. He concluded by arguing that 'contrary to both the received view and the prevailing nostalgia, the best time to die and grieve in modern Britain is probably now'.<sup>14</sup>

At a similar time, David Vincent sought to challenge the idea of a 'Victorian' attitude to death by illuminating the differences between middle and working-class responses to death and arguing that 'the key factor controlling the nature and variation of the response to bereavement was how death interacted with poverty'.<sup>15</sup> Whilst Vincent was right to challenge the assumption that the middle-class 'celebration' of death was shared by the working class, he treated working class attitudes as being largely homogenous, arguing that 'not many working men could afford the luxury of investing so much emotion in a child' and 'the loss of a close relation was so bound up with the material problems of life that at its worst it seemed no more than an intensification of the misery of existence'.<sup>16</sup>

This interpretation has been challenged by Julie-Marie Strange, who has sought to emphasise the diversity of working class responses and to challenge the notion that the poor were fatalistic toward death. Strange was critical of Vincent, arguing that he 'seems to deny the working-class autobiographer the capacity for human emotion which he implicitly confers on those in wealthier circumstances'.<sup>17</sup> Strange also questioned the use of a 'theoretical framework that conceives of the pauper and private grave as social and economic opposites', instead arguing 'for a flexible and inclusive definition of a working class culture of death which seeks to privilege alternative languages of loss'.<sup>18</sup>

One of the most significant contributions to the historiography of Victorian attitudes to death was Pat Jalland's *Death in the Victorian Family* (1998). Although Jalland, like

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<sup>14</sup> *Ibid.* p.189.

<sup>15</sup> Vincent, D. *Bread, Knowledge & Freedom: A Study of Nineteenth-Century Working Class Autobiography*. Methuen, London, 1981, p.58.

<sup>16</sup> *Ibid.* p.59.

<sup>17</sup> Strange, J.M. *Death, Grief and Poverty in Britain, 1870-1914*. Cambridge University Press, Cambridge, 2005, p.11.

<sup>18</sup> *Ibid.* p.21, p.26.

Morley and Curl, devoted most of her book to Victorian mourning practices, several chapters were given to the care of the dying and a chapter to the Evangelical model of a 'good death'. Jalland asserted that 'the major motors of change affecting attitudes to death between 1830 and 1920 were the transformation in religious beliefs and the demographic pattern, both reinforced by the trauma of the Great War'.<sup>19</sup> Jalland shifted the emphasis away from generalised discussion of Victorian funeral and mourning practices to trying to understand how particular families responded to death. She presented the Evangelical model of a 'good death' as being the most influential factor in understanding how most Victorian Christians prepared for death and cared for their dying.

Julie-Marie Strange has however seen this focus on Evangelical interpretations of a 'good death' as limiting and has questioned 'how useful a single model is in exploring what must have been a highly individual and diverse experience'.<sup>20</sup> Jalland's study was restricted to upper and upper-middle class families and although she acknowledged that 'there were enormous differences between the upper and lower classes in attitudes and customs relating to death and in the management of the dying', without explaining in detail what these differences were, it is difficult to assess from her work how influential Evangelicalism was outside of the social elite covered by her study.<sup>21</sup>

Strange attempted to fill this gap left by Jalland's study by examining working class experience. Whilst Strange commendably challenged stereotypes of working class attitudes to death founded in middle-class fiction and the reports of utilitarian and philanthropic reformers, who often viewed the working class as a homogenous entity, her evidence base was heavily reliant upon published autobiography, reflecting the paucity of working class testimony in an age before mass literacy and leisure time.

Between Jalland's study of the upper and upper-middle classes and Strange's investigation of working class experience the historiography remains at present incomplete, with relatively little attention having been paid to the experiences of the 'middling sort'.

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<sup>19</sup> Jalland, P. *Death in the Victorian Family*. Oxford University Press, Oxford, 1996, p.2

<sup>20</sup> Strange, J.-M. Death and Dying: Old Themes and New Directions *Journal of Contemporary History*, Vol.35, No.3 (July, 2000), p.496.

<sup>21</sup> Jalland, *op. cit.* p.1.

Turning to the historiography of Victorian medicine and its role in end of life care, in the early 1960s Michel Foucault offered a groundbreaking interpretation of medicine's professional emergence in eighteenth and nineteenth century France in *The Birth of the Clinic* (1963). Foucault identified the influence of Enlightenment scientific rationalism and the development of teaching hospitals, founded on scientific principles and knowledge gained through anatomy, as important in redefining the role of medicine in society. He claimed that in the late eighteenth century the medical profession reinvented itself by throwing off the shackles of both classical medical theory and religion. In so doing it created a new form of institutionalised, scientific, professional medicine that was able to categorise, control and survey the sick, defining them as 'patients' and in terms of their condition, rather than holistically as individuals. For Foucault, legislation to regulate the profession served the interests of the medical elite, allowing them to exclude alternative discourses and exercise power through a medicalised discourse only accessible to those who had their approval (which could only be gained through examination and qualification in the forms of medicine they sanctioned).

Foucault's theories have always been controversial as they suggest that medical 'truth' is social constructed and thus challenge the concept of medical progress as a scientifically driven imperative. Marxists criticise Foucault's lack of emphasis on social class as a means of preserving and disseminating the power of professional elites.<sup>22</sup> Deborah Lupton meanwhile has criticised a failure 'to acknowledge the interpersonal aspects of the medical encounter, the mutual dependencies that doctors and patients have upon each other and the emotions and desires that motivate behaviour'.<sup>23</sup> Foucault's somewhat arbitrary and cursory attention to historical sources has also met with criticism.<sup>24</sup> This study will partly examine the extent to which Foucault's theories can be supported when applied beyond the institutional setting in which he framed them to end of life care located in the Victorian home.

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<sup>22</sup> For a full discussion of Foucault's relationship with Marxism see Poster, M. *Foucault, Marxism and History: Modes of Production versus Modes of Information*. Polity Press, Cambridge, 1984.

<sup>23</sup> Lupton, D. Foucault and the medicalisation critique In: Petersen, A. and Bunton, R. (eds.) *Foucault, Health and Medicine*. Routledge, London, 1997, p.104.

<sup>24</sup> Oksala, J. *How to Read Foucault*. Granta Books, London, 2007, p.23.



Since the 1970s the study of attitudes to death has become increasingly interdisciplinary. Sociology, psychology, anthropology and literary studies continue to offer theoretical perspectives that can enhance understandings of attitudes to death in the past. The move away from an assumption of 'progress' in history has perhaps enabled a more sympathetic interpretation of our ancestors' care of their dying. At the same time modern grief and bereavement theory has helped to contextualise and explain the Victorian response to death. The sociologist Tony Walter, for example, has argued that through the enduring influence of eighteenth-century Romanticism 'the Victorian period positively celebrated marital affection and encouraged individuals – especially women – to invest all their emotional energies in spouse and children' with the result that 'this led in the nineteenth century to an obsession with the death of the other'.<sup>25</sup> Walter identified the value of the Victorian emphasis on home death and family support networks, which he argued, helped to extend 'social life so that the person remains socially alive as far as possible until the moment of physical death'.<sup>26</sup>

### ***Sources and methodological concerns***

This study has gathered evidence from a diverse selection of sources, but has focussed on introducing previously unexplored material from the archives of the three counties of Gloucestershire, Herefordshire and Worcestershire. Some sources that have appeared in previously published work have been revisited for the depth of insight they provide, or because they have featured so strongly in the arguments put forward in others' work. Thus, accounts from unpublished letters and diaries are included alongside material from familiar novels by Dickens, Gaskell and Hardy, and the investigative journalism of Mayhew, Thomson and Smith and Jack London. The study has also explored published diaries and journals from the Victorian period, which had yet to be used in this context.

A study of this kind presents a number of methodological concerns. Attempting to understand accounts of end of life care in the Victorian period inevitably involves interpreting subjective emotional responses, founded in the complex individual belief systems of people now long dead. As Keir Waddington has noted, 'experiences of

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<sup>25</sup> Walter, T. *On Bereavement: The Culture of Grief*. Open University Press, Buckingham, 1999, p.35.

<sup>26</sup> *Ibid.* p.50.

illness are essentially personal and hard to quantify'.<sup>27</sup> What was physically done in caring for the dying was the manifestation of beliefs and attitudes that will always be obscured, and were subject to the particular structural influences and discourses of their time and place, and, of course, 'we must consider the author's motives, ignorance, or capacity for self-deception'.<sup>28</sup>

To attempt to generalise beyond the specific individuals and families in question is fraught with difficulty. As Keith Jenkins observed, 'we read the world as text, and, logically, such readings are infinite'.<sup>29</sup> Nevertheless, these first-hand accounts provide a unique perspective on end of life care that cannot be rivalled by other sources. Even accounts written retrospectively from memory can offer important insights, despite precise details sometimes becoming distorted by time and hindsight.

It is clear that some families were more disposed toward recording and keeping accounts of the deaths of loved ones than others and the question has to be asked as to why they did this and whether their actions were atypical?

It can be expected that large numbers of accounts of last illness written in the Victorian period have been lost or destroyed over the passage of years, which suggests such practices were perhaps widespread, given the relatively high number of surviving accounts. Unsurprisingly, the majority of these come from educated and affluent families. The motives for writing and keeping them appear varied: some were clearly acts of religious devotion, some acted as *memento mori*, and most were part of a 'normal' grieving process. The aristocracy may also have kept such accounts as part of the ongoing process of recording their lineage. Overall, there is nothing to suggest that the accounts that have survived are not representative, their diversity in fact suggesting the contrary.

All of these accounts, even if not always an accurate record of what actually happened, or was felt, can still at least point to what the author perceived should have happened or been felt. As such, they can illuminate the values and beliefs that were personally important to them and to the social world they inhabited at the time. Although it is

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<sup>27</sup> Waddington, K. Health and Medicine In: Williams, C. (ed.) *A Companion to Nineteenth-Century Britain*. Blackwell, Oxford, 2007, p.413.

<sup>28</sup> Brundage, A. *Going to the Sources*. 4<sup>th</sup> edition, Harlan Davidson, Wheeling ILL., 2008, p.22.

<sup>29</sup> Jenkins, K. *Re-thinking History*. Routledge, Oxford, 1991, p.11.

never fully possible to discover all the intricacies of an individual's personality, or of their world view and experiences, a sense of what mattered to them can be gleaned. The accounts identified for this study do demonstrate the presence of widely shared understandings of, for example, what constituted a 'good death'. They also identify the existence of shared frameworks of beliefs, through which the objectives of end of life care were constructed and shared emotional, psychological and practical support could be accessed by the dying and their carers.

The length of Victoria's sixty-four year reign demands that this study sets manageable and meaningful boundaries. Consequently, it does not attempt to examine bereavement and mourning, subjects that have received considerable attention already, most notably from James Stevens Curl, John Morley, Julian Litten, Pat Jalland and Julie-Marie Strange.<sup>30</sup> The study is also focused on death in the Victorian home and does not concern itself with sudden deaths in the workplace or in battle, deaths in hospitals, or in workhouse infirmaries. As the study concerns care in the home and avoids these other locations for death, it can reflect only one dimension of the multitude of differing experiences of dying in Victorian England. This approach has been taken to enable sufficiently in-depth analysis and because, as previously mentioned, home death has a particular relevance to contemporary debates in palliative care.

The disadvantages of this narrowing of focus however need to be recognised. Home deaths were clearly not representative of the full spectrum of deaths in Victorian England and were not evenly distributed across the population. Many of the poorest died in workhouse infirmaries, many of those injured at work in voluntary hospitals, and many of the richest at private establishments located at spa towns and mountain retreats in Britain or abroad.

The study is also limited to English sources and, as mentioned previously, predominantly from the archives of Gloucestershire, Herefordshire and Worcestershire. Although most of the families included led quite cosmopolitan lives, it should be remembered that significant cultural, religious and economic differences existed between the regions of Victorian England, as they do today, and therefore a degree of caution is required if attempting to generalise from the evidence presented.

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<sup>30</sup> See Litten, J. *The English Way of Death: The Common Funeral Since 1450*. Robert Hale, London, 1991.

Wherever possible the study introduces previously unexplored sources, against which interpretations reached by historians based upon other evidence can be tested. It also seeks to explore the influence of the medical profession from the point of view of patients and their carers rather than, as has so often been the case in the past, doctors. As mentioned previously, some familiar deaths, real and fictional, such as that of Prince Albert, of Dickens' Little Nell, and of Charlotte Brontë's Helen Taylor, are included because of their influence at the time or because of their importance to the historiography of the subject. Particularly illuminating accounts from outside of the three counties are also included, such as the death of the missionary Isaac Allen who died at Poona, India in 1855.

Although the study relies heavily upon diaries and personal correspondence, as this evidence potentially offers the clearest insight into the beliefs and motivations of the dying and their carers, it is supplemented by material from newspapers, novels and visual art. The use of fictional material presents methodological concerns, as fictional deathbed scenes served the purposes of the author's plot and character development as much as they reflected 'real life'. Having said this they can still be valuable, as they were clearly intended to connect with readers on an emotional level and for these scenes (which were such a common convention of Victorian fiction) to work they had to be plausible. To be so, they had to be in tune with the beliefs, opinions and values of readers, and for this reason 'popular literature...can tell us much about a society's common, unexamined assumptions'.<sup>31</sup> Geoffrey Gorer recognised that:

'...one of the reasons...for this plethora of death-bed scenes - apart from their intrinsic emotional and religious content - was that it was one of the relatively few experiences that an author could be fairly sure would have been shared by the majority of his readers'.<sup>32</sup>

There was clearly a complex and symbiotic relationship between the deathbed of reality and fiction, but as Penny Kane argued 'novels are...a rich source of information about how people lived at the time, and what they thought'.<sup>33</sup>

It should be noted that the working classes are under-represented in this study and this is recognised as a significant limitation. What is known about their living conditions and financial resources would, in itself, have made end of life care very different to that

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<sup>31</sup> Brundage, *op. cit.* p.23.

<sup>32</sup> Gorer, *op. cit.* p.172.

<sup>33</sup> Kane, P. *Victorian Families in Fact and Fiction*. Macmillan Press, London, 1995, p.x.

possible in middle- and upper-class homes. Unfortunately, the working classes, in an age when literacy and leisure time were only beginning to become available to them, left little record of their lives. What it is important to acknowledge is that the working class was not a homogenous entity and there could be significant differences in virtually every aspect of care between skilled artisans and unskilled labourers, and between different families of the same class. Where working class testimony has been found it has been included, but it is not in sufficient quantity to make confident generalisations.

### ***Structure***

Chapter one of this study attempts to provide the context in which care of the dying in the Victorian home should be understood. Firstly, it looks at the main causes of mortality in Victorian England and how these differed from today and changed over time. It examines the impact of industrialisation and urbanisation on public health and the response of the Victorian middle class and of government to poverty and disease. The chapter then considers the changes in the Victorian home that were to have a profound impact upon the quality and type of care that could be provided, examining also the miasma theory that underpinned the war on filth, and which helps to explain much of the behaviour and decisions of carers in the sickroom. It also examines social changes that occurred in the Victorian period, whereby the home became an increasingly private space, starting a process of distancing death from the wider community.

In chapter two the focus is on the role of Christianity in end of life care and the extent of its influence, even upon families that were not devout Christians. It will be argued that even after its early-century revival had begun to decline, Christian doctrine and imagery continued to exercise a powerful and enduring influence over the care of the dying, the nature of preparations for death and the choices made by carers and the dying. The chapter also discusses the influence of the Christian tradition of visiting the sick and dying, which was enthusiastically taken up by legions of predominantly middle class Victorian women, as well as the clergy, and which, it is argued, provided invaluable practical, emotional and spiritual support to the dying and their carers. The chapter explores the concept of a 'good death' in detail, identifying its features and their significance, and seeks to demonstrate its importance as an objective of care. It will attempt to show how alternative forms of 'good death' were important beyond the confines of Evangelicalism, with which the concept is usually associated, and to

demonstrate both change and continuity in what constituted a 'good death' during the Victorian era.

Chapter three examines the role of medical professionals in end of life care and seeks to identify the extent and the limitations of medical power and authority. It considers the causes and significance of medicine's rise in status during the nineteenth century and how this affected the role of the doctors and nurses in end of life care. The chapter then looks at the limitations of medical power by focussing on the processes of diagnosis, breaking bad news, the frequent resort to second opinions and the effectiveness of treatments. Finally, the chapter considers the contribution of increasingly effective pain management and the rise of the hospitals to an increasing medicalisation of end of life care by the end of the century.

In chapter four the role of the family in the care of the dying is explored. The chapter looks at the respective roles of male and female carers, and the perhaps surprising degree of autonomy exercised by the latter. It also seeks to demonstrate the ways in which carers were supported by extended family networks and members of their local community. The chapter considers the impact of the enduring influence of Romanticism over the Victorian middle classes, which helped produce the characteristically sentimental and melancholy Victorian response to death, so often confused with 'obsession'. Finally, It considers the extent to which the poor may have been fatalistic in their attitudes toward death.

Finally, the objectives of the study are revisited and conclusions suggested from the evidence explored in the previous chapters. Through the examination of previously unexplored accounts of end of life care in the Victorian home, it is hoped that a fresh perspective can be offered, in which the positive elements of Victorian care can be demonstrated. By so-doing, it is hoped that an objective understanding of the dynamics of end of life care in Victorian England can be reached, that has relevance and resonance to today's palliative care debates.

## CHAPTER ONE: DEATH AND DYING IN VICTORIAN ENGLAND

This chapter examines some of the key features of the context in which end of life care in the Victorian home should be considered. The chapter will examine how the frequency of premature death and the nature of the diseases that caused it, shaped Victorian attitudes towards death, dying and care of the sick. It will show how a succession of epidemics struck fear into the populace and exposed the extent of medical impotence in the face of killer infections, driving central and local government to embark upon public health reforms and civic improvement projects that eventually contributed to a consistent, if uneven, fall in mortality rates. It will also be shown how Victorian understandings of disease transmission influenced how the dying were cared for, and how improvements in the home changed the practice of end of life care in the latter part of the nineteenth century.

### *Death in Victorian England*

The inter-related processes of industrialisation and urbanisation that began in the mid-eighteenth century, intensified and gathered pace in the Victorian period, resulting in a rapid and haphazard growth of British cities that 'fundamentally affected the everyday environment of the mass of people'.<sup>1</sup> When Helen McKenny, the daughter of a Methodist minister living in London's City Road, wrote in 1886 of the 'great rush and excitement' of the age 'so different to the quiet of the last century' her views were shared by many who were increasingly uncomfortable and fearful of the world they had created.<sup>2</sup>

A transport revolution, and the levels of international trade associated with industrialisation, allowed the rapid spread of contagious diseases around the globe. The overcrowding, filth and squalor associated with urbanisation allowed these diseases to flourish and urbanisation certainly contributed to both the prevalence and morbidity of epidemic disease in Victorian England. As a result, the Victorians 'found themselves chastened by scorpions that they themselves had created' and were

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<sup>1</sup> Woods, R. and Woodward, J. (eds.) *Urban Disease & Mortality in Nineteenth-Century England*. Batsford, London, 1984, p.20.

<sup>2</sup> Binney, A. and Vickers, J.A. (eds.) *A City Road Diary 1885-1888: The record of three years in Victorian London by Helen G. McKenny*. 2<sup>nd</sup> edition. WMHS Publications, London, 1978, p.30.

acutely aware of this fact.<sup>3</sup> Death before old age was commonplace, even usual, and although 'where one lived in Victorian England critically affected not only one's life chances [and] also the manner in which death might occur', the sense that death was ever near was almost universal.<sup>4</sup> In the 1840s, average life expectancy at birth was 40 for males and 42 for females.<sup>5</sup> When Hannah MacDonald wrote in her diary in 1852 that 'we spend our years as a tale that is told to teach us to number our days that we may apply our hearts unto wisdom' she wrote knowing that, even in a prosperous upper-middle-class family such as hers, death constantly lurked in the shadows.<sup>6</sup>

When death occurred, it usually occurred in the home and, in overcrowded working class homes, it also happened in front of everyone. It could not be avoided or hidden away and caring for the sick and dying was often accompanied by fear of infection. Contagion was not properly understood and families, especially of the working class, lacked the means and knowledge to stop the spread of disease. No-one knew who would be struck down next, or how to prevent it happening, and if the breadwinner was the one dying, it was also accompanied by the fear of destitution and the workhouse.

The very young were especially vulnerable with 100,000 infants under one year old dying each year in Victorian Britain and the death of a child was a real danger for families of all social classes.<sup>9</sup> Archibald Tait, the future Archbishop of Canterbury, for example, lost five of his seven children in five weeks to scarlet fever in 1856. Children were also at risk from measles, whooping cough, diphtheria, tuberculosis and diarrhoea, and when Helen McKenny, wrote in 1887 of a family that 'had buried eight children, none living', this was a tragic, but far from unprecedented, case.<sup>10</sup> Hannah MacDonald's diary entry for her son's birthday in 1838 read: 'My dear little Henry's

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<sup>3</sup> Morley, J. *Death, Heaven and the Victorians*. Studio Vista, London, 1971, p.7.

<sup>4</sup> Woods, R. and Shelton, N. *An Atlas of Victorian Mortality*. Liverpool University Press, Liverpool, 1997, p.142.

<sup>5</sup> Woods, R. Mortality patterns in the nineteenth century In: Woods, R. and Woodward, J. (eds.) *Urban Disease & Mortality in Nineteenth-Century England*. Batsford, London, 1984, p.37.

<sup>6</sup> Diary of Hannah MacDonald, 31<sup>st</sup> December 1852. Baldwin papers. 705: 775/8229/13(ii), Worcestershire Record Office. Hannah MacDonald nee Jones was a Methodist and the wife of Methodist minister George Browne MacDonald. Their daughter Louisa became a convert to Anglicanism after her marriage to industrialist Alfred Baldwin in 1866.

<sup>9</sup> Wohl, A.S. *Endangered Lives: Public Health in Victorian Britain*. J.M. Dent & Sons, London, 1983, p.11.

<sup>10</sup> Binney and Vickers, *op. cit.* p.83.



birthday. He has passed through the first three years of his life & may God bless him and spare him': a genuine expression of relief and gratitude.<sup>11</sup> Hannah lost several children and her daughter Mary had died two years previously. Nine years later she was to record this tragic sequence of events in her diary:

‘June 25 <sup>th</sup>	Baby poorly. I am very uneasy about him Mr Horsfall thinks his case rather serious.
July 2 <sup>nd</sup>	Baby not well.
July 5 <sup>th</sup>	Baby not well this evening.
July 6 <sup>th</sup>	Baby poorly Mr McLean baptised in the presence of the whole family.
July 7 <sup>th</sup>	My poor baby taken with violent sickness which continued many hours.
July 8 <sup>th</sup>	My distress is very great for the affliction of my dear little baby still increases.
July 9 <sup>th</sup>	Death is the only prospect of relief for our sweet little sufferer.
July 10 <sup>th</sup>	This day my sweet baby’s short life terminated at 28 minutes past 12 o’clock at noon after much suffering. <sup>12</sup>

Even when the overall death rate began to decline from the mid 1870s, for infants under one year old it remained as high in the 1890s as it had been in the 1850s.

Tuberculosis or ‘consumption’ accounted for an average of 60,000 deaths a year in the period 1839-1843, with the highest rates of incidence in London and the industrial towns.<sup>13</sup> Woods and Shelton have concluded that ‘there can be no doubt that pulmonary tuberculosis was one of the most important diseases in the nineteenth century’.<sup>14</sup> It was also one of the diseases most associated by Victorians with the toxic urban environment they had created. Although its virulence declined in the second half of the nineteenth century for reasons still not fully understood, tuberculosis, together with cholera, was to be seen as a defining illness of the Victorian age.

In addition, accidents and industrial injuries and diseases were, unsurprisingly, frequent in an age where the safety of workers was of minimal concern to employers or government. For the relatively few who survived to reach it, old age meant being over 60 and it is a sobering thought that ‘of those babies born alive in the 1850s only 40 per cent reached their sixtieth and less than 10 per cent their eightieth birthdays’.<sup>15</sup>

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<sup>11</sup> Diary of Hannah MacDonald, 24<sup>th</sup> September 1838, *op. cit.*

<sup>12</sup> Diary of Hannah MacDonald, 1847, *op. cit.*

<sup>13</sup> Lane, J. *A Social History of Medicine: Health, Healing and Disease in England 1750-1950*. Routledge, London, 2001, p.142.

<sup>14</sup> Woods, and Shelton, *op. cit.* p.96.

<sup>15</sup> *Ibid.* p.119.

Epidemics of cholera, typhus, typhoid, and influenza occurred with alarming regularity. Typhus, a disease carried by lice and prevalent in overcrowded unsanitary living conditions, often afflicted the poor, the armed forces and prisoners (hence its alternative name of 'gaol fever') and was chosen by Charlotte Brontë as the fatal illness of Helen Burns in *Jane Eyre* (1847) (partly no doubt to emphasise the appalling conditions at Lowood School), while typhoid despatched the Prince Consort in December 1861 and an influenza pandemic carried off the second-in-line to the throne, Albert Victor, Duke of Clarence, in 1892. However, it was cholera in particular that created widespread fear and panic because of its sudden plague-like emergence from the east, its seemingly indiscriminate selection of victims from all classes, and for the speed with which otherwise healthy individuals succumbed.<sup>16</sup> It was often characterised in terms of a Biblical plague and it brutally exposed the extent of medical impotence in the face of epidemic disease. Doctors had no clear idea of the means of its transmission, or how to treat it, and medical advice initially consisted of a mixture of muddled science, moralising and superstition, exemplified in the advice of 'Dr Challice of Bermondsey' (Appendix A).

This cocktail of Evangelical moralising, miasma theory and classical medicine, also intriguingly provides glimpses of a dawning understanding of the link between cholera and contaminated water.<sup>17</sup> It is a product of its time, written on the cusp of a revolution in the scientific understanding of disease. It contains both the traditional inference that cholera, like the plagues of previous centuries, was a punishment inflicted on the individual and the nation for its sins, and some surprisingly insightful realisations of its biological origin. The advice also hints at the way in which cholera was often misdiagnosed and its symptoms confused with those of food poisoning. A similar dim awareness of cholera's means of transmission was apparent when in 1849 the General Board of Health concluded that:

'Although it is so far true that certain conditions may favour its [cholera's] spread from person to person, as when great numbers of sick are crowded together in close unventilated apartments, yet this is not to be considered as affecting the general principle of its non-contagious nature'.<sup>18</sup>

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<sup>16</sup> Often within 48 hours.

<sup>17</sup> It is interesting to observe here the perhaps surprising power of Evangelicalism's moral perspective even over the medical profession.

<sup>18</sup> Report of the General Board of Health on Cholera *Parliamentary Papers 1849 XXIV* cited in: Midwinter, E.C. *Victorian Social Reform*. Longman, Harlow, 1968, p.83.

## ***The Victorian response to poverty, filth and disease***

For those living in poverty 'every aspect of life...was marred by unhealthy and revolting conditions, the shadow of premature death and the constant danger of dread disease'.<sup>19</sup> Overcrowding placed the dead and dying amongst the living and when 'not one family in a hundred had a third room, most living in cellars, part of a room or one room', proper care was near to impossible.<sup>20</sup> Mayhew's account of London's lodging houses in the 1860s luridly described the privations faced by the poor:

'The sanitary state of these houses is very bad. Not only do the lodgers generally swarm with vermin, but there is little or no ventilation to the sleeping-rooms, in which 60 persons, of the foulest habits, usually sleep every night. There are no proper washing utensils, neither towels nor basins, nor wooden bowls. There are one or two buckets, but these are not meant for the use of the lodgers, but for cleaning the rooms. The lodgers never think of washing themselves. The cleanliest amongst them will do so in the bucket, and then wipe themselves with their pocket-handkerchiefs, or the tails of their shirts.'<sup>21</sup>

Helen McKenny recorded meeting a:

'...bright, refined, cheery young woman, who has had a terrible year of privation and trouble. Her husband, a painter, has been ill for long months with rheumatic fever. Her boy of age 7 has hip disease, obliged to be always on the bed. The eldest girl of 8 was blind as a result of measles'.<sup>22</sup>

And Reverend Sale lamented:

'Mrs Jones; Poverty, Poverty! 6 children, scarcely any fire – 2 crouching almost on the embers – she with a baby, man out of work'.<sup>23</sup>

Despite the sympathy evident in such accounts, in the early Victorian period poverty and deprivation such as this was widely regarded by the middle classes (and by policy makers) to be a largely self-inflicted condition, the result of indolence, drunkenness or profligacy. Herbert Schlossberg has concluded that 'poverty was considered a normal and even honourable state, especially by Tories who regarded social and economic

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<sup>19</sup> Midwinter, E.C. *Victorian Social Reform*. Longman, Harlow, 1968, p.13.

<sup>20</sup> Kellehear, A. *A Social History of Dying*. Cambridge University Press, Cambridge, 2007, p.201.

<sup>21</sup> Mayhew, H. *London Labour and the London Poor*. Wordsworth Classics, Ware, 2008 [1861], p.509.

<sup>22</sup> Binney and Vickers, *op. cit.* p.84.

<sup>23</sup> Diary of Reverend John E. Sale Curate of Dymock 1872-84. Dymock. D8465/1 Acc. No. 8465, Gloucestershire Archives.

states as part of the God-given order'.<sup>24</sup> However, although early Victorian social policy was often deliberately punitive towards the poor (the 1834 Poor Law Amendment Act and the 1832 Anatomy Act being the most notorious examples), it was accepted, in more enlightened quarters at least, that for many poverty was the result of unavoidable circumstances, or the wayward behaviour of others, and that such cases were deserving of assistance.

This realisation and the fear and economic disruption caused by epidemic diseases (cholera in particular), together with political and social change, led to a gradual re-evaluation of the state's role in social welfare and public health, which finally began to bear meaningful fruit in the years immediately preceding the Great War.<sup>25</sup> However, despite the efforts of campaigners, it took a long time to achieve significant and consistent progress in public health reform, and for this to translate into falling mortality rates.<sup>26</sup> Before the 1870s most Victorian social policy enacted by Parliament was permissive rather than coercive. Legislation passed in 1848 gave those towns and cities that were incorporated the right to set up local Boards of Health, but it did not compel them to do so. Although the case for doing so may seem overwhelming today, there was fierce opposition in many towns. Local vested interests resisted anything that would involve an increase in rates and were also determined to assert their local independence and oppose anything they perceived as a threat to it from central government.

The period of permissive legislation had, by the 1870s, resulted in widely differing standards of sanitation, water purity and housing across the country. Furthermore, public health reforms were not accompanied by interventions to raise the living standards of the poor. Although, in general, living standards did rise during the Victorian period as a result of Britain's economic prosperity, swathes of extreme poverty remained, most noticeably amongst unskilled labourers, widows and orphans, and those unable to work due to infirmity, disability or old age.<sup>27</sup> Filth may have been

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<sup>24</sup> Schlossberg, H. *The Silent Revolution and the Making of Victorian England*. Ohio State University, Columbus OH, 2000, p.172.

<sup>25</sup> Although the Boer War recruitment scandal highlighted the continued prevalence of ill-health and malnutrition amongst the working class.

<sup>26</sup> Most notably Edwin Chadwick (1800-1890) and George 'Graveyard' Walker (1807-1884).

<sup>27</sup> See Curran, C. *When I First Began My Life Anew: Middle-Class Widows in Nineteenth-Century Britain*. Wyndham Hall, Bristol, IN., 2000.

in retreat from the 1850s onwards, but it was far from eradicated by the end of Victoria's reign. This account from Jack London written in 1902 could have been from fifty or a hundred years earlier:

'Yesterday Dr. Wynn Westcott held an inquest at Shoreditch respecting the death of Elizabeth Crews, aged 77 years, of 32 East Street, Holborn, who died on Wednesday last. Alice Mathieson stated that she was landlady of the house where the deceased lived. Witness last saw her alive on the previous Monday. She lived quite alone. Mr Francis Birch, relieving officer for the Holborn district, stated that deceased had occupied the room in question for thirty-five years. When witness called, on the 1<sup>st</sup>, he found the old woman in a terrible state, and the ambulance and coachman had to be disinfected after removal. Dr Chase Fennell said death was due to blood-poisoning due to bed-sores, due to self-neglect and filthy surroundings, and the jury returned a verdict to that effect'.<sup>28</sup>

The poor remained largely ignorant of basic principles of disease prevention, hygiene and nutrition, and their diet and living conditions often remained inadequate. They distrusted and hated the authorities that had given them the workhouse and anatomisation, and attempts to gain entry to these communities were often resisted. Places like Whitechapel in London's East End, where some of the worst slum housing was located, were virtual 'no-go areas' for council officials and even the police. The problems faced by sanitary inspectors were recorded by Thomson and Smith in *Street Life in London* (1877):

'When the inspector of nuisances ascertains that small-pox or a fever has broken out within his district, he calls at the house in question to see that the provisions of the Sanitary Act are properly observed. A certain amount of skill and delicacy are, however, necessary in the execution of this task. This official is not always well received. He is sometimes met with a direct denial; and, as the law does not allow him to force an entrance, he is obliged to leave the house if the person who answers his knock declares there is no case of infectious disease within. When this occurs, the inspector must resort to some stratagem; he must question the neighbours or inveigle some indiscreet servant or child to disclose the truth. Generally the inspectors seek to discover who is the medical attendant at the suspected house, and will call and ascertain from him the real nature of the complaint. If his earlier suspicions are confirmed, and it proves to be some form of zymotic disease, the officer can then obtain a summons from the police magistrate, and the persons who sought to avoid the Sanitary Act are either fined or imprisoned'.<sup>29</sup>

Education and financial resources remained key indicators of the standard of care the dying could expect to receive. Even at the end of the century 'many Victorian city-dwellers continued to live in squalor mitigated only by the philanthropy of enlightened

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<sup>28</sup> London, J. *The People of the Abyss*. Journeyman Press, London, 1977 [1902], pp.24-25.

<sup>29</sup> Thomson, J. and Smith, A. *Street Life in London*. Sampson Low, Marston, Searle, & Rivington, London, 1877 [Online] Available from: <http://www.victorianlondon.org/> [Accessed 26<sup>th</sup> August 2010].

and compassionate individuals'.<sup>30</sup> What social care that was available to poor families caring for dying relatives continued to come from charitable and religious organisations.

As well as being an age of philanthropy, the Victorian age was one of 'self-help', founded amongst the working class in Nonconformity (particularly Methodism), and amongst the middle class in Anglican Evangelicalism. In both traditions work was regarded as an act of worship and self-reliance as a marker of 'respectability'. The great exemplars of Victorian self-help were the friendly societies, which in terms of care of the dying offered a limited safety net if the breadwinner was dying, paying for medical treatment and sickness benefit, and, if worst came to worst, funeral costs.<sup>31</sup> The poorest however often could not afford the subscriptions and could only turn to the far less welcome option of the workhouse infirmary in the event of serious illness or injury.

Despite these limitations on improvements to the health of the nation, a series of more effective public health and housing reforms using coercive legislation were made from the 1870s onwards. Their success was helped by the fact that 'by the last quarter of the nineteenth century, the British had developed a sense of communal and civic attachment', which linked success in combating filth and disease with civic pride.<sup>32</sup> Huge construction projects, such as Joseph Bazalgette's London sewerage network and Joseph Chamberlain's slum clearances in Birmingham, did make real differences to the health of communities and particularly of the working class, so that 'by every criterion, there was a marked improvement in the nation's health, notably from the 1870s to 1900 [when] the overall mortality rate fell from 23 per thousand in 1855 to 18 per thousand in 1895'.<sup>33</sup>

### ***Dirt, miasmas and change in the sickroom***

The layout of Victorian sickrooms and the conduct of end of life care in 'respectable' Victorian homes was driven by the association of hygiene and cleanliness with godliness, apparent, for example, when Helen McKenny, a devout Methodist, 'went to

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<sup>30</sup> Halliday, S. *The Great Filth: The War Against Disease in Victorian England*. Sutton, Stroud, 2007, p.217.

<sup>31</sup> Friendly society membership reached its peak in about 1900 when 'at least half of all adult males in Britain belonged' Lane, *op. cit.* p.79.

<sup>32</sup> Walvin, J. *Victorian Values*. Andre Deutsch, London, 1987, p.111.

<sup>33</sup> *Ibid.* p.37.

visit dear old Mrs Downing, a beautiful old saint, living in a dreadful slum, but so clean, and even her *doorstep* preaches the Gospel!<sup>34</sup>

The crusade against filth that gathered pace from the 1840s was both a middle and a working class phenomenon. Christianity (and again particularly Methodism and Evangelicalism) provided its moral inspiration whilst the crusade gained its scientific validity from miasma theory, which attributed disease to the spontaneous product of the noxious gases and effluents of the cities. These two influences are critical to explaining the decisions and behaviours of those who cared for the dying.

Miasma theory was largely responsible for the Victorian preoccupation with light and fresh air for the sick room, and for the migration of the dying to spa and seaside resorts in England and abroad. Mrs Beeton wrote in 1861 that 'cleanliness, sobriety, and free ventilation almost always defy pestilence',<sup>35</sup> and Edward Bradley described in 1870 how 'Hampstead is the northern lung of London... [where] the people of the Upper Classes come for the benefit of their health'.<sup>36</sup> The attraction of miasma theory lay in the fact that 'in the mid 19<sup>th</sup> century the air of cities seemed to be much fouler than their water'.<sup>37</sup> Dr James Kay, for example, writing about Manchester in 1832, described how:

'The state of the streets powerfully affects the health of the inhabitants. Sporadic cases of typhus chiefly appear in those which are narrow, ill-ventilated, unpaved, or which contain heaps of refuse, or stagnant pools. The confined air and noxious exhalations, which abound in such places, depress the health of the people, and on this account contagious diseases are also most rapidly propagated there'.<sup>38</sup>

Miasma theory was a double edged sword, it inspired the cleanup of the streets and of the home, but it also delayed the acceptance of theories of disease transmission that were eventually proved correct. Even though Louis Pasteur had shown in the 1860s that infection was caused by microbes and not noxious vapours, and Robert Koch

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<sup>34</sup> Binney, and Vickers, *op. cit.* p.36.

<sup>35</sup> Beeton, I. *Beeton's Book of Household Management*. Facsimile edition. Chancellor Press, 1982 [1861], p.1073.

<sup>36</sup> Letter dated 24<sup>th</sup> August 1870. Records of Brookes and Badham solicitors, Tewkesbury. D2079 II 3 F1 2<sup>nd</sup> bundle, Gloucestershire Archives.

<sup>37</sup> Halliday, S. Death and miasma in Victorian London: an obstinate belief *British Medical Journal* No.323 (2001), p.1470.

<sup>38</sup> Kay, Dr J.P. *The Moral and Physical Condition of the Working Classes...in Manchester* [1832], pp.12-34 In: Royston Pike, E. *Human Documents of the Industrial Revolution in Britain*. George Allen & Unwin, London, 1966, pp.309-310.

identified the bacteria that caused tuberculosis in 1882 and cholera in 1883, belief in miasmas as the cause of other diseases such as malaria lingered on into the 1890s.<sup>40</sup>

‘...the worst feature of the swamp was the awful smell of rotting vegetation that hung about it, which at times was positively overpowering, and the malarious exhalations that accompanied it, which we were of course obliged to breathe’.<sup>41</sup>

Miasma theory helps to explain the seemingly reckless attitude of carers and visitors of the sick toward their own health. Mrs Beeton’s advice on avoiding contagion was to:

‘never venture into a sick-room if you are in a violent perspiration (if circumstances require your continuance there), for the moment your body becomes cold, it is in a state likely to absorb the infection, and give you the disease. Nor visit a sick person (especially if the complaint be of a contagious nature) with *an empty stomach*; [original italics] as this disposes the system more readily to receive the contagion. In attending a sick person, place yourself where the air passes from the door or window to the bed of the diseased, not betwixt the diseased person and any fire that is in the room, as the heat of the fire will draw the infectious vapour in that direction, and you would run much danger from breathing it’.<sup>42</sup>

Given this advice, the spread of contagious diseases is hardly surprising, although in practice there was little people could do to avoid infection if they were crammed into single room accommodation or unknowingly drinking contaminated water.

Although some diseases like smallpox and scarlet fever had always been recognised as transmittable from person to person, the means of transmission was unclear and in addition, the contagious nature of diseases such as tuberculosis was not properly realised. Even when it was established that there was a risk of contagion, carers still took risks with their own health in tending the dying, sometimes through choice and sometimes because there was no alternative. Francis Kilvert (1840-1879), a young Anglican curate, highlighted the dilemma faced by many carers when he recorded a visit to one of his parishioners:

‘Mrs Prosser at the Swan, a young pretty woman dying I fear of consumption which she caught of her sister, Mrs Hope of the Rose and Crown in Hay. It was a sad beautiful story. She was warned not to sleep with her sister who was dying of decline and told that if she did she herself would probably be infected with the disease. But her sister begged her so hard not to leave her and to go on sleeping with her that she gave way. ‘What could I do? she said. ‘She was my only sister and we loved each other so’.<sup>43</sup>

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<sup>40</sup> It was not discovered that the mosquito was the vector until the 1890s.

<sup>41</sup> Haggard, R. *She*. Penguin, London, 2001 [1886], p.120.

<sup>42</sup> Beaton, *op. cit.* p.1096.

<sup>43</sup> Plomer, W. (ed.) *Kilvert’s Diary 1870-1879*. Penguin, London, 1977, p.190.



It was only the advent of professional, hospital-based care that removed the fear of infection from caring for the dying, something which did not get fully underway until the following century.

In the home, the standard of care available to the dying was inexorably tied up with the financial resources available to the family. For the Victorian middle classes, who had the financial means to make it so, home and family was a private retreat from the world of work and industry, and childhood was a time of protected innocence, a view fostered and encouraged by the royal family. For the poor such ideals were however impossible; their tiny, overcrowded dwellings did not permit them.

However, public health reform did eventually set about dispensing with shared privies and standpipes and required houses to have a through draft of clean air, prohibiting the building of courtyard and back-to-back houses and cellar rooms below the water table. As a result it became possible for many of the more 'respectable' working class to share these middle class family values. To keep a parlour became an established signifier of 'respectability' in skilled artisans' homes by the 1880s and it has been argued that 'separate houses intended for one-family occupation encouraged the domestication of the family by emphasizing the concentration of activities inside the house where they were not shared by strangers'.<sup>44</sup>

This increase in domestic space meant that the dying could be cared for in a separate sick-room (usually a bedroom) and their interaction with family members and other members of the community could be better regulated by carers. For middle-class families with the disposable income and space to convert a room into a sickroom, there was much advice available on how to furnish it. As Judith Flanders noted, 'it was recommended that, at the commencement of illness, the sickroom be emptied as much as possible of all furniture and ornaments'.<sup>45</sup> As the importance of cleanliness came to be realised, the sickroom came increasingly to be furnished in the manner of a hospital ward, with minimal clutter (the antithesis of a normal Victorian middle class home), which was considered to harbour filth. Relentless scrubbing of everything with carbolic soap or chloride of lime must have added to a sense of disconnection of the sickroom from the familiar home environment.

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<sup>44</sup> Thompson, F.M.L. *The Rise of Respectable Society: A Social History of Victorian Britain, 1830-1900*. Fontana Press, London, 1988, p.192.

<sup>45</sup> Flanders, J. *The Victorian House*. HarperCollins, London, 2003, p.315.

In this separation of public and private space, and then within private space, are perhaps the origins of one component of the distancing of death that gathered pace after the Great War, when death started to transfer increasingly to the even more sparse and sterile hospital ward. As families gradually became more private and community ties weakened, death in the family became less of a shared communal event and neighbours became less important in the care of the dying. As the sickroom evolved into a separate, clinical, space, entry to which was regulated increasingly by professionals, the dying became more separated from everyday life even within the family home.

The interior design of the home also changed considerably in the Victorian era and this too impacted upon the care that could be given to the dying. Most notably, piped water became much more common, replacing the well or standpipe. Queuing for water was an arduous task that added to the burden of carers. Joseph Quick, Engineer to the Southwark Water Company, gave this account of the evils of the standpipe to a Parliamentary committee in 1845:

‘The labour of fetching the water, the loss of time in waiting for what they call their turns, and the demoralisation from the numbers brought and kept together. I have seen as many as from 20 to 50 persons with pails waiting round one or two standpipes; the strongest pushing forward, and the pails, after they are filled, being upset. In the winter time the inconvenience is increased by the likelihood of the cock being frozen, and injuries to health from the weather, and getting wet-footed. It happens frequently that a man and woman are out at work during the time the supply is on the common tap. When they return home there is no supply, and this may occur from day to day’.<sup>46</sup>

From the 1840s piped hot water to upstairs rooms began to appear in the homes of the wealthy, although cold water only to upstairs rooms remained the norm in smaller houses throughout the Victorian period. In wealthier homes separate bathrooms also became more widespread with fitted baths and, after being demonstrated at the Great Exhibition in 1851, the water closet rapidly became *de rigueur* in polite society. By the 1890s new build middle-class homes invariably featured a bathroom with hot piped water and a separate indoor water closet. Improved washing facilities, with a copper located in the scullery for boiling clothes, meant washing could be done by servants in-house. The really wealthy also benefited from the development of central heating.

These innovations considerably improved the practical care that could be provided for the dying in more affluent homes (although ironically, the increased use of water

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<sup>46</sup> Parliamentary Papers. 1845, vol. XVII, p.397 In: Royston Pike, E., *op. cit.* pp.349-350.

closets initially added to the death toll from water-borne infections). The dying could be kept warmer than previously possible, and cleaner, and their bedding could be changed and washed regularly. Greater levels of hygiene became possible as a range of patented household soaps began to fill the pharmacist's shelves.<sup>47</sup> Carbolic soap was used in profusion to disinfect rooms and furnishings. Personal hygiene, so neglected in previous centuries, was enthusiastically embraced as yet another opportunity to demonstrate 'respectability'.

In conclusion, this chapter has attempted to identify the context in which the key aspects of end of life care in the Victorian home examined in the following chapters should be considered. Amongst the many consequences of industrialisation and urbanisation were changes of key importance to end of life care. Of these, the growth in size and influence of the middle classes, the erosion of tradition, deterioration then gradual improvement in mortality rates, with associated changes in prevalence of life-threatening diseases, sanitary and housing crisis followed by reform, improvement and innovation, all had significant impact, albeit in differing ways. The roles of religion, medicine, the community and the family in end of life care were all swept by the tides of change. What would emerge would be the recognisable origins of modern palliative care. Nowhere was the impact of this upheaval more keenly felt than upon Christianity and the concept of a 'good death'; it is to this subject that the study now turns.

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<sup>47</sup> Encouraged by the repeal of the Soap Tax in 1853.

## CHAPTER TWO: CHRISTIANITY AND THE VICTORIAN DEATHBED

### *The influence of Christianity in the care of the dying*

The first third of Victoria's reign witnessed the last great Christian revival and renewal in England. As J.F. Harrison remarked 'the early Victorian era was essentially a religious age'<sup>1</sup> and the 1851 religious census showed that 7 million of the 18 million inhabitants of England and Wales still attended regular public worship.<sup>2</sup> The 1850s were however to be the high tide and only half a century later 'it seemed that all religious indices were pointing in the same downward direction'.<sup>3</sup>

Despite the beginnings of a long decline, 'the ordinary Victorian [excepting perhaps a significant proportion of the urban poor] had been reared in a culture circumscribed by Christian teaching' and Christianity provided the language and imagery through which most Victorians, even those who were not regular churchgoers, conceptualised death and dying.<sup>4</sup> It also provided a level of comfort and consolation that is easy to underestimate in today's secular society and recognising this is one of the keys to revealing the objectives and aspirations of end of life care in the majority of Victorian homes.

Dominant in the Christian revival of the early decades of the century was Evangelicalism. This protestant Christian movement, which had its origins in the early eighteenth century, emphasised the importance of personal conversion (being 'born again') and upon living by and proclaiming the Gospels. It has been suggested that 'middle-class culture was shaped by the moral revolution of evangelicalism' and certainly Evangelicalism was behind the high moral tone so ubiquitous of the Victorian age.<sup>5</sup> Even for non-Evangelical families, Evangelical morality became indissoluble from 'respectability', the pervading symbol of status amongst the Victorian middle and

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<sup>1</sup> Harrison, J.F.C. *Early Victorian Britain, 1832-51*. Fontana Press, London, 1979, p.123.

<sup>2</sup> *Ibid.* p.123.

<sup>3</sup> McLeod, H. *Religion and Society in England, 1850-1914*. MacMillan Press, Basingstoke, 1996, p.170.

<sup>4</sup> Altick, R.D. *Victorian People and Ideas*. W.M. Norton & Co., London, 1973, p.203.

<sup>5</sup> Thompson, F.M.L. *The Rise of Respectable Society: A Social History of Victorian Britain, 1830-1900*. Fontana Press, London, 1988, p.250.

upper working classes, and these concepts of 'respectability' would endure long after Evangelicalism itself subsided.<sup>6</sup>

Although medicine offered increasingly convincing biological and physiological explanations of the dying process, whilst it remained unable to provide effective interventions to forestall death, it did not for the most part challenge traditional Christian interpretations of death as being an act of divine will. When new and terrifying epidemics struck, which medicine could do nothing to contain, the Victorians for all their reverence of science, instinctively turned to religion for deliverance. This was demonstrated in the response to the Asiatic cholera epidemics, which witnessed widely supported days of national prayer and abasement, for which the following prayer was composed:

'Nineveh repented of their iniquity, Thou didst lay aside the fierceness of Thine anger, and sparedst the guilty city, when Thou sawest that they turned from their evil way.

And now, O Lord, we entreat Thee after Thy rich mercy to grant unto us Thine afflicted servants the like spirit of repentance, that Thou mayest withdraw Thy chastisements from our land, and stay the plague and grievous sickness which is abroad, making many desolate. May the judgements which Thou hast sent, work in us a more lively faith, a more entire obedience, a more earnest endeavour to conform to Thy will, and to advance Thy glory. Make us duly sensible of Thy goodness in maintaining the domestic tranquillity of our land, in preserving us from intestine commotions, and in granting a plentiful return to the labours of our husbandmen. Teach us to show our thankfulness for these mercies, by an increasing desire to relieve distress, to remove all occasions of discontent and murmurings, and to promote goodwill and concord amongst ourselves. Any may the frequent instances of mortality which we have beheld, remind us all of the nearness of death, and dispose us to number our days, that we may apply our hearts unto wisdom: that, whether living or dying, we may be found faithful disciples of Him who has taken away the sting of death, and opened the gate of everlasting life to all believers...'<sup>7</sup>

The broad church Anglican minister Thomas Arnold (1795-1842) offered an intriguing alternative Christian interpretation to the arrival of cholera in 1832 (Appendix B). Arnold argued that cholera was not the visitation of an angry and vengeful God targeted upon sinful individuals, but a warning from God to the whole nation to return to the path of righteousness. Such arguments found favour amongst the devout, who, lacking any awareness of cholera's biological origins, were convinced that it was an act

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<sup>6</sup> See, for example, Schlossberg, H. *The Silent Revolution and the Making of Victorian England*. Ohio State University, Columbus OH, 2000, p.312.

<sup>7</sup> *A Special form of Prayer to be used in all Churches and Chapels throughout those Parts of the United Kingdom, called England and Ireland, instead of the Prayer used during any Time of Common Plague or Sickness*. George Edward Eyre and William Spottiswoode, London, 1849. 850 HARVINGTON/13/i/17 Worcestershire Record Office.

of God that could only be alleviated through prayer and repentance. Even in urban working class communities, where religious observance was markedly less evident, some (and perhaps many) retained Christian beliefs about death, apparent for example when the soldier Sergeant Edward Bradley offered this consolation to his sister upon the death of her husband in 1866: 'I dare say it will be some time before you get over it, but God is good and he won't forget you was a Good Wife...but such is life, you will meet together in a better world'.<sup>8</sup>

Jack London, who documented his experiences of London's East End at the start of the twentieth century, claimed that for the poor he encountered 'religion passes them by. The Unseen holds for them neither terror nor delight. They are unaware of the Unseen'.<sup>9</sup> London did not however acknowledge the diversity of attitudes present amongst the urban working class, or the tenacity of residual Christian beliefs. David Vincent found that 'while the great majority of the [working class] autobiographers evaluated and comprehended their daily lives in secular terms, when death came there was some turning back to religion for explanation and solace'.<sup>10</sup> A letter from Edward Bradley describing an outbreak of scarlet fever amongst the families of soldiers at his barracks in London in 1870 seems to support Vincent's interpretation: 'we buried two pretty children three days ago but they were both very young – God is good I trust in him this day'.<sup>11</sup> Whilst Christianity had, by the 1860s, entered a long and seemingly irreversible decline in England, for those who continued to believe, it provided an essential source of emotional and spiritual support when confronted by death.

Perhaps the most obvious manifestation of Christianity's influence over the care of the dying was that care was focussed primarily on spiritual preparation and comfort, rather than on alleviating bodily suffering. The latter was always important, but there is no doubt that ensuring the dying were fully prepared for, and thus would be granted, the promises of the Christian afterlife was the first priority. Hannah Southall, who was from

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<sup>8</sup> Letter to Mary Ann Dudfield from her brother Edward Bradley 29 November 1866. Records of Brookes and Badham solicitors, Tewkesbury. D2079/II/3/F1, Gloucestershire Archives.

<sup>9</sup> London, J. *The People of the Abyss*. Journeyman Press, London, 1977 [1902], p.25.

<sup>10</sup> Vincent, D. *Bread, Knowledge and Freedom: A Study of Nineteenth-Century Working Class Autobiography*. Methuen & Co., London, 1981, p.57.

<sup>11</sup> Letter dated 18<sup>th</sup> August 1870 from Edward Bradley to his sister Mary Ann Dudfield, *op. cit.*

a family of Gloucestershire Quakers, gave an account of her widowed aunt's eulogy for her late husband in which the importance of preparation was alluded to:

'...from his first awakening to a sense of his sinfulness to the conflicts which he endured near the end of his course & exhorting all to prepare so that the day of death might be to them better than the day of birth'.<sup>12</sup>

The consolations of Christian belief were summarised by Michael Lloyd-Baker, the son of an established family of Gloucestershire gentry, during his mother's last illness in 1890:

'It does indeed seem wonderful to me that if God in his mercy sees fit to take you, you will then according to my most firmly established belief be able to watch over us and perhaps even intercede for us'.<sup>13</sup>

Similarly, upon the death of Mrs Henry Arkwright in 1844, Sarah Arkwright wrote to her son that 'she may still speak to you, as righteous Abel still does, if you look into Hebrews II verse 4'<sup>14</sup> and in 1888, recalling the death of her mother, Louisa Baldwin wrote:

'I beseech thee that in thine own good time all her children may be gathered around her, that we with her may have our perfect consummation & bliss, both in body and soul in Thy abundant glory'.<sup>15</sup>

Firm belief in the Christian afterlife meant that grief at the loss of a loved one was tempered by hope that the departed would be among the Saved. In this context prayer was integral to care. With the secularisation of society in the twentieth century the importance of addressing the spiritual needs of the dying as an important aspect of end of life care was increasingly neglected, but it is now being recognised again through the work of researchers like Rachel Stanworth, who has argued that 'spirituality is not an 'extra' ordinary feature of life but a suffusing dimension, mediated and disclosed to us by the workings of metaphor and symbol'.<sup>16</sup>

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<sup>12</sup> Letter from Hannah Southall to her brother Henry dated June 4<sup>th</sup> 1850. Southall family archive. BG99/2/176a, Hereford Archives.

<sup>13</sup> Letter to Catharine Lloyd-Baker from her son Michael dated 18 May 1890. Lloyd-Baker family of Hardwicke Court. D3549/28/1/8, Gloucestershire Archives.

<sup>14</sup> Letter from Sarah Arkwright to her son John on the death of Mrs Henry Arkwright, 28 February 1844. Arkwright family of Hampton Court. A63/IV/21/1, Hereford Archives. The Arkwrights were a well-known Herefordshire family and owners of the Hampton Court estate. Hebrews 2 v4 'God also testified to it by signs, wonders and various miracles, and gifts of the Holy Spirit distributed according to his will'.

<sup>15</sup> Diary of Louisa Baldwin, 2<sup>nd</sup> March 1876. Baldwin papers. 705: 775/8229/7(ii), Worcestershire Record Office.

## ***Christian philanthropy in the care of the dying***

The prevalence and visibility of urban poverty and disease stimulated an effort of unprecedented philanthropic endeavour from the Victorian middle classes, who drew upon Evangelical Christianity for their inspiration. The work of Dickens, Mayhew, Booth and Rowntree both inspired and reflected this philanthropic *zeitgeist*. Legions of middle class Victorians (who were perhaps conscious of the fortuitous circumstances that had allowed them to emerge into 'respectability') took up the call, received either from the pulpit, or directly from their own reading of scripture, to follow Christ's example in attempting to alleviate the suffering of the 'deserving' poor and the sick.<sup>17</sup> Their actions reflected genuine personal concern, a commendable community spirit and the perhaps less noble fact that indulging in public acts of philanthropy had become a signifier of their own 'respectability' and status. Agnes Cain, for example, felt it important to make it known to the public through her late father's biographer that he was 'deeply impressed by the misery of the poor in London...the sight of them prevented his spending a penny on his own comfort which might not be absolutely necessary'.<sup>18</sup>

The efforts of Victorian philanthropists have often been undervalued and discredited as judgmental and patronising, but the scale of their endeavour was extraordinary. Taking Worcestershire as an example, in 1839 a Parliamentary Commission listed 246 charities for the poor in Worcester, a further 30 in Kidderminster, 22 in Evesham and 19 in Stourbridge.<sup>19</sup> The majority of those who undertook to visit the sick, dying and destitute in their local communities were 'respectable' middle class women, denied access to gainful employment and with servants to undertake the drudgery of daily household chores.

For these women visiting the sick was felt to be not only morally uplifting and conferring of 'respectability', but it also provided an independent role and social life for women outside of the home. They undertook this duty often knowingly at considerable risk to

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<sup>16</sup> Stanworth, R. *Recognising spiritual needs in people who are dying*. Oxford University Press, Oxford, 2004, p.22.

<sup>17</sup> Schlossberg, *op. cit.* p.172.

<sup>18</sup> Notes by Agnes Caine describing her father's last illness and death, c.1894. Hyett family of Painswick. D6/F181/5, Gloucestershire Archives. Agnes' father was General Sir Richard Meade who had a distinguished army career in India.

<sup>19</sup> Braby, P. *The Church and its People*. [unknown publisher and date], p.21.



their own health. The Church actively encouraged lay people to visit the sick and dying, The Society for Promoting Christian Knowledge, for example, advised in 1860 that 'there are many ways in which the laity may assist the parochial clergy in their labours among the poor and sick, and in none more usefully than in reading by the bedsides of the afflicted and the dying'.<sup>20</sup>

Philanthropy, entwined as it was with Evangelical and Nonconformist morality, inevitably had the potential to be divisive and to make judgements as to who might be deemed 'deserving' of help. Such moral judgements often influenced hospital admission policy and determined who was considered to be worthy of charitable support and assistance. Those considered morally weak or corrupt, prostitutes for example, were treated as social outcasts fit only for the workhouse. Inevitably help was on occasions delivered with 'holier than thou' condescension, or a complacent sense of superiority, and as such could be unwelcome. Sarah Thomas recorded visiting a villager named Martha Brown and being told that 'Mrs Mills, from the *other chapel* [original italics], had told her last Wednesday that she is sure to die and would probably go to hell', Martha reporting that 'she had worried about it ever since and had not been able to enjoy anything'.<sup>21</sup>

However, it cannot be assumed that all of the tens of thousands of Victorian 'do-gooders' harboured such attitudes and there is much evidence to the contrary. Sarah Thomas, a Baptist, clearly took the duty very seriously, regarding it as an act of worship and on occasions it was a harrowing ordeal:

'...we've been to Meysey Hampton often on visits to the very sick and the poor, but when I saw Sarah Short I was struck by a most pitiable sight. Her face is quite destroyed by disease, only one side is at all like a human face and the smell is sickening. It made me feel sick and faint for sometime'.<sup>22</sup>

Louisa Baldwin's diaries also reveal her compassion for the suffering of those she visited:

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<sup>20</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*. Society for Promoting Christian Knowledge, No.1168, London, c.1860, p. 3.

<sup>21</sup> Lewis, J. (ed.) *The Secret Diary of Sarah Thomas 1860-1865*. The Windrush Press, Moreton-in-Marsh, 1994, p.75. It should be mentioned that this account was written in the context of an intense rivalry between chapels in Fairford at the time, so Sarah's version of events may not have been entirely impartial.

<sup>22</sup> *Ibid.* p.101.

Tuesday 26<sup>th</sup> April [1870]

'I paid a sad call at the Worths where 2 children seem to be at the point of dying, the poor terrible little baby has constant fits & little Madge two years old, who has been ill 12 days with congestion of the lungs. This is the second time I've seen them in this illness...we went into next door where we saw poor little Miss Lee evidently very near the end, but sweet and affectionate as ever'.<sup>23</sup>

Helen McKenny's diary cited many acts of practical and financial assistance that had real benefits for the poor in her community, such as the 'distribution of Christmas dinners to 590 persons'<sup>24</sup> in 1885, or the 'sweets and oranges, etc for the Christmas stockings for the poor little Stevens'.<sup>25</sup> Such accounts attest to the genuine, if on occasions patronising, sympathy of these middle-class women toward the families they visited. The efforts of these women have often been undervalued and derided, particularly by Marxist historians, but were an important, and sometimes the only, source of support in an age before any kind of statutory provision.<sup>26</sup> As F.M.L. Thompson observed:

'The closest the Victorians came to having an apparatus of social services was not, as has sometimes been suggested, the result of legislation and official action through the Poor Laws and support for education, but the consequence of the largely unsystematized efforts of vast numbers of individuals and voluntary organisations mainly inspired by religious motives, and sustained by the work of armies of middle-class women'.<sup>27</sup>

### ***The role of the clergy in the care of the dying***

For the clergy visiting sick and dying parishioners was an integral part of their role, following the example of Christ's own ministry. Death was something over which Christianity claimed particular authority and The Society for Promoting Christian

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<sup>23</sup> Diary of Louisa Baldwin 1870, 26<sup>th</sup> April 1870. Baldwin papers. 705:775/8229/7 (ii), Worcestershire Record Office.

<sup>24</sup> Binney, A. and Vickers, J.A. (eds.) *A City Road Diary 1885-1888: The record of three years in Victorian London by Helen G. McKenny*. 2<sup>nd</sup> edition. WMHS Publications, London, 1978., p.13.

<sup>25</sup> *Ibid.* p.49.

<sup>26</sup> For example, by E.P. Thompson in *The Making of the English Working Class* (1963).

<sup>27</sup> Thompson F.M.L., *op. cit.* p.252. More recently see also Koven S. *Slumming: Sexual and Social Politics in Victorian England*. Princeton University Press, Princeton, N.J., 2004, Humphreys R. *Sin, Organised Charity and the Poor Law in England*. St. Martin's Press, London, 1995 and Lewis, J. *Women in England, 1870-1950*. Prentice Hall, London, 1984.

Knowledge proclaimed in 1860 that 'the clergyman is, of course, the authoritative minister of consolation, and no lay person is competent fully to supply his place'.<sup>28</sup>

Of course, there were families that rejected clerical interference, especially amongst the urban poor, and the same source warned against the 'professed and inveterate infidel', claiming that 'such a person will not, it is probable, seek for religious advice and counsel at the hands of anyone, much less of a minister, whose office he has hitherto despised, and at whose teaching he has scoffed'.<sup>29</sup> However, this study suggests that, in most cases, the clergyman was a welcome visitor to the sick and dying. Most clergy sensibly seem to have avoided households where they knew they would not be welcome and did not attempt to foist themselves upon the unwilling in order to pass judgement upon them. Visiting was for most seen as a Christian duty and as a test of one's own faith, rather than an opportunity to moralise upon the misfortune of others.

For those without family to care for them the clergy were often the only ones who visited. Maud Berkeley, for example, recalled an elderly widow who lived alone 'at her cottage in the woods' and who had 'fallen ill with an inflammation of the leg, and the new vicar from Yaverland is the only mortal being who will go near her'.<sup>30</sup> Excepting the enduring and significant problem of dereliction of duty by absentee vicars, it seems likely that the clergy for the most part took the task of visiting the dying very seriously. Francis Kilvert, for example, recorded his feelings of guilt when 'after neglecting Margaret Thomas' dying son for a long time I went to call and was inexpressibly shocked to find that he had died only ten minutes before'.<sup>31</sup>

Visiting the sick and dying was not a task for the faint hearted (as Sarah Thomas' visit to Sarah Short demonstrated). Francis Kilvert described how he 'visited Edward Evans and the stench of the hovel bedroom almost insupportable. The gaunt ghastly half starved black and white cat was still sitting on a box at the bedhead waiting for the sick

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<sup>28</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*, *op. cit.* p.3.

<sup>29</sup> *Ibid.* p.7.

<sup>30</sup> Fraser, F. (ad.) *Maud: The Diaries of Maud Berkeley*. Secker & Warburg, London, 1985, p.29. Maud Berkeley (nee Tomlinson) (1859-1949) was from a prosperous middle class family living in Sandown, Isle of Wight.

<sup>31</sup> Plomer, *op. cit.* p.18.

man to die'.<sup>32</sup> Kilvert claimed a strong bond of mutual affection with his parishioners and appears (from his own accounts at least) to have been welcomed in his attendance upon the dying. He wrote of a visit to Lizzie Powell, who was dying of consumption, that 'she seemed pleased to see me',<sup>33</sup> and visiting an 'old madwoman Mrs Watkin...I repeated the Lord's Prayer and the old familiar words seemed to come back to her by degrees till she could say it alone. When I went away she besought me earnestly to come again'.<sup>34</sup> As Julie-Marie Strange observed 'it is easy to caricature the well-meaning or sanctimonious Christian philanthropist, yet visits from a clergyman could be welcomed where other professional persons were viewed with suspicion'.<sup>35</sup>

The clergyman was usually influential and respected in his community, as were Nonconformist ministers and Roman Catholic priests within their own congregations, and all had a significant and valued role in the care of the dying. They worked alongside family members and medical professionals, administering Communion, praying, reading from scripture and singing hymns with the dying. As such, they were a key component of day-to-day care in Christian homes and this remained the case throughout the Victorian period.<sup>36</sup>

Different Christian denominations attributed differing levels of importance to the presence of a minister at, or immediately before, a death and the role of a minister also differed between denominations. For Roman Catholics, the ritual of administering the Last Rights, which required the presence of a priest, was essential to a 'good death', as to die without receiving the Last Rights imperilled the soul. For Evangelicals and Nonconformists ritual was less important than Bible reading and prayer. The presence of a minister in these traditions was not essential, as the emphasis was on a personal relationship with God, but the minister still had an important role in leading the family in prayer and directing them to passages of scripture that could offer comfort, strength and consolation. For all denominations therefore a sympathetic minister or priest

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<sup>32</sup> *Ibid.* p.88.

<sup>33</sup> *Ibid.* p.293.

<sup>34</sup> *Ibid.* p.149.

<sup>35</sup> Strange, J-M *Death, Grief and Poverty in Britain, 1870-1914*. Cambridge University Press, Cambridge, 2005, p.52.

<sup>36</sup> It is important to remember too that even in the secular twenty first century, Chaplaincy services are an important and widely respected component of the modern hospice multi-disciplinary team.

usually had an important role in end of life care centred on spiritual preparation for death.

Sometimes offering appropriate comfort was not easy when the manner or circumstances of a death were not conducive to the usual words of Christian consolation. Kilvert, for example, recalled how:

‘This afternoon I went to see Mrs Drew and if possible to comfort her concerning the death of her child. She was filled with sorrow and remorse because when the child had mouched from school last Monday and had wandered about all day with scarcely any food she had whipped him as soon as he came home and sent him supperless to bed, although he had besought her almost in agony to give him a bit of bread. Her heart smote her bitterly now that it was too late, when she remembers how the child had begged and prayed for food. The next morning soon after rising he fell down in a fit and he died...’<sup>37</sup>

The clergy did not just offer words of support, they often assisted with the physical routine of care. Kilvert, on another occasion, described how ‘after tea I went to see Hannah and read the poor child to sleep. I stayed there an hour or more turning her in bed every quarter of an hour. She says I turn her and lift her better than any one else’.<sup>38</sup> Similarly, Linley Blathwayt wrote that in the last illness of Sylvie Rose in 1874 ‘Mr Bazeley [the vicar] had been constant in bringing her things he thought would strengthen her’.<sup>39</sup>

Another important role also befell the clergy: when newly born infants fell ill, families were desperate for them to be baptised before death, as Hannah MacDonald’s account of the death of her baby son in 1847 demonstrated (see chapter one). Baptism offered grieving parents the comfort that their baby would be among the Saved and it also made a full Christian burial service possible. The desperation of mothers to ensure their children died baptised was epitomised by the death of Baby Sorrow in *Tess of the D’Urbervilles* (1891). It is also likely that the burial of un-baptised infants in ‘that shabby corner of God’s allotment where He lets the nettles grow’ did little to endear the

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<sup>37</sup> Plomer, *op. cit.* p.235.

<sup>38</sup> *Ibid.* p.293.

<sup>39</sup> Letter dated 26<sup>th</sup> March 1874 Blathwayt family of Dyrham Park. D2659 20/2 Acc. No. 9167, Gloucestershire Archives. Linley Blathwayt was part of the Anglican Blathwayt family of Dyrham Park, Gloucestershire.

Church to its parishioners in a world where sudden infant death was so commonplace.<sup>40</sup>

The clergy shared a professional interest in the dying with the medical profession, but whereas one was concerned with attempting to prolong life, the other was concerned with preparing the person for death. Instructions for clergy ministering to the sick, issued in the 1860s, made clear what clergy were to say to the sick about the role of their doctor and emphasised that the doctor's curative powers were to be attributed to God:

'In your own case, you may probably be able accurately to name and describe the disorder which now afflicts you, and to trace its origin and course; or, if you cannot do this, your physician, doubtless, has formed an opinion. What I am anxious, however, to impress upon you is this truth, namely, that it is God's hand, that has imposed this sickness upon you; it is God, who has appointed this your present trial; it is God who is now visiting you...He does nothing in vain.

And the knowledge of this fact need not cause you to desist from using the ordinary remedies, which medical skill can suggest for the restoration of your health. Only do not suppose that these will be able to cure you, apart from God.'<sup>41</sup>

Such pronouncements might be an anathema to many doctors and medical researchers today, but many Victorian doctors were devout Christians themselves and shared this view of their limited role, especially when it involved the deathbed, where their curative powers were exhausted. This study found no evidence of overt antagonism or rivalry between clergy and doctors. There were obviously zealots on both sides, but most it seems appreciated a need to co-operate in order to effectively support the patient and the family. Information was apparently shared freely and the patient's well-being discussed, as for example, when Francis Kilvert, on visiting a dying parishioner, 'met the doctor (Mr Spencer) here this morning. He told me he had feared at first inflammation of the spinal cord'.<sup>42</sup>

This harmonious accommodation between medicine and Christianity is nicely illustrated in the person of Henry Graves Bull M.D., J.P. (1818-1885), whose memorial in Hereford Cathedral reads:

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<sup>40</sup> Hardy, T. *Tess of the D'Urbervilles*. Spring Books, London, 1988 [1891], p.83.

<sup>41</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*, *op. cit.* p.13.

<sup>42</sup> Plomer, *op. cit.* p.293.

'He practised in this City as a physician for 44 years and served as a magistrate for 12 years.

As a physician to the infirmary, dispensary and other public institutions.

Unwearied in his efforts for the relief of human suffering, in the pursuit and illustration of natural science eager, energetic, persevering;

Forward and zealous in the works of Christian charity and social improvement;

A humble and devout Christian and a constant worshipper in this Cathedral.'

Both clergyman and doctor knew they could be judged by the family on their ability to work together and put the interest of their loved one first. It therefore benefited the interests of both professionals to maintain an amicable working relationship that placed the care of the patient ahead of dogma. The reward for effective partnership working could be the enduring gratitude and respect of the family, as was the case when Sylvie and Philippa Rose died in 1874 and Laura Rose wrote that 'words cannot express what Dr Astley and Mr Bazeley are to us'.<sup>43</sup> Co-operation was often made easier by the fact that an Anglican vicar and a country GP occupied broadly the same social position and in most cases it appears that the two professions respected each other's field of expertise.

### ***The 'good death'***

As a consequence of the Evangelical revival, which reached its zenith by the 1850s, it has been argued that 'the moral strictures of serious people increasingly were evangelical ones', and Evangelicalism was to exercise a profound influence over the care of the dying with its particular interpretation of what constituted a 'good death'.<sup>44</sup>

Although the concept of a 'good death' or dying well had much earlier origins, it underwent a revival through the influence of Evangelicalism. An Evangelical 'good death' reflected the importance placed by Evangelicalism upon a personal relationship with God and upon the teachings of the Gospels. As Elisabeth Jay commented:

'It was to the heart's consciousness of sin and the need for Christ's redemptive power that Evangelicalism addressed itself...an insistence on the primacy of the individual's relationship with his Saviour, maintained through prayer and the search for guidance from Scripture'.<sup>45</sup>

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<sup>43</sup> Diary of Anne Linley Blathwayt, 26<sup>th</sup> March 1874, *op. cit.*

<sup>44</sup> Schlossberg, *op. cit.* p.235.

<sup>45</sup> Jay, E. *Faith and Doubt in Victorian Britain*. MacMillan, Basingstoke, 1986, p.1.

A 'good death' allowed an Evangelical Christian family the spiritual and emotional consolations of knowing their loved one was among the Saved and consequently, the dying and their carers aspired to achieve such a death. Jalland outlined its key components:

'...death ideally should take place at home, with the dying person making explicit farewells to each family member. There should be time, and physical and mental capacity, for the completion of temporal and spiritual business, whether the latter signified final Communion or informal family devotions. The dying person should be conscious and lucid until the end, resigned to God's will, able to beg forgiveness for past sins and to prove his or her worthiness for salvation. Pain and suffering should be borne with fortitude, and even welcomed as a final test of fitness for heaven and willingness to pay for past sins.'<sup>46</sup>

A few of these criteria are still important today, such as the dying being able to set their worldly affairs in order and to say their goodbyes. Other elements are now less familiar. Evangelicals, having admitted and repented their sins, looked forward to a personal encounter with God and a triumphant admittance to Heaven. For carers this consolation was accompanied by the opportunity to learn from any last words the dying person might impart in their proximity to God.

Although Jalland viewed the 'good death' in its Victorian guise as predominantly the product of the Evangelical revival, the sociologist Allan Kellehear suggested that its renaissance was also due to the rise of the Victorian urban middle classes, for whom 'the prescription to prepare well conforms with and confirms the pattern of middle-class response to trouble overall'.<sup>47</sup> There is much to commend this argument, both because non-Evangelical families clearly shared a belief in its importance, but also because the concept of a 'good death' was closely related to middle-class notions of respectability, which although founded in Evangelical morality, were also embraced by non-Evangelical families. High Church Anglicans (who bore considerable animosity toward the Evangelicals and *visa versa*) and Roman Catholics also shared a belief in the importance of a 'good death', although its form differed from the Evangelical model in each case. Both, but especially Roman Catholicism, placed more emphasis on sacred ritual, the administration of the Last Rites being an essential to the Roman Catholic tradition, as Mary Berington's account of her husband's death in 1846 illustrates:

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<sup>46</sup> Jalland, P. *Death in the Victorian Family*. Oxford University Press, Oxford, 1996, p.26.

<sup>47</sup> Kellehear, A. *A Social History of Dying*. Cambridge University Press, Cambridge, 2007, p.153.



'I sent off for Mr Scott who was at Hanbroke but came very soon and going into the room, he began to say something to him [William Berington] about receiving Holy Communion that night but my dear husband said at once "Sir, I am quite ready, do not delay, Mary give me the Last Sacraments as soon as possible". His voice and manner were strong & firm as usual. We had him put into bed as quickly as possible and as soon as he was there the last rites of our Holy Church were administered to him – all the servants and myself being in the room – he answered all the prayers & received the Holy Viaticum in the most pious and edifying manner. He then asked me to give him a crucifix he had with indulgences for the hour of death. He lifted it most fervently and from that moment held it tight in his hand to the last, often lifting it and saying "Oh my God I love thee with all my heart, Oh my dear Saviour have mercy on me".<sup>48</sup>

For Roman Catholics death remained a divine mystery, in which God's reasoning would always remain obscured and, as such, should be accepted with meekness and humility. In Catholic tradition prayers to the saints, or the Virgin Mary, for intercession on behalf of the dying often featured, rather than Evangelicalisms direct appeal to God and, like the chastisement of pain before death discussed later, through such prayers it was hoped time in Purgatory after death could be reduced. Protestant Christianity does not recognise Purgatory or the intercession of saints, but there were nevertheless similarities with the Evangelical interpretation of a 'good death'. In all traditions prayer and preparation in some form was important, as was lucidity at the point of death, setting worldly affairs in order, and the gathering of family members at the bedside for last goodbyes.

Whatever motivated people to want to facilitate their particular notion of a 'good death', its importance as an objective of care is unquestionable. When Prince Albert died in 1861, his death was portrayed to the public as an exemplary 'good death', as would befit a member of the royal family, who were expected to provide the moral compass for the nation (a role Albert had wholeheartedly embraced in life). Albert was not an Evangelical, but politically it was nevertheless important that he was seen to have died a death that most people would recognise as 'good'.<sup>49</sup> The literate Victorian had been brought up on novels where the 'death scene' was used to affirm the moral status of a character. A classic example of this can be seen in the comparative deaths of Little Nell and Daniel Quilp in Dickens' *The Old Curiosity Shop* (1840-1). Nell, the heroine, died serenely and quietly, surrounded by her loved ones, whereas her nemesis, the morally corrupt Quilp, was drowned in the stinking filth of the Thames 'beating the

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<sup>48</sup> Account by Mary Frances Berington of the illness and death of her husband William Berington, 1847. Berington collection. 705: 24/673, Worcestershire Record Office.

<sup>49</sup> It is worth noting that Queen Victoria apparently hated the picture (overleaf) and wished to have it destroyed.



Given this reaction to Albert's death, and in the prevailing moral climate of the time, it is unsurprising that Oakley's portrayal contains many elements of a 'good death': a family vigil at the bedside, gathered advisers to ensure all affairs are settled and with Albert lucid, dignified and composed to the last.<sup>54</sup>

Albert's death was, of course, no ordinary event and it produced an outpouring of national mourning, but the importance of a 'good death' is also apparent in accounts of care of the dying across a broad range of social classes and religious denominations. A particularly detailed and insightful description of a 'good death' was provided to the family of the Anglican missionary Isaac Allen, who died at Poona, India in 1855, by his friend Reverend W. Goodhall, who was present during his final illness. Goodhall's description of Allen's last hours was intended to provide comfort and solace to his family. Both the structure and content of the account point to what this family perceived as the key components of a 'good death'. The first thing Reverend Goodhall chose to make reference to was how 'the sterling qualities of his [Isaac's] character and the manner of his death remarkably corresponded with each other'.<sup>55</sup> At the outset he thereby affirmed that the manner of Isaac's death, as with Prince Albert's, reflected his unblemished moral character, which demonstrates the importance of this aspect of the death to the grieving relatives.

Reverend Goodhall next reassured the family that Isaac was fully prepared for death and 'had long settled his worldly affairs, and for some time had engaged his mind and thoughts upon the great change which was about to take place in his condition'.<sup>56</sup> The idea of preparedness for what Thomas Hardy once described as 'the all-delivering door' appears to have been of central importance in demonstrating that Isaac had died well.<sup>57</sup> Those who were not prepared were unlikely to be Saved and hence a sudden unexpected death was not a 'good death'. The idea of settling 'worldly affairs' addressed more secular concerns and conformed to middle class notions of an

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<sup>53</sup> Source: [Online] Available from: <http://www.wellcomecollection.org/explore/life-genes--you/topics/death/images.aspx?view=the-last-moments> [Accessed 16<sup>th</sup> December 2010].

<sup>54</sup> In reality, Albert's death from typhoid was unlikely to have been quite so serene.

<sup>55</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855. Papers relating to Samuel James Allen and Family. Acc 100/D2, York City Archive.

<sup>56</sup> *Ibid.*

<sup>57</sup> Hardy T. *The Works of Thomas Hardy*. Wordsworth, Ware, 1994, p.139.

appropriately managed death as one of order and control: to leave ones affairs in chaos and dependent relatives un-provided for was not 'respectable'.

In a 'good death', the dying, it was hoped, would be afforded the opportunity to provide an example that others might follow in how to die well. Louisa Baldwin, writing in 1876, felt her mother had provided such an example: 'this day twelve months [ago] our darling Mother died, but I try to think of it as her birthday because she entered this day on the higher better life. O God, for Christ's sake prepare and fit me to follow her'.<sup>58</sup> Reverend Goodhall's account made clear from the outset that Isaac's death had been exemplary.

The account continued by describing how 'Mr and Mrs Fenton and ourselves were constantly around his bed'.<sup>59</sup> This reassurance was intended to provide further consolation through the knowledge that Isaac was surrounded by friends and relatives, who could nurse him and provide him with spiritual and emotional support by engaging in shared prayers, but also through his exemplary death being witnessed by others who could learn from the lesson he provided. Reverend Goodhall continued:

'Your great anxiety I know to be respecting the religious state of his mind. The ordinances of religion had I believe been administered before our arrival, but much passed while we were with him to enable me to say that when my hour comes, I could rejoice in the certainty of the same frame of mind being justly mine, as I witnessed in my friend. He emphatically rejected any notion of triumph or joy. He renounced all title to anything of the kind.

He protested nothing but the durable faith of a Christian knowing himself to be a sinner whose salvation is the purchased blessing of Christ's redeeming and atoning blood and the sentiment his demeanour and gesture simply and accurately signified, when about nine o'clock in the evening Mr Fenton celebrated Evening Worship with reference – in the portions of Scripture he read (2 Cor. V. first eight verses) and in his prayer – to his situation'.<sup>60</sup>

This part of the account was again intended to reassure the relatives that Isaac was spiritually prepared for death, had confessed his sins, and by 'emphatically' rejecting 'any notion of triumph or joy', was meeting his end in sound mind and with appropriate humility, sobriety and self-control.<sup>61</sup> The confession of past sins, recognition of one's inherently sinful nature, and earnest repentance and submission, were all essential

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<sup>58</sup> Diary of Louisa Baldwin, 2<sup>nd</sup> March 1876, *op. cit.*

<sup>59</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855, *op. cit.*

<sup>60</sup> *Ibid.*

<sup>61</sup> *Ibid.*

components of a 'good death'. Hannah MacDonald, who unlike Allen was a Methodist, wrote of her young daughter Carrie's preparedness in these terms when she died in 1854: '14<sup>th</sup> [May] Very ill but happy and resigned to the will of God... 15<sup>th</sup> My precious child is sinking, her confidence in God is strong, calm and unwavering'.<sup>62</sup> When Josiah Marling died of consumption in 1834, the account of his last days described the process of preparation:

'When the fears of his family as to the dangerous nature of his complaint & of the little hope they had of his recovery were first intimated his agitation for the moment was considerable least his repentance had not been sincere; one of his brothers endeavoured to console him & at his request engaged with him in prayer. He afterwards appeared more composed, and from this point entirely gave up the world & all its concerns and bent all his endeavours to prepare for the change which evidently awaited him.

He frequently commented that his hatred to sin and his love to the Saviour were so faint & were so far from what he desired, that he was sometimes led to question his sincerity. These fears in great measure subsided, but almost to the last he was unhappy somewhat & disquieted by them. At times he enjoyed a peaceful hope and at one period declared to his brother that he was blessed with a far more confident assurance of his interest in Christ than he enjoyed at the commencement of his illness & that he now believed there was reserved for him a mansion in the Heavenly [?] This assurance was founded entirely on the mercies of the Redeemer he placed not the least dependence on any supposed righteousness of his own'.<sup>63</sup>

This account shows that preparation was not an easy affair, there was much soul searching, much awareness of one's unworthiness, and a struggle for faith to master fear before a final state of acceptance and resignation was reached. The account emphasised the comforts of scripture in this struggle:

'On the Saturday preceding his decease, on his mother's asking him about what account she should send to his absent brother of the state of his mind, he said "tell him I cannot believe, according to Scripture, that one who has offered the sincere prayers I have can be lost" [original underlining].<sup>64</sup>

Marling appears to have been repeatedly assailed by doubts and feelings of his unworthiness and this part of the account of his death perhaps expressed more hope than expectation, which was interpreted by the correspondent as reflecting his state of humility before God (prerequisite of a 'good death'), rather than as a state of religious doubt.

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<sup>62</sup> Diary of Hannah MacDonald, 14<sup>th</sup>-15<sup>th</sup> March 1854, *op. cit.*

<sup>63</sup> Notes on the life and last illness of Josiah Marling, 1834. Marling family. D873 F34, Gloucestershire Archives. Josiah Marling (1816-1834) was the son of William Henry Marling of Stanley Park, Gloucestershire.

<sup>64</sup> *Ibid.*

Reverend Goodhall offered this reassurance about Isaac Allen's demeanour:

'...his manner and behaviour during the whole time we were with him appear to me to have been characterized by gratitude, fortitude and patience. As I have already said he was attended after by Mrs Fenton and my wife and he showed how grateful he was for all that they did for him in many lively and touching ways'.<sup>65</sup>

Here again, the account lists the necessary components of 'gratitude', 'fortitude' and 'patience', required if one were to meet their Maker properly prepared.

What is perhaps striking to the modern reader is that Reverend Goodhall made no attempt to conceal Isaac's physical suffering, and reported on the contrary that 'his sufferings were considerable occasioned by an enlargement of the heart which pressed upon the lungs causing a very painful cough and expectations'.<sup>66</sup> Instead he reassured the family that:

'He never uttered an impatient or complaining word. On the contrary he uttered many expressions of a sense of mercies that he had experienced – manifested an even subdued cheerfulness all the time and even indulged his habit of joking which he did concerning the profuse perspiration that flowed from his head saying its might be called "Riverhead", and talked about the reservoir of the New River at Islington from which all London is supplied with water'.<sup>67</sup>

The reassurance was not then that Isaac died a pain free death, but that he showed fortitude and cheerfulness in the face of pain. This attitude toward pain was also apparent in Granville Lloyd-Baker's account of his father's death in 1886:

'...there was another terrible night. He took food patiently as he said "It is my duty to live as long as I can". At times he suffered terribly. He said more than once "I cannot think why it sh'd [sic] be right that I sh'd [sic] suffer so much, but it is right, so thank God for it".<sup>68</sup>

And again in Quaker John Southall's account of his mother's death in 1846:

'...her faith in God as her Saviour and her ever present Friend has never been destroyed even in the most trying situation of her life or in her deepest sufferings And this implicit reliance on Him, who careth for this own, on Him who is the same yesterday, today and forever, seemed to grow stronger as her end approached'.<sup>69</sup>

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<sup>65</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855, *op. cit.*

<sup>66</sup> *Ibid.*

<sup>67</sup> *Ibid.*

<sup>68</sup> Account of the final illness of Thomas Barwick Lloyd-Baker written by his wife and son. Lloyd-Baker family of Hardwicke Court. D3549 25/9/1, Gloucestershire Archives.

<sup>69</sup> Letter dated 7<sup>th</sup> November 1846. Southall family archive. BG 99/2/10, Herefordshire Archives.

Even Ellen Buxton, who was a child when her younger brother Leonard died in 1861, recorded in her journal that her mother 'told us [Leo] had died about 4 o'clock in the morning, and that [he] had been in great pain before'.<sup>70</sup>

Miriam Bailin has argued that 'it would, I think, be difficult to overestimate the sway that the Evangelical reading of pain had over the Victorian representation of illness' and certainly the cleansing and redemptive nature of pain is alluded to often in accounts of last illness.<sup>71</sup> In an age before effective pain relief such understandings made sense. When pain could not be avoided Christianity gave it purpose and offered hope of a blissful release upon death. Neither, it seems, was this understanding confined to Anglican Evangelicalism. When Ellen Berington, a Roman Catholic, died painfully in 1866, a letter to her husband offered this condolence:

'Poor dear Mrs Berington's death had fixed itself in her mind long long before. After so many months of suffering God took her in His own good time. May He help you know in this awful moment...her suffering here was her purgatory and I have not the smallest doubt she is now before the Throne of God. May ours be like to her blessed end!'<sup>72</sup>

This Catholic interpretation again saw pain as redemptive; offering the hope of reducing the time the dying would spend in Purgatory after death.

Julia Neuberger's claim that in the nineteenth century 'the good death was pain free, or pain dulled by laudanum' was not altogether correct: a pain free death was undoubtedly welcome, but it was not a prerequisite of a 'good death'.<sup>73</sup> The evidence more closely supports Lucy Bending's argument that, for devout Christians, pain had a purpose and people 'accepted pain that was retributive and admonitory, whilst their faith in the atonement suggested the redemptive power of their suffering'.<sup>74</sup> The notion of a 'good death' as a pain free death was the product of Victorian advances in pain management, which continued in the twentieth century and resulted in a death free of pain becoming the central tenet of what most people would now perceive as a 'good

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<sup>70</sup> Creighton, E.R.C. (arr.) *Ellen Buxton's Journal 1860-1864*. Geoffrey Bles, London, 1964, p.18. Elizabeth Ellen Buxton was from a middle class family living in Leytonstone, East London.

<sup>71</sup> Bailin, M. *The Sickroom in Victorian Fiction*. Cambridge University Press, Cambridge, 1994, p.10.

<sup>72</sup> Letter of condolence to Charles Berington on the death of his wife Ellen Mary Berington, 24 August 1866. Berington collection. 705: 24/700, Worcestershire Record Office. The Berington family of Little Malvern, Worcestershire were wealthy Catholic landowners.

<sup>73</sup> Neuberger, J. *Dying Well: a guide to enabling a good death*. 2<sup>nd</sup> edition. Radcliffe, Oxford, 2004, p.4.

<sup>74</sup> Bending, L. *The Representation of Bodily Pain in Late-Nineteenth Century English Culture*. Oxford University Press, Oxford, 2000, p.31.

death' (if 'good' and "death' can still be associated at all). The idea that 'God, doubtless, wills that, by this sickness, you should be taught the lesson of patient and meek endurance' was however difficult for even the most devout Victorian Christians to accept when their loved ones were dying in agony.<sup>75</sup>

Pat Jalland has nevertheless claimed that even when more effective pain relief became available (from the 1860s) 'devout Victorian Christians deprecated an extensive use of opium because it undermined the traditional 'good death' of fortitude in the face of suffering'.<sup>76</sup> A suggested form of prayer for clergy ministering to the sick and dying, issued in 1860 (Appendix C), seems to support this interpretation, being unequivocal regarding the role of pain and the duties of the sufferer, as was much religious guidance of the time. However, despite the unflinching rigidity of such instructions, which were rooted in the idea of a vengeful and punitive Old Testament God, the evidence of this study suggests that in practice (and perhaps understandably) most Christians seem to have adopted a more humane approach, especially once pain relief was widely available and effective.

This study in fact found no evidence that Christian families of any denomination resisted pain relief, or that pain was ever welcomed. James Estcourt, for example, wrote in 1853 when his father was dying of 'a better night than usual five or six hours sleep the consequence of a stronger dose of morphine. He complains of being drowsy today and that I dare say is just as well'.<sup>77</sup>

The presence of pain did occasionally provide an opportunity for chastisement of those whose past conduct was felt to have been wayward:

'I went to see Hannah Williams. The inflammatory rheumatism has gone partly out of her legs but her poor hands are now in fiery agonizing pain. She can bear them in almost boiling water. I talked to her very seriously about her past wild conduct since her Confirmation, and prayed with her'.<sup>78</sup>

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<sup>75</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*, *op. cit.* p.71.

<sup>76</sup> Jalland, *op. cit.* p.87.

<sup>77</sup> Letter dated 22<sup>nd</sup> June 1853. Sotherton-Estcourt family papers. D1571/F566, Gloucestershire Archives. The Estcourt's of Shipton Moyne Gloucestershire were long established Gloucestershire aristocracy.

<sup>78</sup> Plomer, *op. cit.* p.293.



However, Kilvert's apparently unsympathetic attitude could be interpreted as genuine concern for Hannah's soul.

A convincing interpretation of changing Christian attitudes to pain relief came from Julie Rugg, who argued that 'as a greater understanding of medicine and use of opiates removed terror of the arbitrary incidence of death and the deathbed agony, Christian teaching on the afterlife could take a gentler tone'.<sup>79</sup> It does seem that Christian expressions of the consolations of pain as spiritually and morally cleansing manifest themselves more frequently before reliable pain relief became available from the 1860s, but as this was also the time from which Evangelicalism, and Christian belief in general, went into sustained decline, it is difficult to draw definitive conclusions.

Returning to the account of Isaac Allen's death, it concluded by confirming that family members were present to the very end, waiting to hear words of guidance offered by one close to his Maker. The letter reassured the family that Isaac was lucid and conscious until his very last moments and able to say his last goodbyes:

'About ten o'clock he evidently began to sink and fail, and when Fenton said to him "Allen you will soon enter into rest, that rest that remaineth for the people of God", he made a sign of glad acquiescence, and presently called to his wife to kiss him. After this I told him that Mrs Allen had consented to come with her children and commit herself and them, under God, to our care until it should please him to permit them to go to England.

He pressed my hand affectionately and so would have died, I think, only that I was anxious to make way for his poor wife. At last he said "Good night all of you, I shall go to sleep now – perhaps I shall not wake again".<sup>80</sup>

Finally, the description of Isaac's final moments gave clear inference that he was to be among the Saved:

'The last breathings, the least senses, as they appeared to me of all his sufferings lasted but a few minutes, they terminated in his death. Altogether it seemed as if he did as he said "go to sleep not to wake again". It was calm and quiet leaving the countenance with an expression of sweetness and content such as I have never seen equalled. So beautiful was it, that we all as by unanimous consent entreated his widow to observe and mark it, and desired that it should be the last impression of him that she should receive.'<sup>81</sup>

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<sup>79</sup> Rugg, J. From reason to regulation: 1750-1850 In: Jupp, P.C. and Gittings, C. (eds.) *Death in England: An Illustrated History*. Manchester University Press, Manchester, 1999, p.204.

<sup>80</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855, *op. cit.*

<sup>81</sup> *Ibid.*

Although Jalland suggested that 'the Evangelical model of the good death declined in influence in the late Victorian period', its presence was still often to be found as an aspiration, even if some of the fervour of earlier accounts was lacking.<sup>82</sup> When Sir Richard Meade died in 1894, his daughter gave an account of his death to his biographer Thomas Thornton:

'The serious nature of his illness had, at my mother's wish, been broken to him that morning. He learned it with perfect fortitude and resignation, and from what passed in the few intervals of consciousness which he had during the five sad days I was with him and still more from his unconscious words, it was evident that his strong child-like faith in his Heavenly Father never failed him, but was his support through the dark valley.

The last time his mind was clear he begged the nurse to read prayers, saying "We must not forget our duty to God and all His mercies to us, in our great affliction" and some hours later, when he was evidently quite unconscious to the things of the earth, he repeated in very broken accents detached sentences from the General Thanksgiving, the prayer of St. Chrysostom and finally the opening words of the blessing 'The peace of God which passeth all understanding...and the blessing of God Almighty' – after which he scarcely spoke again.'<sup>83</sup>

Sir Richard, although a practising Christian, was not an Evangelical. Although his daughter was clearly thankful that Sir Richard 'passed peacefully and painlessly into the Life Eternal', supporting Jalland's assertion that a death free of physical pain was by this time an increasingly important aspiration, it is also clear that the idea of the manner of death defining the moral stature of the individual remained important, as were indications of spiritual preparedness and signs of salvation, such as the uttering of prayers and the 'child-like faith' in which he departed.<sup>84</sup> Sir Richard's death was still some distance away from the point we have reached today whereby 'the subversion of pain must be an ingredient of any good death'.<sup>85</sup>

What the Victorian model of a 'good death' encouraged was a measure of dignity in death. This is perhaps its most useful legacy as a model for dying to a twenty-first century society, where dignity is often felt to be lacking from the impersonal hospital setting and where prolonging life for as long as possible has arguably taken precedence over quality of life. Care focussed (of necessity, it must be remembered)

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<sup>82</sup> Jalland, *op. cit.* p.51.

<sup>83</sup> Thornton, T.H. *General Sir Richard Meade and the feudatory states of Central and Southern India.* Longman, London, 1898, p.366.

<sup>84</sup> *Ibid.*

<sup>85</sup> Waterhouse, M. *Staying Close: A positive approach to dying and bereavement.* Constable, London, 2003, p.106.

on preparation for death, rather than treatment of illness, meant that care was more orientated toward helping the individual to come to terms with their impending death and to meet their end in as composed a manner as possible. Whilst the religious overtones are no longer relevant to most people, the idea of preparation, choice and control still has value, as especially, does the gathering of relatives and friends at the bedside for last goodbyes.

The Christian concept of a 'good death' was so embedded in Victorian culture that the accounts of 'good deaths' seem on occasions to be contrived and, as with Prince Albert's death, one has to question how close in some cases they actually were to reality. Correspondents writing to absent relatives would, for obvious reasons, want to portray a death as being as close to the model 'good death' as possible and were not, perhaps, always adverse to embellishing parts of their accounts that could point to a 'good death' having occurred. Sometimes, where the pathology of the illness prevented some or all of the obvious manifestations of a 'good' death, with some imagination such a death could still be described in such a way as to appear recognisably 'good'. There was, it seems, considerable leeway possible when interpreting the manner of a death that allowed the bereaved to be able to draw upon the comforts of a 'good death' in coping with their loss. This appears to have been the case when Josiah Marling was dying, where his fears of unworthiness were interpreted as appropriate humility and self-examination. It was also evident when, writing of the death of his mother in 1866, Charles Berington described how 'it appeared that God had not granted her prayer for consciousness at the last, but who knows His merciful ways toward those that serve Him faithfully'.<sup>86</sup>

Inevitably also a 'good death' did not always just reward those considered deserving of it. When Charles' estranged brother James died suddenly in Belgium in 1872 within a week of contracting 'a cold and cough', his family in England clearly had not seen or heard of him for some years and he appears to have been something of a 'black sheep'. A Miss Martin, who announced herself as his niece by marriage and who had lived with James for the past 15 years', described in a letter to the Berington family how:

'...when Mr Berington died he was quite sensible to the last, he died in perfect peace...I am sure there could not be a more happy death, although he suffered much before the

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<sup>86</sup> Account by Charles Berington of the death of his mother Mary Francis Berington 12<sup>th</sup> October 1866. Berington collection. 705: 24/697, Worcestershire Record Office.

Priest came but he called out so many times so loudly “Victory! Victory I shall gain Victory”.<sup>87</sup>

It seems Miss Martin wanted to do everything she could to describe the death in terms suggestive of a ‘good death’, apparent for example in her reference to rapturous last words. It is likely this was a conscious attempt to rehabilitate James in the eyes of his family. Charles however did not let the manner of the death sway his opinion of his brother. He refused to pay off his late brother’s debts, or to intervene to prevent the destitute ‘Miss Martin’ from being evicted from the home she had shared with him and from subsequent arrest for his unpaid debts. He also refused to attend the funeral.<sup>88</sup>

Families, it appears, expected the manner of a relative’s death to reflect in some way their character in life, but in the event that this was not the case, the manner of death usually did not fundamentally alter their opinion of the person. Nevertheless, from the efforts families made to try to facilitate a ‘good death’, not to achieve it must have been a source of regret and additional trauma. Conversely, to enable and witness a ‘good death’ was something positive amidst the grief of bereavement.

There were however deaths that could not be easily assimilated into the model of a ‘good death’ and unfortunately such deaths were all too commonplace. These ‘bad’ deaths included cases where the nature of the disease or injury meant the person was delirious, or in a coma, allowing no opportunity for spiritual preparation and farewells, or where the pain was so intense, or the deceased so frightened of death, that they lost composure or refused to submit placidly to God’s will. Fear of such a loss of self-control was widespread until the advent of effective pain management techniques. Such deaths compounded the grief of carers with a sense of failure and disappointment, and sometimes with fears for the fate of the deceased’s soul, reinforcing also their own dread of the horrors of dying.

Similarly, sudden death could also be considered ‘bad’, as it again did not allow time to prepare, or for loved ones to assemble at the deathbed for last goodbyes. To be suddenly struck down could be interpreted as an act of divine judgement, with the implication of retribution for a life or act of sin. With the prevalence of virulent epidemic diseases, such as cholera, and with a virtually complete lack of health and safety in the

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<sup>87</sup> Letter from Miss Martin dated 26 March 1872. Berington collection. 705: 24/713, Worcestershire Record Office.

<sup>88</sup> Miss Martin’s eventual fate was unrecorded.

workplace, sudden death was a common occurrence. Sarah Arkwright wrote in 1844 of the sudden death of Mrs Henry Arkwright in childbirth that it 'brings powerfully before our eyes the blessedness of being prepared as she was'.<sup>89</sup> To be suddenly struck down was a genuine fear amongst Victorians of all classes and Josiah Marling's death was compared favourably with 'some of his late school friends who had a little time before being snatched away in their sins without any previous warning'.<sup>90</sup> Even when such a death seemed completely contrary to the persons character, it created the fear that that the deceased was not, for reasons known only to God, to be among the Saved.

Beyond these scenarios there were those deaths that were unequivocally 'bad' and which had the potential to cast a deep shadow upon the character and 'respectability' of the deceased, and sometimes, their family as well. In an age when death was still regarded by many as an act of God, rather than a biologically determined event, such deaths were indicative to many of an imperilled soul. These were deaths resulting from suicide or syphilis, both of which brought the implication of insanity or immorality. Dying from such causes cast the deceased in the worst possible light. Suicide was a crime (that of self-murder) and brought financial penalties upon the deceased's family unless an inquest verdict of 'temporary insanity' was recorded.<sup>91</sup>

In the case of syphilis, Richard Davenport-Hines has argued that in the Victorian period 'diseases were weapons in the battle to enforce social order: medical ideas were never sacrosanct questions of scientific interpretation, but were given shape and meaning by the social context in which they were conceived'.<sup>92</sup> Syphilis sufferers (if identified as such) were treated as the lepers of Victorian society and the judgement made upon them often took little account of the circumstances in which the disease had been contracted. The censure extended even into the specialist 'lock hospitals' for sufferers, which 'had to emphasize their efforts at moral reclamation in order to raise funds and... [according to Davenport-Hines] subjected inmates to a particularly sententious regime,

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<sup>89</sup> Letter from Sarah Arkwright to her son John dated 28<sup>th</sup> February 1844, *op. cit.*

<sup>90</sup> Notes on the life and last illness of Josiah Marling, 1834, *op. cit.*

<sup>91</sup> Hence the regularity with which it appeared on death certificates, as juries sought to spare the grieving relatives the additional stress of financial penalties.

<sup>92</sup> Davenport-Hines, R. *Sex, Death and Punishment: Attitudes to sex and sexuality in Britain since the Renaissance*. Fontana Press, London, 1991, p.158.

full of interfering religiosity'.<sup>93</sup> Given the symptoms presented in the terminal stage of the illness, the side-effects of the mercury treatments, and the disgrace brought upon the family, a death from syphilis in Victorian England must have been a truly dreadful ordeal for all concerned.

### ***The 'good death' transformed***

In addition to worries caused by falling observance in the rapidly expanding cities, Victorian Christians were assailed by doubts surrounding literal interpretations of the Bible and the Old Testament God of punishment and retribution became increasingly problematic to believers. In the sphere of end of life care, this resulted in worries about the existence of a Biblical Heaven and uneasiness about the purpose of pain and suffering, which impacted directly on interpretations of what constituted a 'good death'. From the 1850s onward believers were confronted by a barrage of scientific discoveries that challenged Biblical truth, so that 'though religious doubt among Christians was familiar before 1850, the numbers afflicted by it increased considerably thereafter'.<sup>94</sup>

The struggle with doubt became a familiar topic for poets and artists as the century progressed. Tennyson's poem *In Memoriam A.H.H.* (1850) addressed the struggle for belief faced by Christians in an age of reason:

'Strong Son of God, immortal Love,  
Whom we, that have not seen thy face,  
By faith, and faith alone, embrace,  
Believing where we cannot prove'.<sup>95</sup>

Thomas Hardy, whose early faith had withered with age, lamented what he had come to believe was the unavoidable finality of death in *Her Immortality*:

'But grows my grief. When I surcease,  
Through whom alone lives she,  
Her spirit ends its living lease,  
Never again to be!<sup>96</sup>

Henry Bowler's painting *The Doubt: Can These Dry Bones Live?* portrayed a young widow pondering dry bones unearthed in a graveyard and wondering whether they

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<sup>93</sup> *Ibid.* p.189.

<sup>94</sup> Jalland, *op. cit.* p.282.

<sup>95</sup> Tennyson, A. *The Works of Alfred Lord Tennyson*. Wordsworth, Ware, 1994, p.285.

<sup>96</sup> Hardy, T. *The Works of Thomas Hardy, op. cit.* p.50.

could really be resurrected to human form at the Day of Judgement. As Michael Wheeler noted, the painting is ambiguous: it can be read in two ways, either as representing a crumbling of faith in the Resurrection after death, or as the triumph of faith over doubt.<sup>97</sup> Whichever interpretation is preferred, the painting is indicative of the struggle for belief in the face of a deluge of increasingly problematic questions.



Henry Bowler *The Doubt: Can These Dry Bones Live?* (1856)<sup>98</sup>

The often painful process of dying had always raised problems for Christianity: how could a benevolent God permit the suffering that often attended the deaths of righteous believers? Darwin pondered this issue and concluded that 'even if suffering had a moral purpose for mankind, it had no value for other creatures' and hence could not be

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<sup>97</sup> Wheeler, M. *Heaven, Hell and the Victorians*. Cambridge University Press, Cambridge, 1994, p.1.

<sup>98</sup> Source: [Online] Available from: [www.tate.org.uk/collection/N/N03/N03592\\_8.jpg](http://www.tate.org.uk/collection/N/N03/N03592_8.jpg) [Accessed 15th December 2010].

the design of a benign Creator.<sup>99</sup> Orthodox Christian theology had, according to Lucy Bending ‘suggested that pain was both profoundly useful – the atonement brought God and humanity back into alignment, as the fear of hell kept it on the straight and narrow – and retributive’.<sup>100</sup> Medical advances and new Christian theology both undermined this traditional understanding of the purpose of pain. If God was not vengeful and pain could be prevented through medical intervention, why had God created it and why had He not made the secrets of its relief known before? Bending concluded that ‘the seeming indifference behind its infliction, was one of the major stumbling blocks to a faith that upheld the beneficence of an omnipotent God’.<sup>101</sup> Once the biological processes that caused pain started to be understood, belief in its instructive purpose started to disintegrate. This transformation is crucial to understanding some of the key changes in end of life care that occurred in the second half of the nineteenth century.

The death of a child was also an area where faith was tested to its limits. For some like the Taits, who lost five daughters to scarlet fever in the space of a few weeks in 1856, their Christian faith undoubtedly brought consolation and comfort.<sup>102</sup> For Hannah MacDonald it offered the hope of ‘a world where sorrow is unknown’ when her children died.<sup>103</sup> But for others, like Charles Darwin, whose daughter Annie died in 1851, it affirmed his conviction that there was no conscious entity determining who lived and who died:

‘Emma [his wife] hoped that Annie would go to Heaven and that she would join her there, but she could not fathom God’s purpose in taking her child from her. Charles, on the other hand, had no belief that there was any divine purpose behind such events’.<sup>104</sup>

In additions to these changes, which gradually eroded the foundations upon which the Evangelical ‘good death’ was based, not everyone in Victorian England was willing to subscribe to such a prescriptive ideal. The implication that the manner of death reflected upon a person’s moral character was always contentious and, as medical and

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<sup>99</sup> Keynes, R. *Creation: The true story of Charles Darwin*. John Murray, London, 2009, p.279.

<sup>100</sup> Bending, *op. cit.* p.22.

<sup>101</sup> *Ibid.* p.31.

<sup>102</sup> See Benham, Rev. W.M. (ed.) *Catharine and Craufurd Tait, Wife and Son of Archibald Campbell Archbishop of Canterbury: A Memoir*. MacMillan, London, 1888.

<sup>103</sup> Diary of Hannah MacDonald, 31<sup>st</sup> December 1868, *op. cit.*

<sup>104</sup> Keynes, *op. cit.* pp.191-192.



psychological knowledge advanced, more people questioned and challenged such inferences. However, although as scientific understandings of disease and illness evolved some of the stigma attracted by 'bad' deaths was eroded,<sup>105</sup> Richard Davenport-Hines has cautioned against assuming it had disappeared completely, claiming that 'a punitive attitude to patients persisted, although it sometimes was more subtle in its expression...catchwords changed – 'sinner' was replaced by 'delinquent'...[but] the fear, dread and secrecy surrounding the disease [in this case syphilis] proved less eradicable than the microbes'.<sup>106</sup> In general however a more liberal and non-judgemental approach did become more noticeable, as Evangelicalism receded and secularism increased, and it must also be said that many Christians subscribed to a more humane approach even when Evangelicalism was at its height (evidenced by the unwillingness of many Christians families to deny their loved ones pain relief).

Turning to the Victorian novel, a valuable barometer of Victorian middle-class attitudes, resistance can be found to the sentimentalised 'good deaths' that pervaded much Victorian literature, and which were epitomised by the death of Dickens' Little Nell. Although it is unwise to regard these purely as a critique of the 'good death', they do show that it was at least possible for a Victorian middle-class readership to have conceived of 'good deaths' that did not satisfy conventional wisdoms.

Elizabeth Gaskell, who had witnessed life in the Manchester slums at first hand, did not always give her characters the deaths that 'respectable' middle-class readers would perhaps have expected. Her novels give an interesting insight into what her audience would have recognised as a 'good' or 'bad' death and to the extent of deviation from the prescriptive conventions of the Evangelical model, within which a death could still be interpreted as recognisably 'good'. An example of this was the death of Alice Watson in *Mary Barton* (1848):

'She imagined herself once again in the happy, happy realms of childhood; and again dwelling in the lovely northern haunts where she had so often longed to be. Though earthly sight was gone away, she beheld again the scenes she had loved from long years ago! She saw them without a change to dim the old radiant hues. The long dead were with her, fresh and blooming as in those bygone days. And death came to her a

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<sup>105</sup> For example, Durkheim's pioneering work on the causes of suicide *Le Suicide* (1897) and the identification of the syphilis organism in 1905.

<sup>106</sup> Davenport-Hines, *op. cit.* p.246.

welcome blessing, like as evening comes to the weary child. Her work here was finished, and faithfully done.<sup>107</sup>

Gaskell did not describe a conscious and lucid death and Alice was consequently unable to impart words of guidance or confess her sins, there was no rapture or elation in the presence of her Maker, but nevertheless Gaskell knew her readers would interpret this as a 'good death', given the character's long expressed desire to escape the grime and troubles of Manchester and return to her birthplace. References to Alice as 'a weary child' quash any ambiguity, for to approach death in the manner of an innocent child was a familiar indicator of a 'good death' that her readers would have easily recognised. Gaskell also made clear Alice's spiritual worthiness:

'The form faith which her mind no longer had power to grasp, had left its trail of glory; for by no other word can I call the bright happy look which illuminated the old earth-worn face. Her talk, it is true, bore no more than constant earnest reference to God and His holy word which it had done in health, and there were no deathbed words of exhortation from the lips of one so habitually pious'.<sup>108</sup>

In *Ruth* (1853), Ruth Hilton contracted typhus as a result of nursing her dissolute former lover Bellingham, with whom she had an illegitimate child. Despite being led into sin by Bellingham, Ruth was redeemed in death:

'They stood around her bedside, not speaking, or sighing, or moaning; they were too much awed by the exquisite peacefulness of her look for that. Suddenly she opened wide her eyes, and gazed intently forwards, as if she saw some happy vision, which called out a lovely, rapturous, breathless smile. They held their very breaths.

"I see the Light coming" said she. And, raising herself slowly, she stretched out her arms, and then fell back, very still for evermore'.<sup>109</sup>

Gaskell used the death of Ruth both to demonstrate that sin can be redeemed through faith, but also to challenge hypocritical attitudes toward unmarried mothers in Victorian society. Ruth died a 'good death' because despite the hand fate had dealt her she was fundamentally 'good', being in her heart unblemished. Returning to *Mary Barton*, Gaskell chose not to inflict the expected 'bad death' on John Barton, a murderer whose poverty had eroded his faith:

'...the departing soul looked out of the eyes with gratitude. He held the dying man propped in his arms. John Barton folded his arms as if in prayer. 'Pray for us', said Mary, sinking on her knees, and forgetting in that solemn hour all that had divided her father and Mr Carson.

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<sup>107</sup> Gaskell, E. *Mary Barton*. Penguin, London, 1996 [1848], p.339.

<sup>108</sup> *Ibid.* p.339.

<sup>109</sup> Gaskell, E. *Ruth*. Oxford University Press, Oxford, 1985 [1853], p.448.

No other words would suggest themselves than some of those he had read only a few hours before –  
'God be merciful to us sinners. Forgive us our trespasses as we forgive them that trespass against us.'  
And when these words were said, John Barton lay a corpse in Mr Carson's arms.<sup>110</sup>

Of course, the manner of Barton's demise was primarily dictated by the requirements of the novel's plot, but it is nevertheless important to note Gaskell's emphasis on forgiveness rather than retribution. Gaskell obviously believed that her readership would understand and accept that prayer and confession could redeem even those who had committed deadly sins, allowing them to die well, an interpretation in accord with Christ's own teaching.

Thomas Hardy, whose novels and poems reflected his strong social conscience, rejected the notion that the manner of death reflected upon a person's character. This conviction was manifest, for example, in the death of Giles Winterbourne in *The Woodlanders* (1887), who 'never recovered consciousness of what was passing...in less than an hour the delirium ceased: then there was an interval of somnolent painlessness and soft breathing, at the end of which Winterbourne passed quietly away.'<sup>111</sup> For Hardy, a man perhaps ahead of his time, a pain free death was more important than lucid deathbed confessions. Winterbourne's death is more recognisable as a twentieth century 'good death' than a nineteenth century one.

Hardy's dissent from a prescriptive Evangelicalism that had contributed to such sentimentalised fictional deathbeds earlier in the century, reflected (and perhaps even to some extent encouraged) changes in attitudes toward death that were occurring in English society at the time. From the 1870s onwards the emphasis on spiritual preparation gradually gave way to a peaceful and pain free death as the primary objective of end of life care. This was partly due to the decline of Evangelicalism and the rise of more humane Christian discourse, partly due to increasing secularism, and partly because advances in medicine made it more frequently achievable.

The change in attitudes gathered pace from the 1880s and by the early years of the twentieth century a noticeably different concept of what constituted a 'good death' had emerged. The change is apparent in a funeral sermon from 1908, a transcript of which was kept by the Baldwin family (who knew the deceased):

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<sup>110</sup> Gaskell, *Mary Barton*, op. cit. p.372.

<sup>111</sup> Hardy, T. *The Woodlanders*. Penguin, London, 1981 [1887], p.387.

‘...death has given us a shock for it was so sudden. Yet there has been in it no sting. I mean that, though sudden, it was not a shocking death. No, it was not that at all. It was rather an enviable sort of death. In him there was no bed of languishing, no sad decline of strength, no weary days and wearier nights, no pantings and no pain. He passed with enviable speed from serving God on earth to that world where God’s people can serve Him much better. And we can all feel the fitness and the mercy of an end like this, those of us at least who knew anything of him’.<sup>112</sup>

In this account the avoidance of pain had clearly now become a central tenet of a ‘good death’ and although still religious in tone, its sentiment is far more recognisable to a modern reader than accounts from the early and mid-Victorian period. According to the Evangelical criteria of the 1850s, this would have been a ‘bad death’, with no time for preparation or gathering of relatives to maintain a bedside vigil. However, for this speaker the Evangelical ‘good death’ had come to represent a ‘bad death’, with its ‘bed of languishing’ and ‘weary days and wearier nights’.

Although many families continued to adhere to traditional notions of ‘good’ and ‘bad’ death late into the Victorian period, by 1901 their numbers were diminishing. The final demise came with the shock of the Great War, when such concepts abruptly ceased to have value or relevance for a nation witnessing a generation of young men dying sudden, violent and lonely deaths on the battlefields of Flanders and Picardy. Instead, new understandings had to be forged that had meaning to an urban and increasingly materialistic and secular society engaged in the unprecedented bloodbath of industrialised warfare.

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<sup>112</sup> Funeral sermon preached at Hartlebury Church Lexagesina Sunday 1908 transcribed by Eleanor Robertson. Baldwin papers. 705: 775/8229/7 (i), Worcestershire Record Office.

## CHAPTER THREE: MEDICINE AND THE VICTORIAN DEATHBED

This chapter examines the role of medical professionals in the care of the dying in the Victorian home, the extent to which their role changed during the century, and the possible reasons for this, focussing on the issue of the extent of medical authority over the deathbed with reference specifically to the work of Michel Foucault.

Foucault argued that:

‘The space of *configuration* of the disease and the space of *localization* of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time – the period that coincides with nineteenth-century medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze...’<sup>1</sup>

According to Foucault, the medical gaze defined the sick and the dying in particular ways, altering the balance of power between the doctor and the patient, who was both dehumanised and disempowered. In essence Foucault argued that the body became ‘an object to be manipulated and controlled’ by means of disciplinary technologies developed and deployed by a medical elite and disseminated through the new-style teaching hospitals that appeared in the late eighteenth century.<sup>2</sup> The clinical counter was de-individualised, its focus becoming the identification of symptoms generic to a particular disease or condition, rather than unique to the person.

This chapter considers the changes in medicine’s professional status that may have led to this process becoming possible. However, it also identifies evidence of the limitations of medical authority and power in the specific context of end of life care located within the Victorian home. Finally, it suggests why Foucault’s claims did start to become reality toward the end of the nineteenth century through medicine’s ability to control pain, the increasing sophistication of diagnostics and treatments, and the increasing relocation of the dying to the hospital.

### ***Medical status and authority in Victorian England***

At the start of the Victorian age medical theory was only just beginning to move beyond the Classical heroic tradition, which conceptualised disease as the consequence of an

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<sup>1</sup> Foucault, M. *The Birth of the Clinic: An Archaeology of Medical Perception*. Trans. A.M. Sheridan, Tavistock, London, 1976, pp.3-4.

<sup>2</sup> Rabinow, P. (ed.) *The Foucault Reader*. Penguin, Harmondsworth, 1984, p.17.

imbalance in the four (supposed) bodily humours. Laboratory medicine was in its infancy and diagnosis was almost exclusively reliant on external observation and the patient's description of their symptoms. Surgery without anaesthetics or anti-sepsis was itself life-threatening and there was virtually no means of knowing what was happening to a patient internally. Hospitals were few in number and limited in who they were prepared to admit. The emetics, bleedings, blisters and apothecary's potions (often containing toxic heavy metals) that doctors had at their disposal were, at best, largely ineffectual against more serious conditions and, at worst, positively dangerous. In all, until quite late in the nineteenth century 'therapeutic medicine had a very limited power to cure disease'.<sup>3</sup> Even when mortality rates started to improve from the 1870s onwards, medicine's contribution to this process, at least initially, is disputed and it is probable that improved sanitation, living conditions, diet and working practices were more significant to the improvements seen in the nineteenth century.<sup>4</sup>

At the start of Victoria's reign, the public had lost little of their distrust of medicine born in the previous centuries of primitive, ineffectual and often excruciatingly painful interventions. Furthermore, medicine was only just emerging from its association with body-snatching. Until the advent of anti-sepsis and anaesthesia in the 1860s, the hospital remained a place to be feared and, if at all possible, avoided. The failure of some doctors to adopt basic hygiene measures, such as washing their hands between examinations, actually contributed to mortality rates amongst their patients.

Vivisection and anatomy, the tools of the new 'scientific' medical researcher, were subject to moral sanction from the middle classes and the latter was hated and feared by the poor as a result of the Anatomy Act of 1832, which attempted to make the trade in illegally exhumed corpses redundant by allowing the unclaimed bodies of paupers to

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<sup>3</sup> Jalland, P. *Death in the Victorian Family*. Oxford University Press, Oxford, 1996, p.77.

<sup>4</sup> The debate has continued, off and on, since at least 1976 when Thomas McKeown argued that improved nutrition was the key factor in 19<sup>th</sup> century improvements to mortality rates. More recently Simon Szreter has contested McKeown's interpretation, arguing that 'the public health movement working through local government, rather than nutritional improvements through rising living standards, should be seen as the true moving force behind the decline in mortality in this period' (Szreter, S. 'The importance of Social Intervention in Britain's Mortality Decline c.1850-1914: a Re-interpretation of the Role of Public Health', *Social History of Medicine*, No.1 (1988), p.2. See also: Szreter, R. 'Morality and Public Health, 1815-1914', *ReFresh, The Journal of Recent Findings of Research in Economic and Social History*, No.14 (Spring, 1992), pp. 1-4 and Hamlin, C. *Public Health and Social Justice in the Age of Chadwick, Britain 1800-1854*. Cambridge University Press, Cambridge, 1998.

be appropriated by anatomy schools.<sup>5</sup> Even the seemingly benign campaign for compulsory smallpox vaccination was distrusted and resisted, leading in some instances to anti-vaccination riots and to the formation of middle class anti-vaccination campaign groups. The legislation that made vaccination compulsory was viewed by many as, like the Anatomy Act, the Poor Law Amendment Act and the Contagious Diseases Acts, an instrument of social control and oppression. The suspicion aroused by vaccination was apparent as late as 1872, when Louisa Baldwin recorded in her diary that 'poor Cordelia's brother died today of smallpox...she had written to him begging him to be vaccinated but he would not be'.<sup>6</sup>

The Victorian medical profession was itself often resistant to scientific advances that challenged accepted practices or threatened to compromise the clearly demarcated territories of its various branches. Medical advances often happened in the face of opposition from a conservative medical establishment (for example, it took many years for the profession to accept the necessity of hand washing between examinations to prevent deaths from puerperal fever). The medical profession was also permeated with long-standing rivalries and inequality between its branches, with a wide disparity in the status of university educated physicians and that of surgeons and apothecaries, who had learned their craft through apprenticeship systems. Over the preceding centuries medicine had also acquired a plethora of fringe elements: bonesetters, homeopaths, hydro-therapists, mesmerists, phrenologists, herbalists, healers and quacks, whom conventional practitioners regarded as dangerous competition.

It is not perhaps surprising therefore that in the early nineteenth century medicine and doctors were often poorly regarded by the public. Doctors were frequently lampooned as incompetent, avaricious, lecherous quacks, surgery was the stuff of nightmares, and medicines thought more likely to kill than cure, as illustrated by Robert Cruikshank's cartoons from the time of the first cholera epidemic (overleaf).

However, Victoria's reign witnessed a profound transformation in medicine's public image, to the extent that by 1901 something closely resembling the modern profession had emerged from this disparate and, for the most part, poorly regarded collection of practitioners, in which 'medical men had certainly acquired a new role as experts, and

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<sup>5</sup> See Richardson, R. *Death, dissection and the destitute*. Penguin, London, 1989.

<sup>6</sup> Diary of Louisa Baldwin, 28<sup>th</sup> February 1872. Baldwin papers. 705: 779/8229/7 (ii), Worcestershire Record Office.

were using their specialist knowledge to deal with new medical and social problems.<sup>7</sup> The reasons for this quite dramatic transition are complex and widely disputed. What is clear is that traditional interpretations of change driven by scientific discovery and advances in medical knowledge comprise only one component of the process.



Robert Cruikshank *A cholera patient experimenting with remedies* (1832)<sup>8</sup>

Legislative reforms, which distanced mainstream medicine from its fringe elements and made it harder, and thus more prestigious, to qualify in one of its recognised branches, have often been cited as both indicative and facilitating of progress toward the modern profession. The Apothecaries Act of 1815 had 'set standards for qualification and licensing of apothecaries' and was 'the first national regulation of medical education

<sup>7</sup> Brunton, D. The Emergence of a Modern Profession? In: Brunton, D. (ed.) *Medicine Transformed: Health, Disease and Society in Europe 1800-1930*. Manchester University Press, Manchester, 2004, p.146.

<sup>8</sup> Source: Wellcome Library, London [Online] Available from: <http://images.wellcome.ac.uk/> [Accessed 5th October 2010].



and practice'.<sup>9</sup> A generation later, the Medical Act of 1858 'although it did not outlaw unqualified practitioners such as homoeopaths, herbalists, naturopaths and quacks... established the Medical Register which ensured that no one who was unqualified could pass themselves off as a 'proper' doctor'.<sup>10</sup> Later still, the Medical Act Amendment Act 1886 'for the first time made both medical and surgical qualifications, as well as qualifications in midwifery, compulsory for all medical practitioners'.<sup>11</sup>

However, both the motivations for, and the effects of, these legislative changes are disputed. Initially historians viewed them as an essential and inevitable result of medical 'progress'<sup>12</sup>, but more recently they have been interpreted by some as primarily attempts by the powerful medical elites to legitimise themselves and eradicate competition from less conventional and lower status healing practitioners.<sup>13</sup> Others, such as Irvine Loudon, have argued that legislation brought little immediate benefit to practitioners and was 'the product not the cause of changes in the profession'.<sup>14</sup>

Foucault interpreted legislative reforms as part of the professionalisation process that served the interests of particular groups within the profession. It allowed such groups to separate themselves and create a medical discourse that was exclusionary and through which they could control access to medical knowledge within their self-defined constituencies. This argument was developed in the 1970s by Nicholas Jewson, who concluded that 'the use of technical jargon and concepts served as a ritual mode of differentiation between the established and outsiders'.<sup>15</sup>

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<sup>9</sup> Carpenter, M.W. *Health, Medicine, and Society in Victorian England*. Praeger, Santa Barbara, CA., 2010, p.14.

<sup>10</sup> Higgs, M. *Life in the Victorian Hospital*. The History Press, Stroud, 2009, p.114.

<sup>11</sup> Carpenter, *op. cit.* p.12.

<sup>12</sup> See, for example, Ackernecht, E.H. *A Short History of Medicine*. Revised Edition, John Hopkins, London, 1982 [1959].

<sup>13</sup> By Ivan Waddington for example (see Brunton, D. (ed.) *Health, disease and society in Europe 1800-1930: A sourcebook*. Manchester University Press, Manchester, 2004, pp.90-94.) and also Christopher Lawrence – see Lawrence, C. *Medicine in the Making of Modern Britain*, Routledge, London, 1994 (Chapter 2).

<sup>14</sup> Loudon, I. *Medical care and the General Practitioner 1750-1850*. Clarendon Press, Oxford, 1986 In: *Ibid.* p.96.

<sup>15</sup> Jewson, N.D. The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870 In: *Ibid.*, p.5 (originally published in *Sociology*, vol.10, no.2, pp.225-244 (1976))

Foucault saw such changes in medicine as part of broader cultural and social changes which had their genesis in the Enlightenment and its accompanying political revolutions, and in the social and economic effects of the Industrial Revolution. For Foucault, these cultural and economic changes were the key to understanding the rise in medical power during the eighteenth and nineteenth centuries because they created a bureaucratic society that provided a suitable environment for the construction and diffusion of a medical discourse that facilitated the objectification of the sick and subjected them to classification, surveillance and the disciplinary regime of the medical or psychiatric institution.

Another dimension to medicine's ascendant trajectory was, according to Richard Davenport-Hines, that 'the ways in which medical authority was exercised were inseparable from the social position of physicians'.<sup>16</sup> Changes in perceptions of medicine amongst the wider public and its accompanying and inter-related professionalisation, increased the social position of those medical practitioners recognised by the establishment. This change in doctors' social position can be observed by comparing Luke Fildes' painting *The Doctor* (1891), in which the doctor is portrayed as the kind of selfless, caring, attentive and learned professional familiar to the twentieth century, with Cruikshank's uncomplimentary cartoons from earlier in the century.

*The Doctor* was enormously popular amongst the middle-class and 'reputedly helped to raise the standing of medical men in the eyes of the public'.<sup>17</sup> A few years later (1895) Maud Berkeley echoed this view of the doctor as someone who could be trusted implicitly when she recorded that when one of her servants was taken ill 'fortunately Jim [her husband] was able to summon Dr Plunket from his home...all is now in his capable hands'.<sup>18</sup> Even as early as 1858, the year of the Medical Act, Susan Cartwright's sister had remarked that 'it is almost a relief to know that you are fairly taken in hand by the good medical man'.<sup>19</sup>

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<sup>16</sup> Davenport-Hines, R. *Sex, Death and Punishment: Attitudes to sex and sexuality in Britain since the Renaissance*. Fontana, London, 1991, p.159.

<sup>17</sup> Brunton, *op. cit.* p.144.

<sup>18</sup> Fraser, F. (ad.) *The Diaries of Maud Berkeley*. Secker & Warburg, London, 1985, p.169.

<sup>19</sup> Letter to Susan Cartwright from her sister dated 9<sup>th</sup> March 1858. Marling family. D873/C29, Gloucestershire Archives. Susan Cartwright was part of the Marling family of Stanley Park, Gloucestershire.



Luke Fildes *The Doctor* (1891)<sup>20</sup>

There were significant advances in the nineteenth century that materially improved medical practice and the experiences and outcomes for patients, and which consequently increased medical prestige. Surgery was profoundly transformed by advances in understanding of physiology and by anaesthesia, anti-sepsis and asepsis, which from mid-century onwards started to dramatically improve survival rates and brought previously inoperable conditions within the surgeons' orbit. As the century neared its close scientific discoveries came at an increasing rate with advances in bacteriology, blood transfusions, intravenous injections and x-ray technology. Although still often unable to provide cures, by the last quarter of the century, these advances in medical knowledge had laid the foundations for the meteoric progress of medicine in understanding and treating disease that would be witnessed in the twentieth century.

With the Victorian public holding science and technology in such high regard and as a source of national pride (witnessed by the enthusiasm for the Great Exhibition of 1851), these advances served to dispel much of the fear and distrust of the medical profession, which was held in increasing esteem as the century progressed, whilst

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<sup>20</sup> Source: [Online] Available from: <http://www.tate-images.com/results.asp?image=N01522&wwwflag=3&imagepos=3> [Accessed 5th October 2010].

hospitals also underwent a re-imagining in the public mind from sites of disease and terror to sites of therapeutic excellence.

The value placed on scientific method by educated Victorians and the increasing status of medicine attracted funding for research and made the public receptive to new treatments when they did arrive. The Victorians sense of wonder at new medical equipment and techniques was a significant factor in this process. Sophie Blathwayt, for example, found her first encounter with a stethoscope (in 1874) worthy of an entry in her diary, remarking that Dr Merriman 'put some instrument on her chest & his ear to it'.<sup>21</sup> These advances helped to create the aura of knowledge, skill and intelligence surrounding medical professionals that underpinned the sustained advance of medicine in the next century.<sup>22</sup>

Perhaps the most significant scientific advances to increasing medical influence in end of life care in the home, rather than the hospital environment, were those in pain management and understandings of hygiene and infection. The former removed one of the main terrors of dying and the latter transformed the organisation and cleaning of the sickroom and led eventually to the relocation of the contagious sick from the home to the isolation hospital or sanatorium.

Although these developments have been interpreted as creating the conditions for the emergence of a dominant medical profession able to exercise its power over the sick, Foucault's interpretation that medicine had achieved a professional hegemony by *early* in the nineteenth century is more difficult to support when applied to end of life care in the Victorian home. The idea of the patient's individual identity being diminished by a 'gaze' focussed on the source of the disease rather than the person, seems particularly antipathetic to the reality of how end of life care was conducted in the home environment.

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<sup>21</sup> Diary of Anne Linley Blathwayt, 19<sup>th</sup> March 1874. Blathwayt family of Dyrham Park. D2659 20/2 Acc. No. 9167, Gloucestershire Archives.

<sup>22</sup> Having said this, George Behlmer has identified that even in the 1890s, the doctor's bag contained only a very limited range of diagnostic equipment, one consequence of which was that on occasions they lacked the necessary tools to determine with absolute certainty that a patient was actually dead. Fear of being interred alive, Behlmer argues, erupted in the 'moral panic of 1895-6' and highlighted again 'the contested nature of medical authority' (Behlmer, G.K. *Grave Doubts: Victorian Medicine and the Signs of Death* *Journal of British Studies*, No. 42 (April, 2003), p.234 & p.210).

### ***The role of doctors in the care of the dying***

A lack of effective treatments and uncertainty of diagnosis meant that doctors were rarely, in the Victorian period, able to enjoy the level of authority and control over end of life care they have today. However, the improvement in their social and professional status during the nineteenth century did mean that they were increasingly regarded as vital to any proper care for the dying. As Julie Rugg observed, by the late eighteenth century ‘the doctor was becoming a common presence for upper- and middle-class families around the time of death’ and this process continued in the nineteenth century.<sup>23</sup> As the social standing of doctors increased, to be able to afford the services of an elite London consultant may have itself become something of a status symbol. For the working class too, the numbers of GPs and access to their services both increased significantly toward the end of the nineteenth century (in part as a result of the growth in friendly society membership) and even here being able to afford a doctor had become associated with ‘respectability’. Edward Bradley, for example, proudly reported on one occasion that ‘I am having the best medical advice that money can buy for Florence [his daughter]’.<sup>24</sup>

Although the daily routine of care usually fell upon female family members and servants, overseen by the male head of household, doctors increasingly assumed a guiding role, organising carers’ duties and the layout and operation of the sickroom. As a result, the influence of medical discourse in end of life care became more noticeable, although, it is argued, never (in the nineteenth century at least) to the extent that Foucault claimed for institutional settings.

The approaches adopted by different doctors toward patients and carers inevitably varied widely. The greater their professional reputation, the greater the influence they could wield over the sickroom. The advice from ‘Dr Challice’ (Appendix A) demonstrates the paternalistic attitude doctors had toward patients and how their advice could reflect their own, and society’s, prejudices. Davenport-Hines argued (like Foucault) that ‘they interpreted personal experiences in scientific language and met patient’s in circumstances which enforced their authority’, and that families ‘often welcomed imperious behaviour from physicians who were accorded the status of

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<sup>23</sup> Rugg, J. From reason to regulation: 1760-1850 In: Jupp, P.C. and Gittings, C. (eds.) *Death in England: An Illustrated History*. Manchester University Press, Manchester, 1999, p.203.

<sup>24</sup> Letter dated 14<sup>th</sup> September 1869. Records of Brookes and Badham solicitors, Tewkesbury. D2079 II 3/F1, Gloucestershire Archives.

Almighty Fathers intervening between the forces of life and death (and often savagely scorned and repelled as fallen, broken deities when their interventions failed)<sup>25</sup>. Certainly the concept of being 'under the doctor' became widespread in the Victorian period, encouraged by doctors, who, like 'Dr Challice', took every opportunity to emphasise their curative powers. The extent to which doctors were able to exercise the levels of authority Davenport-Hines attributed to them is however questionable.

Importantly, GPs usually examined and treated their patients in their own homes (only the medical elite could summon patients to their consulting rooms). When a local GP was called to treat a social superior, the doctor's authority was circumscribed by his lower class status. GPs, although occupying a higher position than servants or tradesmen, were not treated as equals by the upper and upper-middle classes, despite improvements in their professional status, and if they had any sense behaved accordingly.

GPs were continually at the beck and call of their wealthier clients, placing considerable strain upon them (and restricting the time they had available for less influential patients). Requests for 'immediate' attendance several times a day, or night, were frequent, as when Reverend Charles Blathwayt was dying in 1874 and his anxious family repeatedly summoned the local GP, Dr Merriman, sometimes within an hour of his previous visit, in response to any change in symptoms.<sup>26</sup> A GP could not easily refuse such requests, as their livelihood was often dependent on the goodwill of these influential clients. The lot of the provincial GP in Victorian England was not therefore always a happy one. He may have gained respectability and increased professional prestige, but he was often dependent for a living on the patronage of the local elite, who may at any time take it into their heads to transfer their favour to a local rival or a top London physician, and who were notorious for not paying their bills. Roy Porter observed that:

'...most remained overworked, on call at all hours, 52 weeks a year. They had to be unfailingly civil –or, as they all too often experienced it, servile – to socially superior patients, willing to bear with snobs and slow payers, and inured to bad debts.'<sup>27</sup>

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<sup>25</sup> Davenport-Hines, *op. cit.* p.159.

<sup>26</sup> Diary of Anne Linley Blathwayt, 19<sup>th</sup> March 1874, *op. cit.*

<sup>27</sup> Porter, R. *Bodies Politic: Disease, Death and Doctors in Britain, 1650-1900*. Reaktion Books, London, 2001, p.257.

To retain the patronage of important clients (and persuade them to pay their bills), a Victorian GP needed tact and diplomacy. The kind of well-honed bedside manner epitomised by Luke Fildes' doctor was essential to gain the confidence and trust of patients, and to effectively reassure, support and advise them and their families. Consequently, the Victorian GP often spent much more time with patients than a GP would expect to do today. Doctors compensated for their lack of curative powers by providing pain relief and valuable psychological and emotional support to patients and their families, and this calls into question Jacyna's claim that:

'...while an educated eighteenth-century patient might hope to converse on near equal terms with his or her physician about their condition, by the end of the nineteenth century doctors were basing their diagnoses and planning their therapies on theories that would have meant little if anything to those they treated'

and that this 'led to a form of disenfranchisement'.<sup>28</sup> Doctors may have acquired far more sophisticated and scientific understandings of disease and trauma, and a jargonistic professional language with which to impress their patients, but the evidence of this study does not show them using medical discourse to 'disenfranchise' patients, who expected their doctor to listen to and discuss their narrative attentively, and whose good will and patronage were often essential to the doctor's future career prospects. Neither were well-educated middle or upper class families necessarily overawed by complex medical language, as can be seen from the account of Lady Hale's last illness, discussed later. In these circumstances the imposition of an excluding and unintelligible medical discourse was not likely to be advantageous, what was needed instead were strong inter-personal and communication skills. In reality, GPs were often constrained to recognise a need to empathise with the dying and their families and to respect the other professional who could claim authority over the deathbed: the clergyman.

Therefore, despite Stephen Jacyna's assertion that by early in the nineteenth century 'a fundamental shift in the epistemological basis of the clinical encounter' had occurred, whereby 'the initiative had passed from patient to doctor [who] now based his assessment of the case upon arcane knowledge accessible only to him', the evidence of this study suggests that, in respect of terminally ill patients being treated in their

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<sup>28</sup> Jacyna, L.S. The Localization of Disease In: Brunton D. (ed.) *Medicine Transformed: Health, Disease and Society in Europe 1800-1930*, *op. cit.*, pp.27-28.

homes, this shift did not occur until much later in the century.<sup>29</sup> Until that point 'bedside manner' and dialogue with the patient and their carers continued to form a central part of the clinical encounter. Evidence of the extent to which 'bedside manner' remained important appears in James Estcourt's account of his father's last illness when he wrote that 'he has been comforted by much understanding from [Dr] Wickham'.<sup>30</sup> Elsewhere, speaking of another doctor involved in treating his father he wrote 'he [Dr Williams] is an agreeable man to consult and has applied his mind to the subject very satisfactorily'.<sup>31</sup> This was despite the fact that Dr Williams was able to do little to treat his father's condition. Hannah MacDonald wrote that when her husband was dying 'Dr R. [Radcliffe] sat an hour and a half with him'.<sup>32</sup> Even working class accounts suggest that doctors provided such support. Edward Bradley, for example, wrote when his daughter Florence was seriously ill that 'the doctors are very attentive to the little dear for I have had the best advice'.<sup>33</sup>

The continued importance of the 'patient's narrative' and bedside manner, it is argued, points to the limitations of medical power and authority over the deathbed whilst it remained located in the home, where doctors often had to defer to the family's wishes and to the long established authority of the clergy in matters of death. Only in the twentieth century, as doctors' knowledge of disease and ability to treat it grew enormously did this 'bedside manner' diminish in importance with the result that:

'...those who became patients in the modernized, bureaucratic hospitals of the twentieth century were wont to look back on the Victorian era as a golden age when doctors made home visits and spent hours nursing, as well as doctoring, their patients'.<sup>34</sup>

The next section will look in more detail at the importance of 'bedside manner' in the process of negotiating diagnosis and breaking bad news.

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<sup>29</sup> Jacyna, S. Mr Scott's Case: A View of London Medicine in 1825 In: Porter R. (ed.) *The Popularization of Medicine 1650-1850*. Routledge, London, 1992 In: Brunton, D. (ed.) *Health, disease and society in Europe 1800-1930, op. cit.* p.21.

<sup>30</sup> Letter dated 21 June 1853. Sotherton-Estcourt family. D1571/F566, Gloucestershire Archives.

<sup>31</sup> Letter dated 3<sup>rd</sup> June 1853. *Ibid.*

<sup>32</sup> Diary of Hannah MacDonald, 7<sup>th</sup> May 1854. Baldwin papers. 705/8229/13 (ii), Worcestershire Record Office.

<sup>33</sup> Letter from Edward Bradley to his sister [Mary Ann Dudfield] dated 23<sup>rd</sup> March 1868, *op. cit.*

<sup>34</sup> Carpenter, *op. cit.* p.12.



### ***Negotiating diagnosis and breaking bad news***

Although it has long been recognised that ‘the ability to diagnose, recommend and carry out treatments represents a distinctive form of power’, throughout most of the Victorian era the exercising of such power was not straightforward.<sup>35</sup> Diagnosis and prognosis may have had increasing pretensions to being an exact science, but it appears that often, in reality, negotiation between doctor, patient and carers (with the doctor expected to respond appropriately to verbal and non-verbal cues) shaped the doctors’ pronounced opinion of the case. Symptoms were described, interpreted and discussed so as reach a conclusion and a treatment plan that satisfied the expectations of all parties, as much as reflecting the pathology of the illness. Miriam Bailin has argued that:

‘...because the causes and cure of disease were still largely unknown, treatment was idiosyncratic and highly individualised, tailored to the individual for whom it was devised as well as to the image the doctor wished to project of himself in contrast to his professional rivals. Relations between the sickroom attendants and patients were thus in general characterized by intimacy, informality, and shared meaning, and the experience and treatment of illness were deeply bound up with community norms and values, with the complexities of moral valuation, and with one’s sense of identity, self-worth, and placement within the social order...’<sup>36</sup>

Without modern medical tests and with very limited ability to establish what was happening to the patient internally, combined with limited knowledge of disease pathology, this is not perhaps surprising. Throughout most of the nineteenth century ‘medical diagnosis of a patient’s condition depended largely on what the patient told the practitioner or what the practitioner could see with his own eyes’.<sup>37</sup> The fact that doctors often did not know, and could not work out, what was wrong with their patients meant that they often prevaricated and refused to be drawn as to the likely prognosis, which inevitably caused worry, annoyance and frustration to anxious patients and carers. Elizabeth Gaskell’s account in *Mary Barton* (1848) would undoubtedly have struck a chord with her readers:

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<sup>35</sup> Barry, A-M and Yuill, C. *Understanding the Sociology of Health: An Introduction*. 2<sup>nd</sup> edition. Sage, London, 2002, p.46.

<sup>36</sup> Bailin, M. *The Sickroom in Victorian Fiction*. Cambridge University Press, Cambridge, 1994, p.9.

<sup>37</sup> Carpenter, *op. cit.* p.5.

‘And what does the doctor say?’ asked Mary.

‘Oh! Much what all doctors say: he puts a fence on this side, and a fence on that, for fear he should be caught tripping in his judgement. One moment he does not think there’s much hope – but while there is life there is hope! Th’ next he says he should think she might recover partial – but her age is again her. He’s ordered her leeches to her head’.<sup>38</sup>

The prevarication of Gaskell’s fictional doctor finds parallels in accounts of real consultations. In 1853 James Estcourt wrote to his brother giving a detailed account of the doctor’s diagnosis in the case of their father:

‘Tom has written to you to tell you about Dr Williams’ visit... The result is upon the whole comforting. The disease of the heart is there and is extensive but he cares less about that than the [femoral?] want of power in the frame of my father and in his heart in particular that want of power being apart from the disease. He proposes to give some medicines which shall act if they will upon the kidneys and liver and he expects from them relief. The deposit of water in the liver and abdomen he cares little about – This not much and of little consequence. He said that considering the little [?] of the muscles not withstanding the want of rest which my father has suffered and considering he finds the kidneys and liver sound this [?] he cannot look upon the case as a “break up”. He therefore hopes to bring sufficient relief as to enable the system to recover some strength and to go on for a while. That is better than we could have expected but we must not build expectancy’.<sup>39</sup>

Much of this ‘diagnosis’ consists of vague and general observations on the patient’s condition. Elsewhere James remarked that ‘if anything can be accounted for it is curious to see how satisfied he [his father] becomes’.<sup>40</sup> James expressed no dissatisfaction with Dr Williams’ diagnosis or the lack of a clear prognosis, and appears to have considered it a bonus if the doctor was able to explain anything. In the context of the time however it would have been unusual to have expected anything else. The diagnosis given by Dr Williams was quite detailed by the standards of the time and for him to profess more insight than this could have exceeded the bounds of his knowledge and compromised his credibility. Similarly, when Reverend Charles Blathwayt died in 1874 within a few hours of his doctor pronouncing him ‘decidedly better’ again no one in the family appears to have questioned his competence and he continued to treat other family members.<sup>41</sup>

It appears that failure to cure a patient did not always result in doctors being ‘savagely scorned’ as Davenport-Hines suggested (p.68), unless they were shown to be

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<sup>38</sup> Gaskell, E. *Mary Barton*. Penguin, London, 1996 [1848], p.200.

<sup>39</sup> Letter from James Estcourt to his brother Edward dated 3 June 1853, *op. cit.*

<sup>40</sup> Letter dated 21<sup>st</sup> June 1853. Sotherton-Estcourt family, *op. cit.*

<sup>41</sup> Diary of Anne Linley Blathwayt, 14<sup>th</sup> March 1874, *op. cit.*

incompetent, or were publicly contradicted by their professional peers. This may have been because many people still essentially regarded death as an act of God and thus more readily recognised and accepted the limits of medical power than they are perhaps prepared to today. Failure to cure, or correctly diagnose a patient, did not result in immediate recourse to litigation, or even necessarily to finding another doctor, although as will be seen shortly, resorting to second opinions was common. Although the Victorians placed great expectations on their doctors' curative powers, those families encountered in this study were for the most part forgiving of their limitations, whilst at the same time being quite prepared to get another opinion of the case. People responded to medicine's diagnostic deficiencies in a variety of ways, but although they were often sceptical about individual doctor's abilities, this did not necessarily lead them to question the value of the medical profession *per se* in providing care.

Having said this, evidence of dismay and frustration with doctors' inability to form firm conclusions is not hard to find. Elizabeth Gaskell satirised the dilemmas of diagnosis in *Mary Barton*, when Mary asked the doctor attending Alice Wilson:

'How do you think her?  
Why-a,' began he, perceiving that he was desired to take one side in his answer, and unable to find out whether his listener was anxious for a favourable verdict or otherwise; but, thinking it most probable that she would desire the former, he continued:  
'She is weak, certainly; the natural result of such a shock as the arrest of her son would be'.<sup>42</sup>

Reverend John Sale expressed his frustration with medical evasiveness in his diary for 1873:

'Mrs Winter nice clean woman - sister-in-law of Mrs Morgan talkative – husband has been ill & such illness he has had (fainting fits I sh. think) the woman does not know what. The doctor will not tell her.' [original underlining]<sup>43</sup>

As did Sarah Thomas, who during her sister Kate's illness, recorded that 'when confronted with his opinions of her says he [Mr Cornwall] still can't speak with certainty on her recovery as there is still some doubt about it. I find it all most distressing...my mind is so full of Kate's illness.'<sup>44</sup> Similarly, when Hannah MacDonald's daughter Carrie

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<sup>42</sup> Gaskell, *op. cit.* pp. 271-272.

<sup>43</sup> Diary of Reverend John E. Sale Curate of Dymock 1872-84. Dymock. D8465/1 Acc. No. 8465, Gloucestershire Archives.

<sup>44</sup> Lewis, J. (ed.) *The Secret Diary of Sarah Thomas 1860-1865*. The Windrush Press, Moreton-in-Marsh, 1994, p.36.

was finally given a terminal diagnosis after much conflicting information from her doctor, Hannah recorded that 'Dr Radcliffe has told us today that our dear Carrie is so much worse, that her case is hopeless and the end might be very near. God help me I am bewildered'.<sup>45</sup> When Hannah herself was dying, her daughter Louisa was similarly frustrated, despairingly recording in her diary that she 'wrote to Mr Brown asking him to come tomorrow & tell us plainly how our mother is'.<sup>46</sup> Mr Brown was obviously struggling, as when he arrived the following day he 'said plainly our darling Mother could not recover but that he saw no immediate danger'.<sup>47</sup> Hannah however died the following day.

Sarah Thomas' detailed account of a consultation with the two doctors treating her sister (Appendix D) gives an insight into the way the medical profession reacted to confusing symptoms. Kate had had recurrent bouts of illness during which numerous consultations with her regular GP had failed to identify a cause. Sarah's account shows the difficulties faced by doctors when trying to diagnose in a time before modern medical tests. The fact that the two doctors 'went downstairs to consult privately then returned to tell the treatment', suggests that the doctors did not wish to discuss their thoughts as to the nature of Kate's illness in front of the family. To do so this may have revealed how little they knew or, perhaps, they felt it important to present a united front to the family. The eventual 'diagnosis' was formed more around concepts of female delicacy prevalent at the time than actual symptoms and Sarah despairingly found it necessary to call upon the Almighty to guide the doctors' deliberations.<sup>48</sup>

All clearly had no real idea of what was wrong with Kate or the likelihood of her recovery. The consultation between the two doctors only produced a diagnosis and prognosis in the vaguest terms and was clearly a compromise involving their perceptions of what the family wanted to hear balanced against a need to be as non-committal as possible. Consequently, Dr Evans' prognosis tried to offer reassurance, but without compromising his aura of knowledge and insight: like Gaskell's fictional doctor, he offered hope for the best but also a warning to be prepared for the worst.

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<sup>45</sup> Diary of Hannah MacDonald, 6<sup>th</sup> March 1854, *op. cit.*

<sup>46</sup> Diary of Louisa Baldwin, 26<sup>th</sup> February 1875, *op. cit.*

<sup>47</sup> *Ibid.*

<sup>48</sup> The 'appropriate' advice for a young middle-class woman usually being to lie down, not to go out unless strong enough and the weather was clement, eat only light nourishing meals, and do nothing that would excite the senses.

What this account also demonstrates is the continued importance of the patient's narrative, especially when the nature of the condition was not easily diagnosable by other means.<sup>49</sup>

Lack of reliable diagnostic techniques, it is argued, continued to constrain medical power and authority over the deathbed into the twentieth century and nowhere is this more apparent than in the difficulties doctors faced in pronouncing a terminal diagnosis.

Medical opinion in the nineteenth century generally discouraged doctors from withholding bad news. Dr William Munk recommended the earliest disclosure of a terminal diagnosis in his influential *Euthanasia: or Medical Treatment in Aid of an Easy Death* (1887). Based on Munk's work and articles by other leading experts of the time, Jalland concluded that 'medical candour was the norm' with doctors being anxious to give a terminal diagnosis as early as possible.<sup>50</sup> However, there appears to have been quite a discrepancy between theory and practice over this issue, at least away from the consulting rooms of the medical elite.

Although early terminal diagnosis may have been an aspiration for doctors, many, it appears, felt unable to deliver it. Certainly doctors would be aware that ideally the dying and their families needed time to prepare for death, but given the crude and limited diagnostic tools and techniques available, it was often very difficult to say with certainty that a patient was dying until late in the dying process. When Ellen Buxton's younger brother Leonard contracted scarlet fever in 1861, 'Dr Ansle told us that dear Leo had it also but very slightly, he had only a little rash under his arms and legs'.<sup>51</sup> Four days later he was dead, apparently before Dr Ansle could prepare the family for the worst.

Uncertainty was everywhere apparent and it seems reasonable to assume that doctors sometimes lacked confidence in their own judgement. Mistakenly giving a terminal diagnosis could obviously cause unnecessary pain to the family and compromise the doctor's credibility. In addition, hope was widely regarded in itself as having therapeutic

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<sup>49</sup> Kate continued to suffer persistent symptoms of constipation, rheumatic pains and headaches, which were not fatal but were never properly explained and sadly she died 6 years later, probably in childbirth.

<sup>50</sup> Jalland, *op. cit.* p.113.

<sup>51</sup> Creighton, E.R.C. (arr.) *Ellen Buxton's Journal 1860-1864*. Geoffrey Bles, London, 1967, p.19.

benefits and doctors may well have failed to give terminal diagnosis because patients, or their carers, simply did not want to hear or accept it. The problems for doctors of judging when to declare an illness terminal is apparent in several of the accounts examined for this study. Sometimes it was left to others to break the bad news, or the dying to form their own conclusions, as was the case when Reverend John Sale visited a parishioner in 1873: 'Load much worse – read Ps.51 & prayed – the woman began to realise that it is an illness to death – now is much changed'.<sup>52</sup>

Because giving a terminal diagnosis was such an imprecise art and was recognised to be such, when a terminal diagnosis was made families were in a dilemma as to whether to believe it or not, especially if the patient appeared to be recovering. In 1872 when James Berington was dying in Belgium one letter read:

'I am very happy to tell you that Mr Berington is very much better, there is no danger at all now, but from what the doctor said on Wednesday, I quite thought Mr Berington had but a few hours to live.'<sup>53</sup>

Mr Berington apparently declared that 'the doctors here are so stupid they know nothing and it is only to get the responsibility off their shoulders'.<sup>54</sup> Two days later another letter was sent: 'I am very sorry to say that what the doctor said on Wednesday is too true, he has just left (11 o'clock) and he says Mr Berington is sinking but he may live for 4 or 5 days longer', and the following day another letter stating that 'the doctor gives no hope of Mr Berington's recovery'.<sup>55</sup> James Berington died the following day. In this case there was little tolerance shown of the doctors' dilemma: the English were highly sceptical of the abilities of foreign doctors.<sup>56</sup>

Giving a terminal diagnosis involved an implicit admission that the doctor could do no more and thus curtailed his role in the care of the dying to that of providing pain relief and supervising the sickroom. It also removed the doctor's own hope that he might stumble upon an effective treatment. Doctors frequently appear to have been quite reticent in breaking bad news, deferring the pronouncement for as long as practicably

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<sup>52</sup> Diary of Reverend John E. Sale, *op. cit.*

<sup>53</sup> Letter dated 15<sup>th</sup> March 1872. Berington collection. 705:24/713, Worcestershire Record Office.

<sup>54</sup> *Ibid.*

<sup>55</sup> Letter dated 17<sup>th</sup> March 1872. *Ibid.*

<sup>56</sup> Largely the product of an ingrained xenophobia and an assumption of the superiority of British medicine, and to some extent perhaps through experience.

possible. Three days before the death of her husband in 1868, Hannah MacDonald recorded in her diary that 'Mr Gable thinks him very poorly but hopes he may be relieved a little'.<sup>57</sup> The doctor sensing Hannah's fear of the impending crisis seems to have offered the best comfort he could, using the word 'relieved' but not 'improved'.

Often the family could see for themselves that death was near and had come to terms with this before receiving confirmation from the doctor, as was the case when Edmund Temple Godman's mother was dying in 1882:

'Napper has just been – says mother is very much worse to not be surprised at any time if she were to go off and he can now say with certainty she cannot last many days...to my mind it is just what we have known ourselves for a long time'. [original underlining]<sup>58</sup>

Again, terminal diagnosis appears to have been a negotiated process and the timing of the breaking of bad news may on occasions have had as much to do with the doctor's relationship with the family and the family's psychological needs, as it had to do with developments in the patient's condition. When her daughter Carrie was terminally ill in 1853, Hannah MacDonald thought that it was 'well that I am this day ignorant of the future'<sup>60</sup>, and when Philippa Rose was dying the family 'had no opportunity of asking Dr Astley privately' and felt they 'could not with Philippa'.<sup>61</sup> However, when Josiah Marling was dying in 1834, Dr Smith, who had been consulted for a second opinion, was 'asked for his candid opinion of the case' (which it seems he readily provided and was 'most melancholy').<sup>62</sup>

In the case of Lady Theodosia Hale, who died in 1845, Lady Hale had access to some of the top physicians and surgeons of the age. Her husband also had a scientific view toward his wife's illness, taking a strong interest in her doctors' assessment of her case and the results of the subsequent *post mortem*, and leaving a detailed account of the progression of the disease, written on the day of his wife's death. Initially, the couple consulted the local physician, Mr Norman about Lady Hale's condition:

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<sup>57</sup> Diary of Hannah MacDonald, 11<sup>th</sup> November 1868, *op. cit.*

<sup>58</sup> Letter dated 4<sup>th</sup> June 1882. Telegrams & letters relating to the final illness and death of Edmund Temple Godman's mother, 1882. Records of Francis, Wickins & Hill, Solicitors, Stow-on-the-Wold. D4084/Box 72/7, Gloucestershire Archives. The Godman's were wealthy Gloucestershire landowners.

<sup>60</sup> Diary of Hannah MacDonald, 1<sup>st</sup> January 1853, *op. cit.*

<sup>61</sup> Diary of Anne Linley Blathwayt, 21<sup>st</sup> March 1874, *op. cit.*

<sup>62</sup> Notes on the life and last illness of Josiah Marling, 1834. Marling family. D873 F34 10/76/2, Gloucestershire Archives.

'1845 August twenty third:

She had for a long time past (more than twelve months) been afflicted with serious ailments complaining occasionally of pain in the side particularly the left side and suffering from want of appetite: whilst in Ireland in the winter of 1843-4 she complained of rheumatic pains but then appeared otherwise in health and able to exert herself.

In January last she appeared to be far from well and in consequence of increased disposition and by the advice of Mr Norman on 17<sup>th</sup> Feb. we went into Bath. She was very minutely examined by Mr Norman, a solid substance appeared to exist near the lower part of the stomach of this she had been for some time aware. This did not occasion much pain even when handled but she felt the pain both sides particularly the left and could not with comfort lie on that side, nor with much ease on either – at one time she appeared to derive some benefit from drinking the Bath waters & from bathing; her appetite was somewhat improved but soon after she discontinued drinking the water'.<sup>63</sup>

Lady Hale continued to deteriorate so that by 10<sup>th</sup> April, with her 'continually ill', the couple went to London to consult Sir Benjamin Brodie, one of the leading surgeons of his day.<sup>64</sup>

'Sir B. Brodie and Dr Chambers met in consultation: some medicine, a strong alkali was prescribed to be taken in small beer, clove tea or other liquid. They again met on 20<sup>th</sup> the disease (organic) was supposed to be occasioned by a weakening of the lower part of the stomach. Dr Chambers then informed me that the disease he considered to be of a very serious nature, that it was not accessible to medicine but that there was no immediate danger to be apprehended.'<sup>65</sup>

The language here is interesting: 'supposed to be occasioned by' suggests that the diagnosis was speculative, but the account gives no indication that the couple expected anything more definite. The announcement that her condition was 'very serious', but that 'there was no immediate danger', seems to have covered Dr Chambers against all eventualities and has similarities with the diagnosis given by Dr Evans in the case of Kate Thomas. He allowed room for the couple to continue to hope, but sowed the seed that preparation for the worst was advisable. This may either be viewed as Dr Chambers hedging his bets or diplomatically preparing the couple for death. Dr Chambers certainly gave no indication of wanting to pronounce a terminal diagnosis at the earliest opportunity. When the couple returned home Lady Hale continued taking the medicine prescribed 'though with great distaste' until mid-July, 'sometimes appearing rather better her appetite improved but no decided [original underlining]

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<sup>63</sup> Account of the death of Lady Theodosia Hale by her husband, 23 August 1845. Hale family of Alderley. D1086/F179/10/95/3, Gloucestershire Archives. Lady Hale (1781-1845) was the wife of Robert Hale Blagden Hale (1780-1855) of Alderley, Gloucestershire.

<sup>64</sup> And incidentally, also a devout Christian.

<sup>65</sup> Account of the death of Lady Theodosia Hale by her husband, 23 August 1845, *op. cit.*



change for the better appeared'.<sup>66</sup> She died from what eventually transpired to be cancer in the August.<sup>67</sup>

From the patient's point of view terminal diagnosis may sometimes have been a relief, as it ended the doctor's sometimes highly unpleasant interventions aimed at cure and also because it meant an end to further suffering was in sight. For example, when Philippa Rose was dying of 'acute bronchitis' in 1874, 'the week was one of severe illness with great suffering, so that she was glad when the doctor answered her question "if it was death" "it was" he said'.<sup>68</sup>

From the doctor's perspective, the death of a patient was not necessarily accompanied by the feelings of failure that doctors sometimes attest to today.<sup>69</sup> Of course, the picture is infinitely complicated by doctors' individual beliefs and the circumstances of the individual case, but doctors did not appear to consider the provision of a cure as the sole measure of their success, and understandably so in the circumstances.

### ***Recourse to second opinions***

The frequent and almost obligatory resort to second, even third or fourth opinions, in the medical care and treatment of the dying in wealthier homes is another important indicator of the limitations upon medical power and authority in the nineteenth century.

In virtually all the accounts looked at for this study that involved wealthy families, a second opinion was sought if a period of treatment from the family's usual GP did not produce the desired results. Often more than one doctor could be in attendance at any one time. The account of Lady Hale's last illness records that after her visit to Sir Benjamin Brodie and Dr Chambers in London 'Mr Norman was consulted occasionally'.<sup>70</sup> Similarly, the account of W.H. Prescott's last illness recorded that 'in the shortest possible space of time, several medical attendants were at his bedside,

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<sup>66</sup> *Ibid.*

<sup>67</sup> Interestingly, Lady Hale's husband kept detailed notes on the progression of his wife's illness and the results of a subsequent *post mortem*, which illustrate his ability and willingness to engage with medical discourse and discuss his wife's condition on an equal footing with her doctors.

<sup>68</sup> Diary of Anne Linley Blathwayt, 23<sup>rd</sup> March 1874, *op. cit.*

<sup>69</sup> See, for example, Humphries, J. and Jarvis, S. *The Welcome Visitor: Living Well, Dying Well*. Hodder & Stoughton, London, 2009, p.61.

<sup>70</sup> Account of the death of Lady Theodosia Hale by her husband, 23 August 1845, *op. cit.*

among them – and chief of them – was his and his father’s old friend, Dr Jackson’.<sup>71</sup> On Barwick Lloyd-Baker developing a worrying (and ultimately fatal) cough, his wife within days summoned two doctors to consult together on his condition.<sup>72</sup> Such evidence lends support to Jalland’s observation that ‘the number of such specialists consulted could be quite large when a family was confronted with the likely death of a loved one and wanted to be sure they had explored all possible avenues’.<sup>73</sup>

Given the professional rivalries that pervaded medicine in the nineteenth century, this study found surprisingly little overt evidence that GPs resented a second opinion being sought. Any resentment was well hidden, or at least ignored, by the families, who expected as a matter of course that their local GP would be happy to support any diagnosis and treatment given by a professionally and socially superior rival. Guidance for doctors on the subject in 1849 was that ‘if your patient expresses a very decided wish to have a particular person called in, you ought to acquiesce, provided there be no professional stain on his character’.<sup>74</sup>

On other occasions doctors themselves initiated the involvement of a colleague when they were uncertain about an aspect of the condition they were treating. When the boxer Tom Sayers was dying from consumption in 1865, the physician treating him, Mr Adams, a Fellow of the Royal College of Surgeons consulted ‘Mr Brown’ and ‘Doctor Gull’ ‘for the satisfaction of Dr. Adams himself’.<sup>75</sup> Even the eminent surgeon John Marshall immediately called in a specialist, Dr Seaton, when he suspected his daughter had smallpox.<sup>76</sup> Hannah MacDonald similarly noted in her diary for 1863 that she ‘went with Dr Radcliffe to consult Dr Malem’ regarding her husband’s illness<sup>77</sup> and during Edward Estcourt’s last illness in 1853, his family were employing two doctors at once,

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<sup>71</sup> ‘Last Illness of Prescott’ *Manchester Times* Saturday, August 13, 1864. Gale Document Number: BC3206413466

<sup>72</sup> Account of the final illness of Thomas Barwick Lloyd-Baker by his wife and son Lloyd-Baker family of Hardwicke Court. D3549 25/9/1, Gloucestershire Archives.

<sup>73</sup> Jalland, *op. cit.* p.105.

<sup>74</sup> Fraser, W. ‘Queries in medical ethics’ *London Medical Gazette*. 1849, II, pp.181-3 In: Brunton, D. (ed.) *Health, disease and society in Europe 1800-1930. op. cit.*

<sup>75</sup> ‘Sayers His Last Illness and Death’ *Birmingham Daily Post* 13<sup>th</sup> November, 1865; Issue 2287.

<sup>76</sup> Shonfield, Z. *The Precariously Privileged: A Professional Family in Victorian London*. Oxford University Press, Oxford, 1987, p.182.

<sup>77</sup> Diary of Hannah MacDonald, March 17<sup>th</sup> 1863, *op. cit.*

remarking that 'Dr Williams visit has no doubt obtained for us as [Dr] Wickham would hardly have'.<sup>78</sup>

In the case of Edward Estcourt's illness, the family were clearly dissatisfied with Dr Wickham's diagnoses and treatments, his son remarking that his father was 'apparently thrilled' when it was proposed to send for Dr Williams 'immediately after breakfast before Wickham's visit'.<sup>79</sup> Even working class families, it appears, were not averse to seeking a second opinion if the first was not favourable. Joseph Meason wrote to his sister-in-law Mary Ann Dudfield in 1872 concerning her brother Edward Bradley advising that 'he has had two doctors and they give no hope'.<sup>80</sup>

Occasionally rivalries did become noticeable to patients' families: Sarah Thomas recorded that when it was suggested a rival doctor, Dr Evans, call on her sister:

'Mr [Dr] Cornwall came alone and seemed a little cross with Dr Evans, said he stayed only 10 minutes in Miss Tovey's house and charged her 2 guineas...but we thought his vexation was a sop as he didn't really want Dr Evans to call, thinking he can do for Kate all that is necessary'.<sup>81</sup>

Elsewhere, Sarah recorded that Mr Cornwall 'tried to make out that the medicine Dr Evans had prescribed was only the same as that he himself had given her a fortnight ago, but in different form'.<sup>82</sup> However, the evidence of this study suggests that doctors usually managed to keep any affronts to their ego well hidden from their patients.

Criticism from professional superiors could be very damaging for the unfortunate GP involved, especially if such criticism became public, as was the case when Lord Melbourne died in 1848. An account of his last illness published in the press reported that owing to a deterioration in Lord Melbourne's condition the family consulted 'Dr. Holland of London, that distinguished physician' and went on to describe how:

'...his lordship's local medical adviser treated the case, owing to the new aspect which it had latterly assumed, as one with which indigestion had a great deal to do; but Dr. Holland at once discovered that this was a mistake, and that the peculiar phase of his

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<sup>78</sup> Letter dated June 5<sup>th</sup> 1853. Sotherton-Estcourt family, *op. cit.*

<sup>79</sup> Letter dated 2<sup>nd</sup> June 1853. *Ibid.*

<sup>80</sup> Letter dated 8<sup>th</sup> July 1872. Records of Brookes and Badham solicitors, Tewkesbury, *op. cit.*

<sup>81</sup> Lewis, *op. cit.* p.36.

<sup>82</sup> *Ibid.* p.31.

lordship's illness, which caused him great pain, had its origin in an entirely different cause. Dr Holland accordingly adopted a different mode of treatment'.<sup>83</sup>

Such public criticism is virtually unheard of today and the unnamed (fortunately for him) local GP had little opportunity to reply to the criticism of a professional superior.

The fact that patients and their families were so willing to resort to second opinions demonstrates the fragility of doctors' authority in the period. Their opinions and advice were subject to a considerable degree of scepticism and families were quite prepared to contest medical opinions that they did not agree with, or treatments that did not produce the desired effects. This all points to the limitations of medical power whilst care of the dying remained located in the home.

### ***The limitations of treatment***

Another area in which these limitations upon medical power and authority can be observed has been alluded to already: the medical profession's limited ability to cure or treat most serious diseases. At the start of the Victorian period, treatments in the Classical tradition remained in widespread use. Bleedings, emetics, leeches, enemas, blisters and a range of herb based potions were the usual response to life threatening illness and were for the most part ineffective. Alongside, and in competition with, conventional medicine a plethora of alternative practitioners also flourished. This was the heyday of hydrotherapy, homeopathy, mesmerism and various bizarre electrical treatment devices. It was also an age that saw a flourishing trade in all manner of patented remedies and cure-all elixirs.

Even those who could afford a doctor's prescription faced taking medicines that could do more harm than good and the use of toxic heavy metals in treatments was widespread. Mercury, for example, continued as the primary treatment for syphilis until the advent of salvarsan in the early twentieth century. Arsenic, opium, and hemlock were also commonly found as ingredients in medicines. The administration of blisters, an often prescribed treatment intended to draw toxins from the body, seems to have been particularly unpleasant, Louisa Baldwin recording that 'it hurt diabolically'.<sup>84</sup>

The unlikelihood of a treatment being effective, the cost, and the real threat of potentially lethal side-effects, meant that prescriptions were sometimes challenged but

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<sup>83</sup> 'Lord Melbourne's last illness' *Freeman's Journal and Daily Commercial Advertiser* (Dublin, Ireland) Tuesday, November 28, 1848.

<sup>84</sup> Diary of Louisa Baldwin, 1875, *op. cit.*

more often ignored. Catherine Lloyd-Baker's husband described in a letter how in her last illness 'I lunched at the Highnam to consult Ernest about a plastic jacket. This I found was too painful to be thought of'.<sup>85</sup> Sometimes treatments, even if potentially effective, proved too unpalatable to continue with, as was the case with Martha Southall, whose brother described how:

'...symptoms of suffusion of water which she suffered from in 1838 have returned and she does not feel it right again to reduce herself by strong medicines...but may occasionally [have] taken milder remedies, which however have not removed the complaint'.<sup>86</sup>

Similarly, Lady Hale was prescribed 'a strong alkali...to be taken in small beer, clove tea or other liquid', which as mentioned previously, she took with 'great distaste' and eventually discontinued.<sup>87</sup>

Unfortunately, the inability of doctors to cure or alleviate the symptoms of many life-threatening diseases did not discourage them from prescribing treatments and medications, even when the patient was clearly dying. There was probably an element of placebo effect in some of the treatments prescribed and also of a need for the doctor to appear to be doing something, and to be in control of the situation.

Treatments for deadly epidemic diseases were particularly ineffectual and reflected the lack of understanding of the underlying causes of diseases like cholera and their effect on the internal organs of the body. The treatments for cholera suggested by Dr Challice (see Appendix A) included administering rhubarb (a laxative), and Sylvia Barnard in her work on Victorian Manchester identified treatments that 'consisted of large doses of capsicum, small doses of calomel' (a purgative!) and 'the assiduous application of blankets rung out in boiling water, hot sandbags and mustard poultices'.<sup>88</sup> Often treatment came in the form of recommendations as to diet, light and fresh air premised in miasma theory. Mrs Beeton, drawing upon Florence Nightingale for advice, recommended that:

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<sup>85</sup> Letter dated 12<sup>th</sup> April 1890. Lloyd-Baker family of Hardwicke Court. D3549 28/1/8, Gloucestershire Archives.

<sup>86</sup> Letter dated 14<sup>th</sup> October 1841. Southall family archive. BG99/2/9, Herefordshire Archives.

<sup>87</sup> Account of the death of Lady Theodosia Hale by her husband, 23<sup>rd</sup> August 1845, *op. cit.*

<sup>88</sup> Barnard, S. *'To prove I'm not forgot': Living and dying in a Victorian city.* Manchester University Press, Manchester, 1990, p29.

‘...the patient’s room must be kept in a perfectly pure state...with proper windows, open fireplaces, and a supply of fuel, the room may be as fresh as it is outside, and kept at a temperature suitable for the patient’s state<sup>89</sup>[and] ‘under all circumstances...the sick-room should be kept as fresh and sweet as the open air.’<sup>90</sup>

The retired boxer Tom Sayers was recommended to take a trip to Brighton for his consumption and ‘when there he appeared strong and robust, and like his former self’.<sup>91</sup>

Plain food was usually prescribed, as when the family nurse of the Porter family of Burlingham, Worcestershire was dying in 1818 and the doctor recommended ‘a little sago’, but ‘...to put spice and nutmeg into the gruel’.<sup>92</sup> Mrs Beeton also recommended a ‘plain, nourishing diet’ and provided suitable recipes.<sup>93</sup> A whole culinary genre of invalid cookery evolved in the nineteenth century, with any foods likely to cause sensory stimulation being discouraged.

The lack of effectiveness of most treatments and the unpleasantness of others clearly placed limitations upon the authority and power of doctors, which were inevitably bound up with the ability to demonstrate curative powers. A strong undercurrent of fear and distrust continued toward the medical profession throughout most of the Victorian period that its attempts at treatment often did nothing to dispel.

Having said this, medicine’s influence over the deathbed did increase during the nineteenth century in spite of its relatively poor curative record compared to modern standards. A potential explanation for this is that, on the whole, the public had much lower expectations of the medical profession than they have today and were more accepting that treatments might well not work. Sarah Thomas, for example, noted in her diary that she gave her sister Kate ‘hot gin and water, nutmeg and cinnamon at 11 and some more at 3’ and that this homemade remedy ‘seemed to do her more good than Mr Cornwall’s medicine’.<sup>94</sup> Rather than questioning the competence of Mr

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<sup>89</sup> Beeton, I. *Beeton’s Book of Household Management*. Facsimile edition. Chancellor Press, 1982 [1861], p.1017.

<sup>90</sup> *Ibid.* p.1018.

<sup>91</sup> ‘Sayers His Last Illness and Death’, *op. cit.*

<sup>92</sup> Letter dated 11<sup>th</sup> May 1818. Porter family of Burlingham. 705: 262/3940/60/iii, Worcestershire Record Office.

<sup>93</sup> Beeton, *op. cit.* p.1018.

<sup>94</sup> Lewis, *op. cit.* p.28.

Cornwall, Sarah instead resorted to ‘imploing God to bestow a blessing on the doctor that he might have wisdom and skill to prescribe that which would conduce to her recovery’.<sup>95</sup> Similarly, James Estcourt remarked that the ‘treatment pursued since Dr Williams’ visit may account for much of his [father’s] discomfort and languor’, but did not, it seems, discontinue the treatment.<sup>96</sup> Even when treatment was abandoned, the doctor was not necessarily thought any worse of for prescribing it.

Although effective treatments remained elusive, there were advances in the Victorian period as scientific method was increasingly, and more rigorously, applied to the study of disease and pharmacology. For the first time keeping detailed records of the symptoms of illnesses and the dosage and observable effects a particular treatment (from which statistics could then be used to measure its effectiveness) became widespread and co-ordinated. This change was encouraged by the foundation of medical journals like the *Lancet* (founded in 1823) and the *British Medical Journal* (founded in 1840, originally as the *Provincial Medical and Surgical Journal*), through which research findings could be disseminated and peer reviewed.

The introduction of ether, then later chloroform, transformed surgery. Surgeons were no longer judged by how quickly they could get an operation done and now had much more time to do it properly and to undertake more complex procedures. Previously inoperable tumours could be removed successfully once blood transfusion appeared at the very end of the century (although survival rates still remained low by modern standards). Different schools evolved in the prescription of medicines as the century progressed, many doctors eventually renouncing the use of toxic medications, intended to violently shock the body into recovery, for milder medicines intended to support the body to heal itself.

It can be seen therefore that many of the building blocks for the remarkable advances in treatment made in the twentieth century were put in place during the nineteenth century. However, for much of the nineteenth century itself a lack of effective treatments continued to constrain medical power and authority.

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<sup>95</sup> *Ibid.* p.30.

<sup>96</sup> Letter dated 21<sup>st</sup> June 1853. Sotherton-Estcourt family, *op. cit.*

## ***Reliance on Druggists and Quacks***

For many involved in the care of the dying in the early Victorian period, especially the poor, doctors' prescriptions were unaffordable and resort to the dubious remedies of the druggist, healer or quack was sometimes the only option. In isolated rural communities, folk remedies handed down through generations remained widely used, and 'wise-women' and 'wizards' (the like of Mary Webb's Beguildy) still found a demand for their services.<sup>97</sup> Although on occasions recourse to these alternatives may have worked, their popularity also reflected the desperation of people who could not afford access to conventional doctors, whom they often distrusted anyway, and who dreaded the last resort of the workhouse infirmary. Others were attracted to patented medicines by the lavish claims made for these products in advertisements in this age before any advertising standards legislation.

Although apothecaries were professionalised as pharmacists by the Pharmacy Act of 1868 and thus obtained a legal basis upon which to separate themselves from the druggists, quack doctors and purveyors of proprietary remedies, the Act did not take the further step of outlawing less reputable branches of the trade.<sup>98</sup> After 1868 only qualified pharmacists could call themselves such and dispense poisons on the poisons register, but no qualifications were required to be a druggist, or to market the various patented elixirs and remedies that filled the classified pages of Victorian newspapers. Demand for such remedies was enormous and a flourishing industry developed, with the likes of the Newcastle based quack doctor George Handysides (1818-1904) building a small fortune from his elixirs and cure-alls and eventually becoming a wealthy property developer on the proceeds. Handysides' remedies included a 'blood purifier', a 'cure' for rheumatism and even a 'cure' for consumption!<sup>99</sup>

As Elizabeth Burton observed, by the early Victorian period, 'the old quack doctors had not survived to any great extent but the quack remedy and its vendors flourished more

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<sup>97</sup> *Precious Bane*, 1924. See also: Davies O. *Popular Magic: Cunning Folk in English History*. Hambledon Continuum, London, 2007.

<sup>98</sup> See Porter, R. *Quacks, Fakers and Charlatans in English Medicine*. Tempus, Stroud, 2000.

<sup>99</sup> Blakeman, A. George Handysides: The life & times of the little known Newcastle medicine man *The Antique Bottle and Glass Collector Magazine* [Online] Available from: <http://www.glswrk-auction.com/mc28.htm> [Accessed 5th October 2010].



strongly than ever'.<sup>100</sup> Elizabeth Gaskell, who was intimately acquainted with the slums of Manchester, describes how the poor were especially vulnerable to the druggists:

'He reached a druggist's shop and entered. The druggist (whose smooth manners seemed to have been salved over with his own spermaceti) listened attentively to Barton's description of Davenport's illness; concluded it was typhus fever, very prevalent in that neighbourhood; and proceeded to make up a bottle of medicine, sweet spirits of nitre, or some such innocent potion, very good for slight colds, but utterly powerless to stop, for an instant, the raging fever of the poor man it was intended to relieve...Barton left the shop with comfortable faith in the physic given him; for men of his class, if they believed in physic at all, believed that every description is equally efficacious'.<sup>101</sup>

Self-diagnosis was common even amongst those who could afford a doctor. Francis Kilvert, for example, recorded being 'miserable all day with an attack of cholera [!] and diarrhoea'.<sup>102</sup> Remedies from the druggists and quacks were usually cheaper than a doctor's prescription (although there was some limited provision for free prescriptions available to the poor) and no bounds were placed upon the advertisement of their curative properties. Writing in 1877 Thompson and Smith found the trade in quack remedies still flourishing:

'Far from being in a position to record the extinction of the race of "herbalists" and "doctors for the million" who practise upon the poor, my investigations prove they are still about as numerous as their trade is lucrative... I found in the course of my inquiries that the poor, many of them, prefer either resorting to quack remedies or employing their own paid surgeon, to placing themselves in the hands of the parish doctor, or under hospital treatment'.<sup>103</sup>

Mrs Beeton, although strongly advising that a 'medical man' be sent for as quickly as possible in the event of a serious injury or illness, recommended an alarming array of drugs and instruments be kept in the home in case of need:

'Antimonial wine. Antimonial Powder. Blister Compound. Blue Pill [mercury!]. Calomel. Carbonate of Potash. Compound Iron Pills. Compound Extract of Colocynth. Compound Tincture of Camphor. Epsom Salts. Goulard's Extract. Jalap in Powder. Linseed Oil. Myrrh and Aloes Pills. Nitre. Oil of Turpentine. Opium, powdered, and Laudanum. Sal Ammoniac. Senna Leaves. Soap Liniment, Opodeldoc. Sweet Spirits of Nitre. Turner's Cerate. To which should be added: Common Adhesive Plaster. Isinglass Plaster. Lint. A pair of small scales with Weights. An ounce and a drachm Measure-glass. A Lancet. A Probe. A pair of Forceps, and some curved Needles'.<sup>104</sup>

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<sup>100</sup> Burton, E. *The Early Victorians at Home*. Arrow Books, London, 1974, p.208.

<sup>101</sup> Gaskell, *op. cit.* pp.63-64.

<sup>102</sup> Plomer, W. (ed.) *Kilvert's Diary 1870-1879*. Penguin, London, 1977, p.166.

<sup>103</sup> Thomson, J. and Smith, A. *Street Life in London*. Sampson Low, Marston, Searle, & Rivington, London, 1877 [Online] Available from: <http://www.victorianlondon.org/> [Accessed 26<sup>th</sup> August 2010].

<sup>104</sup> Beeton, *op. cit.* p.1061.

For the poor, such a well-stocked medicines chest would have been unaffordable, but remedies such as those advertised by George Handysides were popular. The services of a qualified physician were also often beyond their financial means, unless they had the means and prudence to contribute to a friendly society, which would provide access to medical assistance in the event of illness or injury, or they were fortunate enough to find a GP who would treat them for free.

Despite the continued flourishing trade for druggists, the professionalisation of pharmacy did improve the quality of medicines available. Dosages became more standardised and symptoms could be better managed. Of particular importance was the fact that the quality and strength of pain relieving drugs became more consistent, making more effective pain management possible. Overall though the mainstream medical profession, despite various Acts of Parliament and vociferous lobbying, failed to curtail, let alone eradicate, the druggists' trade or the demand for patented remedies. As a result, the discourse of the medical establishment, throughout the nineteenth century and beyond, continued to be challenged by a renegade and popular counter-discourse from these and other 'alternative' practitioners.

### ***The role of professional nurses in the care of the dying***

Besides the clergyman, the doctors and the family, the other contributor to the care of the dying in the Victorian home could be a paid nurse. Nurses were often regarded in the eighteenth and early nineteenth century as little above prostitutes in the social hierarchy and had a reputation for being dirty, untrustworthy and licentious.<sup>105</sup> They received no formal training, were usually poorly educated and working class, and only capable of carrying out routine menial tasks. Untrained paupers continued to be employed as nurses in workhouse infirmaries until 1897. This only compounded the poor reputation of care in these places, from whence numerous scandals periodically erupted, such as that at the North Union Prison House in Dublin, where in 1841 mortality amongst resident infants was reported to have reached 61%, a scandal that *Freeman's Journal* reported was the result of the Guardians 'leaving the dying children

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<sup>105</sup> Epitomised by the character of Mrs Gamp in Dickens' *Martin Chuzzlewit* (1843-4).

under the unwatched care of alien hirelings, under whose guidance the death-plague had made such fearful havoc during the past year'.<sup>106</sup>

However, beyond the workhouses nursing underwent a profound change in the middle of the nineteenth century, to the extent that 'by the 1880s, nursing represented a respectable profession for middle- and working-class girls and women'.<sup>107</sup> This remarkable transition was arguably due partly to Florence Nightingale, who challenged the image of the nurse in the public imagination and set new standards for care and behaviour in the conduct of nursing.<sup>108</sup> A second factor was the increase in the number of hospitals and the increasingly regulated and complex care regimes within them. This kind of nursing needed the education, skills and training that attracted middle class women, inspired by Nightingale's reformed image of the nurse. Much of the rise in the status of nursing can be attributed to the standards demanded by hospitals, even though the majority of nurses were not hospital trained and it was not until the early twentieth century that registration became compulsory for all nurses.<sup>109</sup>

In the community, the improvement in the professional status of nurses allowed them increasing access to the deathbed in 'respectable' middle class homes, where they provided much needed respite for female family members. The value of a good nurse was suggested when Louisa Baldwin recorded in her diary for 20<sup>th</sup> February 1870 how:

'...after lunch [I] set forth in a cab for Islington but poor little Aggie saw me from her cab & turned me back, as poor Auntie was far too ill for me to see her & her brain quite deranged. They got a proper nurse yesterday'.<sup>110</sup>

When caring became beyond the physical or psychological resources of family members, those who could afford it were increasingly able to turn to capable professional help, as Granville Lloyd-Baker did during his father's last illness in 1886:

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<sup>106</sup> 'Mortality in the Poor House – The Commissioners' Investigation' *Freeman's Journal and Daily Commercial Advertiser* (Dublin, Ireland) Monday, December 13, 1841. Gale Document Number: BC3204535044.

<sup>107</sup> Higgs, *op. cit.* p.137.

<sup>108</sup> She wrote many books on nursing, her *Notes on Nursing* selling 15,000 copies in 6 months when first published in 1860 (Lane, J. *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950*. Routledge, London, 2001, p.126).

<sup>109</sup> In 1881, there were 35,216 female nurses in Britain and by 1901 64,209, but of this figure only 12,500 were trained or registered and less than a third worked in hospitals, with the majority of the rest nursing the wealthy in their homes. Higgs, *op. cit.* p.137.

<sup>110</sup> Diary of Louisa Baldwin, 20<sup>th</sup> February 1870, *op. cit.*

‘As my father did not mend he [Mr Richard’s, the Archdeacon] rode the next day & got Nurse Beard from the Infirmary’,<sup>111</sup> and again, in his wife’s last illness when ‘a night nurse, Jefferies, came. From this time I was much less with her’.<sup>112</sup>

Some nurses remained with their patients for many years becoming confidantes, as well as carers, if never quite social equals. Jalland observed a ‘rapid increase in the employment of trained nurses for dying patients from the 1870s’ but found that ‘few of these employed nurses were recognised in family letters or diaries as human beings with full names: they were treated like occasional staff, with a status somewhere between that of governesses and domestic servants’.<sup>113</sup> Despite this lack of full acceptance, the sight of the wealthy travelling to health resorts at home and abroad, with their paid nurses in tow, became an increasingly familiar one in the late Victorian period. The more frequent supervision of sickrooms by these professional carers who orchestrated a more medicalised regime of care, it is argued, contributed to the process of distancing the dying from the everyday activity of the household. This in turn contributed to creating the change in perceptions necessary for dying to migrate to the hospital in the following century.

### ***Transformations in the care of the dying: advances in pain relief***

It has been suggested that ‘the process of dying in Victorian society lay beyond the control of the medical profession and took place overwhelmingly within the domestic setting’.<sup>114</sup> The latter point is indisputably true, although hospitals were becoming more important by the end of the century. The former however arguably began to change with the advent of effective pain management and improvements in pain management are, it is suggested, key to explaining medicine’s greater influence and control over the deathbed in the last quarter of the century.

The pain relieving properties of opium were well known in the eighteenth century, but although opiates had been available to patients, little scientific method was applied to their administration. The early Victorians consequently feared being left in the kind of

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<sup>111</sup> Notes entitled ‘my recollections of Dec. 1886’ by Granville Lloyd-Baker, *op. cit.*

<sup>112</sup> Account of the last illness of Catherine Lloyd-Baker by her husband Granville, entry dated 26<sup>th</sup> May 1890, *op. cit.*

<sup>113</sup> Jalland, *op. cit.* p.103.

<sup>114</sup> Mulkay, M. Social Death in Britain In: Clark, D. (ed.) *The Sociology of Death*. Blackwell, Oxford, 1993, p.47.

drugged stupor they associated with opium addiction.<sup>115</sup> In chapter two it was discussed how Evangelical Christians in particular feared losing lucidity as death approached. For Christians pain was believed to be redemptive and spiritually cleansing, if still to be avoided whenever possible. In addition, for medical opinion at the start of the Victorian period, 'pain was thought integral to the body's functions, and essential to healing'.<sup>116</sup> The transition to a position where pain is now regarded as being 'without value' and (to quote Michael Waterhouse again) 'the subversion of pain must be an ingredient of any good death' can be traced to the decline in religious belief, but also to medical advances in pain relief in the second half of the nineteenth century.<sup>117</sup>

At the start of the Victorian period, laudanum (a liquid form of opium) administered orally was imprecise and sometimes insufficiently or, at the other extreme, fatally effective. When, in 1862, Hannah MacDonald's husband was dying she recalled that 'he has to take some kind of opiate every night' which turned out to be '40 drops of Butley', but was still in severe pain and unable to sleep.<sup>118</sup> More controlled pain relief came with the introduction of intravenously administered morphine in the 1860s. This improved precision and effectiveness in pain relief contributed to a marked change in attitudes toward pain in the second half of the nineteenth century, with freedom from pain increasingly important to a 'good death'. Doctors also experimented with other innovative treatments designed to make their patients more comfortable, such as the waterbed set up for Catherine Lloyd-Baker during her last illness in 1890.<sup>119</sup>

The increase in effectiveness of pain relief began to remove one of the main terrors of dying. By 1889, when Granville Lloyd-Baker's sister Selina was seriously ill, her sister Nelly reported 'a bad bout of pain which I am sorry to say she has a great deal of', but very shortly after she wrote again advising that 'Dr Lloyd's remedies have taken effect

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<sup>115</sup> Opium misuse had been a significant problem since the eighteenth century and the subject of what may now be called 'moral panics', with its associations of 'opium dens' and all manner of vice and drug induced depravity.

<sup>116</sup> Snow, S.J. *Blessed Days of Anaesthesia*. Oxford University Press, Oxford, 2008, p.14.

<sup>117</sup> Waterhouse, M. *Staying Close: A Positive Approach to Dying and Bereavement*. Constable, London, 2003, p.106.

<sup>118</sup> 23<sup>rd</sup> April 1862 & 2<sup>nd</sup> May 1862. Diary of Hannah MacDonald, *op. cit.*

<sup>119</sup> Letter dated 3<sup>rd</sup> April 1890. Lloyd-Baker family of Hardwicke Court, *op. cit.*

& she is still better today, in less pain'.<sup>120</sup> For Nelly, the effective relief of Selina's pain relieved a huge emotional burden and she wrote that:

'I was so anxious about her yesterday I do not know that I ought to take any real hope but it is such a comfort that the very bad bout is over & she is like herself again today & able even to talk about the shooting & things'.<sup>121</sup>

The ability to control pain effectively made doctors indispensable at the deathbed in a way they had not been in previous centuries and this, combined with their improved social and professional status, meant they were able to exercise greater control over end of life care. According to Jalland, Victorian doctors had 'a remarkably good record of terminal care, comfort, and palliative management'.<sup>122</sup> Stephanie Snow went further arguing that 'medical charisma was heightened by demonstrations of power over pain [and] nowhere was this more clearly showcased than in the care of the dying'.<sup>123</sup>

By the 1890s Herbert Snow, a surgeon at the London Cancer Hospital, was regularly prescribing opiates to his patients 'arguing that the conjunction of both morphine and cocaine could not only relieve the symptoms of advanced cancer but could indeed slow the progression of the underlying disease'.<sup>124</sup> Advances in anaesthesia also meant that in some cases death could actually be avoided with conditions like appendicitis becoming operable for the first time. As mentioned earlier, general anaesthetics meant surgeons had the time to perfect complex techniques and to undertake procedures that would have taken too long for the patient to endure previously.

The new anaesthetics came as nothing short of a revelation for the Victorians. Experiencing or witnessing their use for the first time was often considered remarkable enough to record in their letters and diaries. In 1849 Sarah Arkwright wrote 'Alice went thro' marvels yesterday with the dentist and as she was allowed a little chloroform she was saved from some pain tho' not from exhaustion since [she had five teeth

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<sup>120</sup> Account of the last illness of Selina, Lady Dynevor, 1889. Lloyd-Baker family of Hardwicke Court. D3549 27/1/3, Gloucestershire Archives.

<sup>121</sup> *Ibid.*

<sup>122</sup> Jalland, *op. cit.* p.77.

<sup>123</sup> Snow, *op. cit.* p.151.

<sup>124</sup> Clark, D. and Graham, F. Morphine, cocaine, and 19<sup>th</sup> century cancer care *Lancet Oncology*, vol. 9 (October 2008), p.1018.

removed]'.<sup>125</sup> In 1871 Kilvert recorded that 'I went to see the dentist McAdam. He showed me the apparatus for giving people the new anaesthetic laughing gas which he thinks much safer than chloroform'.<sup>126</sup>

Advances in pain management made a pain free death possible and consequently it rapidly became an aspiration and an increasingly important objective of end of life care. Pain relief also diminished the fear of doctors that had perhaps contributed to their relative lack of status in previous centuries. It meant admission into hospital for surgery was not regarded as the tortuous hell it had once been and consequently hospitals were seen in a different light. These changes, occasioned by scientific advances, brought care of the dying closer to its familiar twentieth-century model of hospital based palliative care and increased medical influence in the sickroom.

### ***Transformations in the care of the dying: the role of the hospital***

Although there had been an unprecedented spate of hospital building in the eighteenth century, unlike today, most Victorians died at home. In the early Victorian period hospitals were feared and for good reason, as at this time there were neither effective anaesthetics for surgery nor antiseptics and disinfectants. Admittance to hospital could be an excruciatingly painful experience and one that it was quite likely would result in death from infection, even if the original cause for admittance was not itself life-threatening. It is a measure of the desperation of the sick that there was no shortage of demand. In 1861 there were 230 voluntary hospitals in England and Wales, offering 14,800 beds and the number of hospital beds available tripled between 1861 and 1911. There were also 50,000 beds in poor law institutions.<sup>127</sup> Despite this, there remained severe under-capacity.

Those who could afford it preferred to be treated in their own home as they considered befitted their status and 'respectability'. As Mary Carpenter observed, 'one important difference between middle- or upper-class patients and poor or working-class patients was that only the poorer classes were hospitalised'.<sup>128</sup> In the early and mid-Victorian

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<sup>125</sup> Letter dated 27<sup>th</sup> June 1849. Arkwright family of Hampton Court. A63/IV/21/1, Herefordshire Archives.

<sup>126</sup> Plomer, *op. cit.* p.143.

<sup>127</sup> Higgs, *op. cit.* p.17.

<sup>128</sup> Carpenter, *op. cit.* p.25.

period the wealthy 'still regarded [hospitals] as institutions for the poorer classes, where cross-infection and death were likely companions'.<sup>129</sup>

The hospice movement was in its infancy in the nineteenth century and the modern concept of the hospice is a post Second World War invention. There was very little specialist provision for the terminally ill, although significantly, Clare Humphreys has identified that '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'.<sup>130</sup> Two of these institutions termed themselves hospices: Our Lady's Hospice in Dublin and St Joseph's Hospice in London. In these institutions, 'for the first time, dying persons were being looked upon as a group requiring a more specialised form of care which could only be administered within an institutional setting'.<sup>131</sup> Apart from this very limited provision however, home was taken for granted as the preferred place for the terminally ill to die.

Another important factor in the prevalence of home death, was that voluntary hospitals, always short of resources, were reluctant to take patients with chronic conditions that would occupy bed space until they died (although having said this, Humphreys found that 'in practice many patients died before they could be discharged').<sup>132</sup> Hospitals funded by public subscription were at the mercy of benefactors who measured their 'success' in terms of patients discharged as 'recovered'. The proportion of successful recoveries directly affected the hospital's ability to attract and retain funding and for this reason they were unwilling to admit 'incurables'. As Joan Lane observed 'being able to cite good statistics for curing or relieving patients was an important aspect of gaining subscriptions'.<sup>133</sup> A death in hospital was bad for business and as usually a letter of recommendation from a doctor or hospital trustee was needed to gain admittance, it was therefore often very difficult for those diagnosed with chronic terminal illness to access hospital care. Even those who were admitted risked being discharged as incurable, witnessed when Sarah Arkwright described an incident in the 1840s:

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<sup>129</sup> Jalland, *op. cit.* p.103.

<sup>130</sup> Humphreys, C. "Waiting for the last summons": the establishment of the first hospices in England 1878-1914 *Mortality* Vol. 6, No.2, 2001, pp.146-147.

<sup>131</sup> *Ibid*, p.162.

<sup>132</sup> *Ibid*, p.151.

<sup>133</sup> Lane, *op. cit.* p.85.



‘Our long waiting at Derby station was disturbed by the affecting sight of a little invalid boy on his way home from a Hospital as being incurable [original underlining]. It was quite a case for Richard! He was in the second class waiting room – his father a poor man & the home he was being taken to die, such a sad one as his mother also was in a dying state’.<sup>134</sup>

In keeping with the moral codes of Evangelicalism, the sick not only had to be regarded as curable, but had to be considered ‘deserving’ in order to gain admittance. Many hospitals excluded those suffering from venereal disease, prostitutes, unmarried mothers, alcoholics, known ex-offenders, opium addicts or anyone else considered to be of dubious integrity.

For those who were granted admission, their families still sometimes had to feed and clothe the patient themselves. Edward Bradley wrote in 1870:

‘Alice is at home with me much better but Maria and Florence and the Mother as [sic] gone two [sic] hospital with the scarlet fever the Mother as [sic] gone to look after the children poor Willy is ordered off to hospital so there is only me and Alice at home. I have to send the food clothes washing it is our hospital all they find is the doctor and the medicine’.<sup>135</sup>

The skilled working class, who aspired to middle class values, for the most part strived to die at home as they perceived befitted their ‘respectability’. Even the poor, whose homes were less than conducive to caring for the sick and dying, seem to have preferred a home death rather than face the humiliation of admission to the workhouse infirmary, where standards of care in any case could at best be described as unpredictable. It is also clear that the poor dreaded the expense that could arise from receiving treatment. When Edward Bradley died in 1872 it was a disaster for his family and within a year his wife was in the workhouse infirmary and his son William writing begging letters for the 18s fee that was incurred for her treatment.<sup>136</sup>

Julie-Marie Strange has suggested that amongst the poor there were ‘implicit associations between admission to hospital and death alongside a fear that the sick would not receive constant individual attention’.<sup>137</sup> Coupled with this was ‘a desire to

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<sup>134</sup> Letter from Sarah Arkwright to her son John dated Wednesday 6<sup>th</sup> [1844?], *op. cit.*

<sup>135</sup> Letter from Edward Bradley to his sister [Mary Ann Dudfield] dated 20<sup>th</sup> September 1870, *op. cit.*

<sup>136</sup> Letter dated 23<sup>rd</sup> January 1873. *Ibid.*

<sup>137</sup> Strange, J-M *Death, Grief and Poverty in Britain, 1870-1914*. Cambridge University Press, Cambridge, 2005, p.47.

maintain contact and an overriding, if sometimes misplaced, faith in domestic care'.<sup>138</sup> This distrust of institutional care was often well-founded when applied to workhouse infirmaries, which also carried the stigma of a pauper's funeral or, worse still, anatomisation of the corpse if relatives could not muster the money needed to claim and bury the deceased. Flora Thompson recalled how in the 1880s a resident of Lark Rise known as the Major, who her mother had nursed, became 'too old and ill to be able to live alone much longer, even with such help as the children's mother and other kind neighbours could give' and was admitted to the workhouse infirmary.<sup>139</sup> When the Major realised where he was going, he 'collapsed and cried like a child', and was dead within six weeks.<sup>140</sup> The stigma of the workhouse was again apparent in Helen McKenny's diary for 1887:

'...my poor old man, Mr Macklin is dead. How sorrowful are the annals of the poor! A fierce struggle with fate, to wrench a crust of bread, an honest struggle to the last in all weathers, in great suffering-and in the end-a terrible disease-a workhouse bed-a parish grave.'<sup>141</sup>

Late in the Victorian period, as the process of contagion became better understood, specialist hospitals became more numerous, with sanatoriums for tuberculosis patients, isolation hospitals for scarlet fever and smallpox (the first isolation hospital for smallpox opening in 1870), and the so-called lock hospitals for venereal disease. These hospitals mainly served the working class, the rich still preferring, and having the space, to create an isolation room at home. Alongside the more conventional hospitals, health resorts developed at sea-side locations, brine baths and spas. Thousands flocked, for example, to Malvern from mid-century onwards to take the water cure pioneered by doctors Gully and Wilson, who set up there in 1842 and eventually numbered Queen Victoria, Charles Darwin and Florence Nightingale amongst their patrons.

As medical understandings of how infections were transmitted advanced, and hospitals started to earnestly wage war on bacteria through the liberal use of disinfectants and antiseptics, the attitude of the wealthy toward them started to change. The use of

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<sup>138</sup> *Ibid.*

<sup>139</sup> Thompson, F. *The Illustrated Lark Rise to Candleford*. Century Publishing, London, 1991 [1945], p.63.

<sup>140</sup> *Ibid.*

<sup>141</sup> Binney, A. and Vickers, J.A. (eds.) *A City Road Diary: The record of three years in Victorian London by Helen G. McKenny*. 2<sup>nd</sup> edition. WMHS, London, 1978, p.68.

disinfectant had become increasingly widespread in hospitals from the 1850s, as the link between filth and disease started to become widely established. Disinfectants and antiseptics dramatically reduced mortality rates in hospitals and, along with advances in pain relief, removed much of the fear associated with them. Despite these improvements however, many people continued to enter hospital with the sense of trepidation expressed in W.E. Henley's poem *In Hospital* (1889):

'THE morning mists still haunt the stony street;  
The northern summer air is shrill and cold;  
And lo, the Hospital, grey, quiet, old,  
Where Life and Death like friendly chafferers meet.  
Thro' the loud spaciousness and draughty gloom  
A small, strange child — o aged yet so young! —  
Her little arm besplinted and beslung,  
Precedes me gravely to the waiting-room.  
I limp behind, my confidence all gone.  
The grey-haired soldier-porter waves me on,  
And on I crawl, and still my spirits fail:  
tragic meanness seems so to environ  
These corridors and stairs of stone and iron,  
Cold, naked, clean — half-workhouse and half jail.'<sup>142</sup>

Although such fears remained widespread, hygiene improvements, nursing reforms, and the increasing use of technology in medicine, began to create a perception of the hospital as both the best place to recover from illness or injury and to die. Hospitals came to be seen as places of knowledge and excellence where the latest and best treatments, and the most expert and professional care could be provided. By the time Maud Berkeley's parlour maid was suddenly taken ill in 1895, it was in a matter-of-fact way that she noted 'Dr Plunket diagnosed rheumatic fever, and whisked her into hospital'.<sup>143</sup>

As technology, equipment and professional expertise became increasingly important and sophisticated, the role of the family in caring for the dying diminished. The dying became more isolated from the family, removed to the ward, accessible only through the mediation of medical professionals and subject to the routines, regulations and procedures of the hospital that Foucault identified as the disciplinary techniques of medical power. Caring for the dying came to be viewed as a professional job requiring

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<sup>142</sup> Henley, W. E. "In Hospital." *Poems*. 2nd edition. London: David Nutt, 1889. [Online] Available from: <http://www.victorianweb.org/authors/henley/inhospital/henley1.html> [Accessed 26th August 2010].

<sup>143</sup> Fraser, *op. cit.* p.169.

qualified practitioners, rather than as an amateur and domestic role belonging to close relatives.

The emergence of the hospital as the preferred setting for death at the end of the Victorian period was, arguably, the most significant factor in the transition to modern practice, although it should be stressed that hospital based palliative care (to give it its late twentieth century name) did not achieve dominance until much later and death in the home remained the Victorian norm.

## CHAPTER FOUR: FAMILY- LED CARE

The previous two chapters have examined the changing roles and influence of the professions most closely involved with the care of the dying; the clergy, the doctors and the nurses. It is now time to focus upon those who provided the majority of care for the dying in the home setting: the family.

This chapter will examine the roles of family members, how they interacted with professionals to deliver in many cases highly organised and effective care and support, and the cultural influences that impacted on their attitudes toward illness and death. The chapter will also examine the valuable contribution of extended family and the local community in supporting carers at the bedside.

It has already been seen that care of the dying not only involved the immediate family, but elicited a communal response with friends, neighbours and the extended family supporting carers and helping to deliver care. From the wider local community support came in the form of visiting and charitable giving from religiously inspired philanthropists and, in rural communities, shared traditions, beliefs and rituals many of which were centuries old and part of the timeless fabric of village life. Care that was family-led and supported by both extended family and the local community helped to prevent the social isolation of the dying and provided invaluable shared emotional and practical support for carers, a model, it is argued, that still has relevance in modern Britain.

Caring for the terminally ill in the home demanded an energetic and organised response from carers, and was as demanding of their emotions as of their time. Every Victorian could expect that they would, at sometime in their adult life, and in some capacity, need to be involved in providing such care. Those they would be called upon to care for would in all probability be their closest relatives, and they could expect, in turn, to one day be the recipient of such care themselves. Caring for someone who is dying is often a physically, emotionally and psychologically gruelling ordeal, even for professionals, and can be one of the most intense and stressful events anyone can face. Given this fact, and the high mortality rates in Victorian England, it is therefore unsurprising that death and dying featured so prominently in the literature and art of the Victorian age. This, combined with the extravagant rituals of Victorian mourning, has led many commentators to conclude that the Victorians were 'obsessed' with death.

An objective of this chapter is to challenge this assertion and re-evaluate the Victorian response to death and dying.

### ***Caring for the dying as a gendered experience***

One of the most obvious features of care of the dying in Victorian England was that the principal carers were for the most part female. Mrs Beeton was undoubtedly stating a fact when she proclaimed that:

‘All women are likely, at some period of their lives, to be called on to perform the duties of a sick-nurse, and should prepare themselves as much as possible...for the occasion when they may be required to perform the office’.<sup>1</sup>

Nursing was a regular part of everyday life for Victorian women, as was visiting sick family, friends and neighbours. Although professional nurses played an increasingly important role in end of life care toward the end of the century, female family members ‘continued to carry a large share of the burden of nursing the dying, often at considerable cost to their own health’.<sup>2</sup> Miriam Bailin has argued that:

‘In a characteristically Victorian adaptation of the moral assumptions underlying the previous century’s cult of sensibility, the shedding of tears over human distress was not in itself sufficient to attest to one’s benevolence but required instead the practical demonstration of compassion that nursing affords.’<sup>3</sup>

This is perhaps a rather cynical interpretation - in reality, unless the family could afford, and was willing to trust, professional nurses, care for the sick and dying was a duty few Victorian women could avoid.

It has been suggested that:

‘...women were required to spend so much of their lives in the borderland between life and death because they were responsible, within the family setting, for maintaining strong social bonds between the living and the constantly increasing number of the dead’.<sup>4</sup>

and certainly the burden of both the care of the dying and of subsequent public mourning fell predominantly upon women. Men occupied the principal professional

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<sup>1</sup> Beeton, I. *Beeton’s Book of Household Management*. Facsimile edition. Chancellor Press, 1982 (1861), p.1017.

<sup>2</sup> Jalland, P. *Death in the Victorian Family*. Oxford University Press, Oxford, 1996, p.103.

<sup>3</sup> Bailin, M. *The Sickroom in Victorian Fiction*. Cambridge University Press, Cambridge, 1994, p.11.

<sup>4</sup> Mulkey, M. Social death in Britain In: Clark, D. (ed.) *The Sociology of Death*. Blackwell, Oxford, 1993, p.40.

roles: doctor, clergyman and undertaker, and within the family itself, the father, brother or husband directed and facilitated care for the sick and dying, but its day-to-day conduct fell upon the women of the household. Unmarried daughters were expected to care for ageing parents and it was the accepted lot of the spinster in a society that offered little prospect of work outside the home for 'respectable' women. As Jalland pointed out, 'nursing the sick and dying was regarded as a natural role for daughters, especially spinster daughters, who regularly cared for elderly parents until they died'.<sup>5</sup> Such was the lot of Harriet Blathwayt, the unmarried daughter of Reverend Charles Blathwayt, who died in 1874. Harriet's sister Anne recorded that 'he died soon after midnight, that is about 15 minutes a.m. He had been ill 12 years, 5 weeks & 4 days in constant suffering, he would have died but for the nursing Harriet gave him day and night'.<sup>6</sup>

Mary Bradbury has argued that in the course of the nineteenth century 'women's traditionally active roles at the deathbed were replaced by more passive roles' and implied that in middle-class homes this was due to an increasing preference for using the services of paid professionals, such as nurses and undertakers.<sup>7</sup> This interpretation has been supported by Judith Flanders, who claimed that 'for the middle classes, the technological advances of medicine – anaesthetics and surgery in general, and in relation to childbirth in particular – meant that men, doctors, now took over where previously women had ruled'.<sup>8</sup> The extent to which this is true is arguable though, at least before the very end of the Victorian period. While doctors did, as Flanders observed, become more involved in childbirth, it has been seen from chapter three that the 'technological advances of medicine' did not immediately lead to an annexation of end of life care by medical professionals. The evidence of this study suggests that even in wealthy upper-middle class homes, female family members usually undertook the daily care of the dying, often assisted by trusted servants and less frequently by professional nurses (who were in short supply). It was only once

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<sup>5</sup> Jalland, *op. cit.* p.99.

<sup>6</sup> Diary of Anne Linley Blathwayt, 15<sup>th</sup> January, 1874. Blathwayt family of Dyrham Park. D2659 20/2 Acc. No. 9167, Gloucestershire Archives.

<sup>7</sup> Bradbury, M. *Representations of Death: A Social Psychological Perspective*. Routledge, London, 1999, p.13.

<sup>8</sup> Flanders, J. *The Victorian House*. HarperCollins, London, 2003, p.305.

care transferred to hospitals that the role of female family members in care was seriously curtailed.

Despite being subject, in varying degrees, to the authority of the male head of the household, female carers appear to have exercised considerable autonomy in their caring duties. When Sarah Thomas's sister was ill, the doctor prescribed the treatments, but it was Sarah that administered them on a daily basis. Sarah recorded on one occasion that Mr Cornwall had left 'a bottle of white medicine and a blister, but not a syllable with it' and continued:

'We have had a sad night. The blister became so intensely painful that dear Kate could bear it no longer. At 3 this morning she called out to me and I lay with her a while, then I woke Elizabeth to go into the garden for plant leaves, but she didn't like it much and didn't offer to hold the candle for me to show her the ones to pluck. She then lit the fire and we boiled water for me to make the cure, she then went off to bed and left me to do it alone'.<sup>9</sup>

Elsewhere Sarah described Mr Cornwall ordering an enema for Kate, which Sarah then had to administer.<sup>10</sup> Sarah Thomas' experiences demonstrate that female family members not only undertook the menial duties of daily care, but had the responsibility of preparing medicines and ensuring they were taken on time and treatments were correctly applied. As well as the doctor's prescriptions, patent 'medicines' of all descriptions were available from Victorian druggists and were bought and administered by family carers.

The routines and responsibilities involved in the care of the dying are revealed in the daily correspondence regarding the last illness of the Porter family's nurse, Watson, in 1818 (Appendix E).<sup>12</sup> The correspondent in this case clearly felt the pressure of sole responsibility with little support from the doctor, but drew great comfort from her regular correspondence with family members. The correspondence demonstrates a clear sense of duty and obligation, as well as affection, toward this much loved family servant. Letters passed to and fro almost daily throughout May and into June, describing a constant round of sleepless nights, attempts to feed and wash the patient

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<sup>9</sup> Lewis, J. (ed.) *The Secret Diary of Sarah Thomas 1860-1865*. The Windrush Press, Moreton-in-Marsh, 1994, p.30.

<sup>10</sup> *Ibid.*, p.34.

<sup>12</sup> Although from earlier in the nineteenth century the exhausting effort described would have been very familiar to Victorian carers.



and administer a range of apparently ineffective remedies. What is movingly evident is the tireless care provided to Nurse Watson by her employer's family until the end.

This account also demonstrates how physically and mentally exhausting the routine of care was in nineteenth century homes, as Hannah MacDonald found when her husband was dying in 1853 and she referred (in typically understated fashion) to the 'considerable monotony in our circumstances at present', occasioned by 'his nights [being] very bad, the pain preventing sleep' and that 'the absence of sleep in the night and the presence of pain [is] very trying'.<sup>14</sup> Only a year before when her daughters Carrie and Sarah were both ill, Hannah had written 'Carrie keeps better but Sarah's indisposition makes us very busy. Will there be any rest on this side of the grave'.<sup>16</sup> Elsewhere Margaret Evans, on the death of Mary Southall, aged 90, in 1860, described how 'Edward and Mary (and Fanny the maid) attended her through those sad years of mental aberration in the most tender and devoted manner, in fact they scarcely ever left her night and day. At last relatives interfered and said Mary must have relaxation'.<sup>17</sup>

The account of Mary Southall's death suggests that although women were usually the primary carers, male relatives could take a share of caring duties and whilst it was certainly true that 'nursing duties were regarded as women's work', men taking an active role in care may have been more common than has been assumed.<sup>18</sup> When Reverend Charles Blathwayt was dying, his daughter recorded in her diary that 'Linley & Charlie [his sons] came to lift him up one on each side of the bed while he took a mouthful of tapioca & drink'.<sup>19</sup> Granville Lloyd-Baker clearly played an important active role in his father's care during his final illness, his father remarking that 'Granville's strong [and] always a great help'.<sup>20</sup> Granville recalled in his account of his father's death in 1886 how:

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<sup>14</sup> Diary of Hannah MacDonald, April 17<sup>th</sup> 1864. Baldwin papers. 705: 775/8229/13 (ii). Worcestershire Record Office.

<sup>16</sup> Diary of Hannah MacDonald 15<sup>th</sup> January 1853, *op. cit.*

<sup>17</sup> Extracts from reminiscences by Margaret Evans (nee Southall). Southall family archive. BG99/2/176, Herefordshire Archives.

<sup>18</sup> Jalland, *op. cit.* p.98.

<sup>19</sup> Diary of Anne Linley Blathwayt, 12<sup>th</sup> January, 1874, *op. cit.*

<sup>20</sup> Account of the final illness of Thomas Barwick Lloyd-Baker, December 1886. Lloyd-Baker family of Hardwicke Court. D3549 25/9/1, Gloucestershire Archives.

‘...once when he was very ill, I think on Tues’ the 7<sup>th</sup>. On this occasion the others went away at luncheon time & I had him to myself for about an hour. It seemed to me that I managed to do everything for him very comfortably. His gentle loving nature seemed to show itself more & that time was one of the happiest of my life’.<sup>21</sup>

According to Mrs Beeton, caring for the sick and dying required ‘good temper, compassion for suffering, sympathy with sufferers...neat-handedness, quiet manners, love of order, and cleanliness’, qualities that would certainly have been needed in circumstances like those just described.<sup>22</sup> Although doctors oversaw the patient’s care and prescribed treatments, as Sarah Thomas’ and the Porter family’s experiences show, they often provided little in the way of instruction or practical assistance. In such situations the mutual support of close family and friends, helped by extended family and neighbours, was essential. Such support often found focus in the maintenance of the bedside vigil, the importance of which is considered next.

### ***The importance of the bedside vigil***

It was discussed in chapter two how ‘reading by the bedsides of the afflicted and the dying’ was an important component of a ‘good death’.<sup>23</sup> As such, these duties occupied many hours of carers’ time on top of the practical routines of care. Family members (usually the women) would be encouraged by the clergyman to maintain a bedside vigil, sitting, talking, praying or reading from the Bible with the dying. When Edmund Temple Godman’s mother died in 1882, he described how ‘Nell & Mary have been reading to her...& I believe she could follow them until about 5pm when I fancy she began to become unconscious’.<sup>24</sup> Similarly, when Lady Hale was dying in 1845 her husband wrote that ‘fully aware that her end was approaching she had the prayers for the sick of others regularly read to her’<sup>25</sup> and again, when Isaac Allen’s died in 1855:

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<sup>21</sup> *Ibid.*

<sup>22</sup> Beeton, *op. cit.* p.1017.

<sup>23</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick.* Society for Promoting Christian Knowledge, No.1168, London, c.1860, p.3.

<sup>24</sup> Letter dated 28<sup>th</sup> June 1882. Records of Francis, Wickins & Hill, Solicitors, Stow-on-the-Wold. D4084/Box 72/7, Gloucestershire Archives.

<sup>25</sup> Account of the death of Lady Theodosia Hale by her husband, 23<sup>rd</sup> August 1845. Hale family of Alderley. D1086/F179/10/95/3, Gloucestershire Archives.

'From that time until about 11 o'clock at night, his wife, Mr and Mrs Fenton and ourselves were constantly around his bed. Mrs Fenton and my wife as nurses, (his wife's situation at that time disabling her from doing anything but sit in a chair beside him). Mr Fenton his colleague, as pastor and spiritual adviser, and I, as a friend of himself.'<sup>27</sup>

Absent family members would often go to considerable lengths to try to be present at the bedside before death occurred. When Edward Bradley and two of his children died in 1872, his wife wrote to Edward's sister Mary Ann Dudfield:

'Willie [his son] was in the room at Alice's death and was with me some days before as the poor boy got his pass renewed to help his mother through some of her troubles as I was obliged to move from the Barracks after a certain time through the death of my poor husband and poor Willie had to come all the way from Glasgow such a fearful expenses to the poor lad was sent a telegram as his father craved so hard to see his boy at his dying moments and he arrived just in time to follow his remains to the grave'.<sup>28</sup>

Remembering Oakley's portrayal of Prince Albert's deathbed in chapter two, the Prince of Wales was portrayed holding his father's hand and listening intently and earnestly to his dying words. This was not accidental: many people blamed the Prince of Wales for his father's premature death and the picture was probably partially an attempt to rehabilitate him in the minds of a disapproving public by showing his reconciliation with his father and his dutiful attendance in his last moments.<sup>29</sup> This points to the emotional and psychological benefits of the bedside vigil – it was a chance to say goodbyes, for reconciliation, and to share mutual comfort and support.

If the symptoms of the illness permitted, children were often encouraged to see dying parents or siblings in the hours before death and to view the body afterwards, something that became increasingly discouraged in the twentieth century as death was banished from the home. Elisabeth Kübler-Ross has argued that it can, under the proper circumstances, be beneficial for children to be included in this manner to give them 'the feeling they are not alone in grief' and offer them 'the comfort of shared responsibility and shared mourning'.<sup>30</sup> Ellen Buxton, who was thirteen when her younger brother Leonard died in 1861, was taken to view his body by her parents:

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<sup>27</sup> Diary of Ebenezer Brown Allen, 1<sup>st</sup> June 1855. Papers relating to Samuel James Allen and Family. Acc 100/D2, York City Archive.

<sup>28</sup> Letter dated 22<sup>nd</sup> August 1872. Records of Brookes and Badham solicitors, Tewkesbury. D2079 II 3 F1 2<sup>nd</sup> bundle, Gloucestershire Archives.

<sup>29</sup> Albert was believed to have contracted typhoid whilst on a mission to attempt to sort out one of Bertie's many scandalous liaisons.

<sup>30</sup> Kübler-Ross, E. *On Death and Dying*. Routledge, Abingdon, 1973, p.6.

'Papa told us to remember his dear face all our life & to look at him intently he did indeed look lovely, and just as though he were asleep; because his beautiful large brown eyes were shut'.<sup>31</sup> For some however, like the sensitive Francis Kilvert, it was a source of trauma that stayed with him into adulthood:

'I had not touched death for more than 30 years, and it brought back the sudden shock I felt when as a child I was taken into a room at Hardenhuish Rectory where our little sister lay dead and was told to touch her hand'.<sup>32</sup>

The opportunity to see loved ones before death was often found beneficial however, as when Hannah Southall died in 1841 and Maria Barr wrote to her husband that 'it gave me peculiar pleasure to learn that the dear young people had all had the great privilege and satisfaction of parting interviews'.<sup>33</sup> Later in the period, when Catherine Lloyd-Baker's children came in to see her in her last illness, her husband recalled that:

'She gathered her strength & told them clearly and brightly that the end was coming & that she did not suffer much & should go away gradually as an Angel. She looked like one then such a beautiful smile "you must think of me not as suffering much but going gradually & peacefully like an Angel".<sup>34</sup>

The value of such goodbyes for the dying, and for their grieving children, appears to have been well understood by Victorian families, but is something that has only been rediscovered relatively recently through the work of people like Edmund Howe, Frances Sheldon and Grace Christ.<sup>35</sup>

A bedside vigil in the last hours before death was important because both last words, if imparted lucidly and without evident suffering, and the countenance of the person at the moment of death, could leave the bereaved with positive memories of the death, especially if they believed in the Christian afterlife. For example, in her diary for 1868,

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<sup>31</sup> Creighton, E.R.C. (arr.) *Ellen Buxton's Journal 1860-1864*. Geoffrey Bles, London, 1967, pp.18-21.

<sup>32</sup> Plomer, W. (ed.) *Kilvert's Diary 1870-1879*. Penguin, Harmondsworth, 1977, p.364.

<sup>33</sup> Letter from Maria Barr to John Southall dated 27<sup>th</sup> November 1841. Southall family archive. BG99/2/9, Gloucestershire Archives.

<sup>34</sup> Letter dated 11<sup>th</sup> July 1890. Lloyd-Baker family of Hardwicke Court. D3549 28/1/8, Gloucestershire Archives.

<sup>35</sup> See Howe, E.G. Red Towels: Maximising the Care of Patients who are Dying *The Journal of Clinical Ethics*, Vol.19 No.2, pp.99-109 [Online] Available from: <http://www.dcsswift.com/military/bioethics/Papers/RedTowels.pdf> [Accessed: 12 November 2011], Sheldon, F. *Psychological Palliative Care: Good practice in the care of the dying and bereaved*. Stanley Thornes, Cheltenham, 1997, chapter 5 and Christ, G.H. *Healing Children's Grief: Surviving a Parent's Death from Cancer*. Oxford University Press, Oxford, 2000, pp.200-201.

Hannah MacDonald recorded on the death of her husband that ‘the sight of the beautiful face in all the calm majesty of death seems to indicate he has fought the fight and won the victory. Thanks be to God, through our Lord Jesus Christ’.<sup>36</sup>

One of the principal carers’ many roles would be to decide, in consultation with the doctor, when visitors to the deathbed should be allowed and who those visitors should be. In some cases the volume of visitors, however well meaning, was an additional burden upon the dying and their carers, as Barwick Lloyd-Baker’s wife recorded: ‘towards the end of the week & the beginning of next week several people came to see him & he had much real [original underlining] talking which increased his cough’.<sup>37</sup> Guidance for clergymen visiting the sick, issued in the 1860s, identified this as an issue and sought to address it:

‘With respect to the proper time of day for paying visits to the poor and the sick, much will, of course, depend upon the circumstances of individual cases, but, as a general rule, the afternoon will be found most convenient, for, the principal meal being over, the house is likely to be least disturbed by members of the family coming and going, and sick persons are notoriously more at ease at that period of the day, than at any other’.<sup>38</sup>

Dying was much more of a public act than in England today. Although its retreat into the private sphere was underway by the start of Victoria’s reign amongst middle-class families, who had started to separate home and work life and turn the home into a private sanctuary, ‘in working-class areas the move away from informal patterns of care in which specific members of the community could be approached...took longer to disintegrate’.<sup>39</sup> The regular stream of visitors brought its strains, but it also avoided the kind of social isolation identified by Geoffrey Gorer and others as characterising the late twentieth century experience of dying in an institutional setting.

### ***The role of absent relatives and friends***

The revolution in communications that occurred during the Victorian period facilitated, for the first time, long-distance family support networks. With two postal deliveries a day, the movement of mail by railway, a network of Post Offices throughout Great Britain, and later the telegraph, it was increasingly possible to keep up to date with

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<sup>36</sup> Diary of Hannah MacDonald, 14<sup>th</sup> November 1868, *op. cit.*

<sup>37</sup> Account of the final illness of Thomas Barwick Lloyd-Baker, 4<sup>th</sup> March 1883, *op. cit.*

<sup>38</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*, *op. cit.* p.8.

<sup>39</sup> Bradbury, *op. cit.* p.13.

events in near real-time. The introduction of the penny post in 1840 and half-penny post cards later in the period also brought postal communication within the affordable reach of the increasingly literate masses for the first time.<sup>40</sup>

As a result of these technological and administrative advances, a noticeable feature of Victorian accounts of last illness and death is the support that carers and the bereaved received through regular, sometimes daily, correspondence from absent family members and friends. A constant stream of letters and telegrams providing updates on the patient's condition flowed in one direction, with words of advice and support in the other. When Edmund Temple Godman's mother was dying in 1882, his brother, who was at his mother's bedside, sent daily bulletins to absent family members.<sup>41</sup> These bulletins detailed any slight changes in her condition or the latest opinion from the doctor.

Sometimes death occurred suddenly, in which case letters and telegrams would bring family and friends to the aid of the grieving, as occurred when, notified of the death of a friend's wife in childbirth, Reverend F.E. Witts rushed to his house, finding:

'...poor Howell very grievously affected at meeting me in his bedroom, where I found him with his children Emmeline and Edward, the latter having been fetched from his tutor's Mr. Moore's at Brimsfield...Howell received a dreadful shock, and it has told on his bodily constitution which appears deranged'.<sup>42</sup>

In an age before professional councillors, family support workers, or social workers, networks of extended family, friends and neighbours provided the only source of support available to the dying and their carers. If comparisons between the present and the Victorian age are appropriate at all, it is perhaps in this area of community and family support that the modern care of the dying compares the most unfavourably. The sense of social isolation experienced by the dying, as communities have withered and families dispersed, appears evident only rarely in Victorian England outside of the most transient urban populations. A communal response to serious illness and death was the norm. The sociologist Allan Kellehear has suggested that 'in the good death, dying roles are shared between the dying and their community with each knowing which roles

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<sup>40</sup> The education reforms of the late nineteenth century also meant the masses were becoming more literate.

<sup>41</sup> Records of Francis, Wickins & Hill, Solicitors, Stow-on-the-Wold, *op. cit.*

<sup>42</sup> Verey, D. (ed.) *The Diary of a Cotswold Parson: Reverend F.E. Witts 1783-1854*. Alan Sutton, Gloucester, 1978, pp.165-166.

belong to whom'.<sup>43</sup> The Victorians would have been entirely at home with this concept, especially in settled rural communities, yet today it seems so difficult to achieve and interaction with the dying and the bereaved is circumscribed by awkwardness and embarrassment.

### ***Romanticism, sentimentality and an obsession with death?***

This section explores the influence of Romanticism on Victorian attitudes to death and how the characteristically sentimental language and imagery that it produced has contributed to a widespread assumption that the Victorians were 'obsessed' with death.

James Stevens Curl, the great historian of Victorian funerary practices, referred to 'the strangeness of the period, with its obsessions about death, its high moral tone, and its sentimentality'.<sup>44</sup> Michael Wheeler claimed that 'evidence of the Victorians' obsessive interest in death is as widely available in the imaginative literature of the period as it is in the theology'.<sup>45</sup> D. Lyn Hunter referred to the Victorians' 'almost fanatical obsession with death'<sup>46</sup>, with A.N. Wilson suggesting that 'medieval Spain could hardly produce images more macabre'.<sup>47</sup> Zuzanna Shonfield even described the entirely prudent custom of Victorian mothers-to-be making a will as 'morbid'.<sup>48</sup> The image of Victoria in her 'widows weeds', the ostentatious funerals of the Victorian middle classes and their rigid mourning practices, and the sentimentality of Victorian literature and art when on the subject of death, have all contributed to this impression.

Sentimentality and melancholy unquestionably permeate Victorian descriptions of last illness and death and Michael Wheeler has suggested that 'an emotional attachment to the sentimental found expression through the 'deathbed scene' so beloved of Victorian novelists and artists', and which became 'a familiar literary convention not only in prose

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<sup>43</sup> Kellehear, A. *A Social History of Dying*. Cambridge University Press, Cambridge, 2007, p.166.

<sup>44</sup> Curl, J.S. *The Victorian Celebration of Death*. Sutton, Stroud, 2000, p.265.

<sup>45</sup> Wheeler, M. *Heaven, Hell and the Victorians*. Cambridge University Press, Cambridge, 1994, p.28.

<sup>46</sup> Hunter, D.L. A Victorian Obsession with Death *Public Affairs*, Vol.28, No.7 (April, 2000) [Online] Available from: <http://www.berkeley.edu/news/berkeleyan/2000/04/05/death.html> [Accessed 21 July 2007].

<sup>47</sup> Wilson, A.N. *The Victorians*. Arrow Books, 2003, p.539.

<sup>48</sup> Shonfield, Z. *The Precariously Privileged: A Professional Family in Victorian London*. Oxford University Press, Oxford, 1987, p.225.

fiction but also in narrative poetry and biography'.<sup>49</sup> Stephen Garton has commented that 'mordant sentimentality and stilted profusion of emotion, in many ways seem typical of Victorian mourning'.<sup>50</sup> The 'deathbed scene' that is apparently 'ludicrously sentimental to us today' has fuelled accusations of hypocrisy, insincerity and vulgarity in the Victorian response to death and the dying.<sup>51</sup> Julia Neuberger has argued that childhood deaths became 'overly sentimentalised' in Victorian fiction, referring to the death of Helen Burns in *Jane Eyre* as 'one which both reduces the reader to tears and irritates beyond measure'.<sup>52</sup>

The 'deathbed scene', as well as affirming the moral status of the character, a need closely associated with Evangelical notions of a 'good death', also affirmed the status of the carer in Victorian society. Given their popularity, it seems reasonable to believe that the sentimentality of such scenes must have had some influence on attitudes toward caring for the dying in the real world, although to what extent and in exactly what ways is hard to establish. Julia Neuberger felt that the conventions of the deathbed scene inhibited a natural grieving process by presenting death in terms of going to a better place, for which sorrow and grief were not an appropriate response. Neuberger went further, arguing that 'the sentimentalisation of childhood death must have slowed quite considerably the effect of the anger of those social reformers who looked at conditions and saw how dramatically and speedily they could be improved'.<sup>53</sup> However, evidence to support this assertion remains elusive.

Sentimentality and melancholy, through Victorian art, literature and the tombstones of the great Victorian urban cemeteries with their weeping angles and broken hearts, provide an enduring and defining impression of the Victorian age. It can be felt in paintings like Edward Killingworth Johnson's *Her First Sorrow*, Henry Wallis' *The Death*

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<sup>49</sup> Wheeler, *op. cit.* p.28.

<sup>50</sup> Garton, S. The scales of suffering: love, death and Victorian masculinity *Social History*, Vol.27, No.1 (January 2002), p.40.

<sup>51</sup> Holubetz, M. Death-bed scenes in Victorian fiction *English Studies*, Vol.67, No.1 (February 1986), p.24.

<sup>52</sup> Neuberger, J. *Dying Well: a guide to enabling a good death*. 2<sup>nd</sup> edition. Radcliffe, Abingdon, 2004, p.7.

<sup>53</sup> *Ibid*, p.8. Neuberger's assessment is questionable: It could be said, equally credibly, that public health reform was inhibited by questions about the role of the state, the nature of Victorian legislative process, and aggressive local interests prepared to fight for their autonomy and refuse increases to their rates.



of *Chatterton*, and John William Waterhouse's *The Lady of Shalott*, as well as in the poetry of Tennyson and Housman, and in the death of Dickens' Little Nell (1840), the 'epitome of Victorian sentimentality':<sup>54</sup>

'For she was dead. There, upon her little bed, she lay at rest. The solemn stillness was no marvel now. She was dead. No sleep so beautiful and calm, so free from trace of pain, so fair to look upon. She seemed a creature fresh from the hand of God, and waiting for the breath of life; not one who had lived and suffered death'.<sup>55</sup>

It presents itself too through the language of accounts written by families engaged in end of life care. John Southall confessed in 1846 that 'I cannot but indulge in a melancholy pleasure, this melancholy arising from the loss to us and the pleasure from the consciousness of her [his wife's] positive happiness...I would not wish her back again'.<sup>56</sup> On New Year's Eve 1854 Hannah MacDonald wrote in a melancholy and reflective tone:

'Are they dead for they have died in the Lord. This is the close of a most sorrowful year, perhaps the most sorrowful in my chequered life. To God above are known the anguish and the consolations of the past and to Him I commit myself and my dear family as we enter the unknown scenes and circumstances of the year 1855'.<sup>57</sup>

However, it was John Morley who sagely observed that for the Victorians 'sentimentality must have given a valuable defence against hard fact'.<sup>58</sup> The prevalence of sickness and death in Victorian England was not unique, but in many ways the Victorians' response to it was. The cumulative effects of the upheavals of a century of industrialisation and urbanisation had a deep impact on the Victorian psyche. In many ways the disturbing and sinister environment that had been created fuelled an already established interest in Romanticism with escapism.

Romanticism, which had its origins in the eighteenth century, continued to hold an enduring appeal for the Victorian middle classes and it was Morley again who suggested that 'it was Romanticism that largely determined the nature and form of early Victorian emotion'.<sup>59</sup> It was the Romantic influence that, for example, produced

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<sup>54</sup> Holubetz, *op. cit.* p.26.

<sup>55</sup> Dickens, C. *The Old Curiosity Shop*. Wordsworth, London, 1995 [1840], p.529.

<sup>56</sup> Letter dated 7<sup>th</sup> November 1846. Southall family archive. BG 99/2/10, Herefordshire Archives.

<sup>57</sup> Diary of Hannah MacDonald, 31<sup>st</sup> December 1854, *op. cit.*

<sup>58</sup> Morley, J. *Death, Heaven and the Victorians*. Studio Vista, London, 1971, p.8.

<sup>59</sup> *Ibid.* p.14.

the melancholy of Tennyson's *Lady of Shalott* so vividly captured in Waterhouse's painting of the subject (1886).<sup>60</sup> Educated middle class families had the time and money to immerse themselves in the works of the Romantic poets, whose tradition continued through the poetry of Tennyson and the art of the Pre-Raphaelites, and its influence could still be perceived at the very end of the period in Housman's *A Shropshire Lad* (1896) and in the gothic horror of Bram Stoker's *Dracula* (1897). Romanticism, it is argued, continued to exercise a powerful hold over the Victorian imagination and to find expression in sentimentality and melancholy toward death and dying until it was violently eclipsed by the shock of the Great War.<sup>61</sup>



Frank Bramley *A Hopeless Dawn* (1888)<sup>62</sup>

Paintings such as Frank Bramley's *A Hopeless Dawn*, connected Romantic sentimentality with social realism and expressed a deep and poignant sadness. The death of a child and the 'empty cradle' were disquieting and uncomfortable subjects for the Victorians. The loss of an infant or young child was a real and present threat for any Victorian family. The subject was still more upsetting, and resonated even more,

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<sup>60</sup> The story appears in *Idylls of the King* (1858).

<sup>61</sup> Although there was a palpable lightening of mood from the 1880s onwards, criticised by the older generation as 'frivolity'.

<sup>62</sup> Source: [Online] Available from: <http://www.tate.org.uk/servlet/ViewWork?workid=1426> [ Accessed 18<sup>th</sup> December 2010].

when, as Frank Holl's *Hush and Hushed* (1877) suggested, poverty was part of the cause (see p.121).

For Victorian middle-class society the home was venerated as a place of retreat and safety. The death of a child could therefore be felt as both a parental failure and a chastening lesson. Heather Paris has argued that 'the problem with the pictorial intersection of Victorian childhood and death was that as subject matter they co-existed uneasily, with adults preferring to think of children as representatives of life, living in a world they could create, supervise and protect'.<sup>63</sup> However, rather than alienating the Victorian public, such images clearly had an enduring appeal.

John Morley identified the influence of Romanticism on Victorian mourning:

'...the congealed romanticism that encapsulated Victorian family life, that produced the keepsake and sentimental ballad, and that effloresced in the Valentine, found its reverse expression in objects, poems, ceremonies, and clothes in remembrance of the defunct'.<sup>64</sup>

In terms of its influence over end of life care, Romanticism venerated both the role of the dutiful carer and dying youth. Its influence encouraged the indulging of 'little comforts' and meaningful gestures, and glorified scenes such as that portrayed by Henry Peach Robinson's *Fading Away* (1858).

An intoxicating mixture of Evangelical Christianity and Romanticism fostered a particular vision of a 'good death' that sentimentalised children's deaths and ennobled death in battle and even, paradoxically, suicide (as in Wallis' *The Death of Chatterton*). Miriam Bailin has argued that 'illness...became one of the principal objects of sentimental pieties about family life and female nurturance' in Victorian Britain.<sup>65</sup>

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<sup>63</sup> Paris, H. "Lifting up the Little Form": Victorian Images of Childhood and Death 1870-1900 *Sociological Research Online*, vol.8, no.3 [Online] Available from: <http://www.socresoline.org.uk/8/3/paris.html> [Accessed 19 September 2007].

<sup>64</sup> Morley, *op. cit.* p.14.

<sup>65</sup> Bailin, *op. cit.* p.11.



Henry Peach Robinson *Fading Away* (1858)<sup>66</sup>

The death of the consumptive in particular acquired a sentimental fascination for the Victorians, with sufferers portrayed as 'young, beautiful, innocent and frequently female', as was the case in *Fading Away*.<sup>67</sup> Consumption was certainly the biggest killer of young adults in Victorian period and although predominantly a disease of poverty, nevertheless struck at the 'respectable' middle classes with alarming frequency. It also fitted well with Evangelical notions of a 'good death' because it allowed time for preparation, lucidity and last goodbyes, and a supposedly serene passing. However, Francis Kilvert, who encountered the disease amongst his parishioners, painted a strikingly different picture of the disease from that in *Fading Away*:

'Poor Lizzie Powell, a wreck and shadow of the fine blooming girl she was when I saw her last, was crouching up in the sunny window opposite the Vicarage, pale, wasted, shrunken, hollow-eyed and hollow-cheeked, dying of consumption, but with the

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<sup>66</sup> Source: [\[Online\] Available from: http://www.google.com/imgres?imgurl=http://www.edinphoto.org.uk/0\\_p/0\\_photographs\\_in\\_exhibitions\\_robinson\\_-\\_fading\\_away.jpg](http://www.google.com/imgres?imgurl=http://www.edinphoto.org.uk/0_p/0_photographs_in_exhibitions_robinson_-_fading_away.jpg) [Accessed 16th December 2010].

<sup>67</sup> Jalland, *op. cit.* p.40.

sanguine and buoyant spirit of that mysterious and fatally deceptive disease, hoping still against hope even with the hand of death upon her.<sup>69</sup>

These two very different consumptive deaths, one fictional, one real, perhaps illustrate the complexity of emotional responses to the disease.

The heady mix of Romanticism and Evangelical Christianity that characterised the early and mid-Victorian period, helps to explain some of the motivations and behaviours of carers and the bereaved toward the dying and the dead. The sociologist Tony Walter has argued that 'nineteenth-century romanticism...legitimated the urge to stay with the dead' whereas 'twentieth-century modernism urged us to leave the dead and the past behind'.<sup>70</sup> Attentive and dutiful care fulfilled both Romantic and Evangelical notions of self-sacrifice and moral duty. Caring for the dying had a *raison d'être* beyond simply looking after a loved one: it could become part of self-identity in a society that placed such importance upon these virtues.

In an age before the means of disease transmission and cross-infection were properly understood, such dutiful caring could have fatal consequences for the carer concerned. Here again, the influence of Romanticism can be felt, as those who died from their exertions as carers were said to have died of a broken heart (in reality, in this age before contagion was properly understood, it was often through cross-infection). When the two spinster sisters Sarah Philippa Rose and Sylvia Rose died within a few days of each other in 1874, an obituary column in the *Dover Chronicle* read 'when one was taken away, the other, broken-hearted, survived her scarcely three days, when she joined her sister in another & brighter world'.<sup>71</sup> Both likely died of the same infection.

In England today it is difficult to understand why death was such a popular subject for artists and novelists. Youth is celebrated now (as it was in the Victorian era) as representative of health, vigour and life. However, whereas the Victorians were acutely aware of youth's fragility, and perhaps needed Romantic sentimentality to deal with the all too likely reality of early death, today death and ageing can be, and are, denied by the young. 'Post-modern' Western society cannot accommodate death easily; it appears as an affront to the possibilities, choices and freedoms of youth, its uncompromising finality cannot be assuaged, however it is branded and packaged, and

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<sup>69</sup> Plomer, *op. cit.* p.254.

<sup>70</sup> Walter, T. *On Bereavement: The Culture of Grief*. Open University Press, Buckingham, 1999, p.xiv.

<sup>71</sup> Diary of Anne Linley Blathwayt (transcribed from the *Dover Chronicle*, 4<sup>th</sup> April 1874), *op. cit.*

unsurprisingly, in the absence of any coherent religious belief, many struggle to come to terms with it. As Michael Waterhouse observed, ‘people experience the death of a loved one with growing infrequency. The bereaved feel and appear peculiar’.<sup>72</sup>

This study argues that although Romantic sentimentality may be beyond the tastes of many modern readers, beneath the language that was a product of its particular time and place, lay universal human emotions that are not difficult to relate to. The fact that accounts of last illness and death from Victorian era, both real and fictional, continue to resonate so powerfully with twenty-first century readers, despite a social chasm between the centuries and the unfamiliar Romantic sentimentality of the language used, testifies to their connection with these universal emotions that transcend time and place.

The evidence of this study calls into question the notion of an obsession with death and suggests that if the Victorians were ‘obsessed’ (if that word is appropriate at all), it was with class, status and ‘respectability’, not with death itself. John Morley had recognised this as early as 1971:

‘This huge new middle class began to ape the gentry, it did so at a time when the impedimenta of ‘gracious living’ were becoming rapidly more numerous and diversified. An intense social competition was generated; despite the ridicule of satirists such as Cruikshank, Cobbett and Dickens, the urge toward visible display found ever more opulent expression...Display did not stop short at life; death also had its consumer goods’.<sup>73</sup>

Esther Schor has since supported this interpretation, claiming that ‘where mourning was, during the Enlightenment, a figurative moral currency for the nation, it becomes in the Victorian period virtually a form of legal tender negotiable for “respectability”’.<sup>74</sup> Certainly ‘respectability’ was a fundamental middle and upper-working class aspiration and there is no reason why its influence over death should not have been as influential as its influence over life.

To conclude that death was a Victorian ‘preoccupation’ is to ignore the sheer frequency of its occurrence. As Kate Berridge noted with regard to its prevalence in children’s literature, ‘the constant morbidity and *memento mori* content of nineteenth-century

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<sup>72</sup> Waterhouse, M. *Staying Close: A positive approach to Dying and Bereavement*. Constable, London, 2003, p.265.

<sup>73</sup> Morley, *op. cit.* p.11.

<sup>74</sup> Schor, E. *Bearing the Dead: The British Culture of Mourning from the Enlightenment to Victoria*. Princeton University Press, Princeton, NJ, 1994, p.230.

children's literature make perfect sense in the context of relatively low life expectancy. Losing a parent and dying young were legitimate fears'.<sup>75</sup> Jalland extended this argument to adults, claiming that 'the Victorian preoccupation with death was understandable – an honest realism given the relatively high mortality rates'.<sup>76</sup> In this context, prayers for the sick had another function, acting as *memento mori* focussing the minds of not only the dying, but their families too, on the nearness of death:

'We know not gracious and merciful God, the time when our great change shall come upon us; but whether Thou continuest our lives to a greater or lesser duration, we are certain that the period of our departure cannot be very far distant from any of us. There may be some in this present company, whom it is Thy will in wisdom shortly to remove out of this transitory scene'.<sup>77</sup>

To the modern reader, unfamiliar with death as a regular, personally encountered, event, this may now appear morbid or obsessive, but this is not how the Victorians would have regarded it. The prayer is a reminder of the importance for the healthy, as well as the sick, of preparedness for a death that could come at any time. This is not obsession but a pragmatic realism. The prospect of death was not a distant fear for Victorians but an all too proximate possibility. This reality was expressed in Louisa Baldwin's diary entry for New Year's Day, 1876:

'The first year I have entered upon in which there will be no dear Mother to love me and be loved. God help me to dwell upon her gain instead of our loss. O God protect and guide us in the unknown future & enable us both in sorrow and injury to serve thee humbly and truly for Christ's sake. Amen'.<sup>78</sup>

Given the loss she had suffered, far from being 'obsessive', these reflections appear entirely consistent with a 'normal' grieving process.

The Victorians encountered in this study often remembered the dead in their diaries and correspondence, sometimes many years afterwards. Both Louisa Baldwin and her mother Hannah MacDonald made frequent reference to deceased family members, usually at anniversaries of their birth or death, for example when Hannah wrote in 1854: 'Oct. 19<sup>th</sup> My precious Caroline would have been 16 years old today. My sense

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<sup>75</sup> Berridge, K. *Vigor Mortis: The end of the death taboo*. Profile Books, London, 2001, p.19.

<sup>76</sup> Jalland, *op. cit.* p.5.

<sup>77</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*, *op. cit.* p. 95.

<sup>78</sup> Diary of Louisa Baldwin, 1<sup>st</sup> January 1876. Baldwin papers. 705: 775/8229/7 (ii), Worcestershire Record Office.

of loss and privation is unutterable'.<sup>79</sup> No psychologist working in the field of modern bereavement support would regard these sad reflections as necessarily indicative of 'obsessive' behaviour and Jalland found that 'by the 1880s most families ceased writing and keeping such lengthy memorials on the death of their loved ones', suggesting that the practice declined with religious belief and was linked to spiritual consolation and meditation.<sup>80</sup> Arguably, in the context of human history as a whole, it is much more 'abnormal' to forget and exclude the dead in the way of modern Western society, rather than to remember them, as Louisa and her mother did.

The realism and pragmatism displayed by the carers whose stories are revealed in this study challenges the presence of an 'obsessive' attitude toward death, which is nowhere apparent in these accounts. The thoughts and actions of those encountered appear for the most part rational, pragmatic and emotionally balanced. It is important to remember also that there was much criticism in the press at the time of Queen Victoria's prolonged mourning<sup>81</sup> and of extravagant funerals, evidenced by anti-mourning societies and widespread press criticism of the undertaking industry. The Victorian press is littered with scandals about unscrupulous undertakers foisting extravagant funerals on the vulnerable bereaved; typical of which was this letter to the *London Daily News* in 1853:

'A member of my family is just recovering from an illness which, for a time, kept all about her in daily apprehension. The fact of the illness becoming known in the neighbourhood, I am forthwith inundated with undertakers' circulars, in which all the horrid paraphernalia of the tomb are set forth, together with the various merits, "readiness," "dispatch," &c., of the applicant, expectant of his job, and all this shamelessly, indecently, wantonly, thrust before the very eyes of the afflicted relatives, watching the sick bed racked between the alternations of hope and despair. Their griefs are to be thus rudely probed and insulted by a ruffian small trader, for the sake of his pickings out of the grave.'<sup>82</sup>

As medical knowledge advanced and Romanticism and Christianity declined, there was less sentimental acceptance of death and more emphasis upon trying to defy death to the exclusion of considerations of spiritual preparation. As the century progressed,

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<sup>79</sup> Diary of Hannah MacDonald, 19<sup>th</sup> October 1854, *op. cit.*

<sup>80</sup> Jalland, *op. cit.* p.52.

<sup>81</sup> For example: 'The Queen's Seclusion' *Liverpool Mercury* (Liverpool), Tuesday, 29th March 1864 and 'The Queen's Seclusion' *The Bury and Norwich Post, and Suffolk Herald* (Bury St Edmunds) Tuesday, 20th December 1864.

<sup>82</sup> 'Undertakers' Circulars', *Daily News* (London) Monday 20<sup>th</sup> June 1853. Issue No. 2209.



death before old-age was no longer easy to attribute simply to the intractable will of a mysterious God. Romanticism as a significant cultural influence has now long since passed away, but the persistent equation of Romantic sentimentality with an obsession with death continues to inhibit the recognition of the many positive aspects care of the dying in the Victorian home.

### ***The attitude of the poor toward care of the dying***

In the face of its ever proximate presence, it has been alleged that the Victorian poor (among whom the Reaper's harvest was most unremitting) were fatalistic toward death. David Vincent for example, argued that 'the financial hardship often suffered by a young couple could not only render the birth of a child unwelcome but could cushion the blow of its early death'.<sup>83</sup> The Victorian middle-class often embraced such a view of the poor, perhaps to ease their consciences at the extent of poverty and inequality that surrounded them. Elizabeth Gaskell, who had seen the slums of industrial Manchester at first hand, made this assumption in her novel of working class Manchester *Mary Barton* (1848): 'the poor are fatalists when it comes to infection; and well for them it is so, for in their crowded dwellings no invalid can be isolated'.<sup>84</sup> There is evidence that poverty bred a cavalier attitude to health and the poor would undertake the most dangerous of work if the pay was better:

'Lucifer match making, accordingly to this young lady's statement, "was a much better game one time. But I'm a speaking now," she continued, "of when my mother was a gal. She worked at it, and so did my Aunt Loo. She died in the London Hospital of it."

"Of what?"

"Of the matches. There wasn't no new-fangled ways of making matches in them times, at least [-10-] so I've heard my mother say, on'y brimstone and fosterous, and the fosterous used to get into your bones and eat 'em away in your face and jaws mostly ; that's what my Aunt Loo died of. But see what she used to earn, and my mother too ! Eighteen shillings or a pound a week!"

"And with the prospect of a dreadful death by phosphorus poisoning ? " I suggested.

"That's 'cordin' to your luck," responded the reckless young matchmaker, "it's like being in a raffle. Some wins and some loses."

"And would you risk it if you had an opportunity?"

"Rather," she replied, with an emphatic wag of her head, that left no doubt as to her earnestness, wouldn't you if you was me?"<sup>85</sup>

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<sup>83</sup> Vincent, D. *Bread, Knowledge and Freedom: A Study of Nineteenth-Century Working Class Autobiography*. Methuen, London, 1981, p.58.

<sup>84</sup> Gaskell, E. *Mary Barton*. Penguin, London, 1996 [1848], p.61.

<sup>85</sup> Greenwood, J. (writing under the pseudonym 'One of the Crowd') *Toilers in London*. Diprose and Bateman, London [c.1890] [Online] Available from: <http://www.victorianlondon.org/> [Accessed 26<sup>th</sup> August 2010].

Julie-Marie Strange however has questioned that such evidence equates to the poor being fatalistic toward death. Strange instead concluded that regularity of bereavement did not necessarily diminish genuine expressions of grief or mean that the poor were less caring and diligent in the care of their dying, claiming that although:

‘...privation often forced families to approach death with pragmatism. Recognition that material circumstances impacted upon responses to death is, however, far removed from the assumption that poverty blunted sensibility’.<sup>86</sup>

Edward Bradley, writing in 1870, although fatalistic toward death, was clearly willing to spend what must have been a considerable part of his limited financial resources on doctors when his children contracted scarlet fever:

‘I have some unhappy news to tell you the Scarlet Fever has broken out very bad in Hampstead and a great number has [*sic*] died with it some in barracks and the other day my dear Alice was taken ill with it all of a sudden they have a room on purpose in another part of the barracks and two surgeons to attend them – Dr Cooper Rose and Mr Shaw and a paid nurse and all that money or skill or kind attendance can procure’.<sup>87</sup>

In another letter to his sister Bradley described his feelings toward death:

‘...our Father’s Children are few now and I dare say in the course of a few years we shall be the same as him in our Graves and the sooner the better if we are not happy and especially if we are prepared to go. I can’t help thinking that we are rapidly growing older but I don’t know about better. I hope all our family will meet in Heaven’.<sup>88</sup>

Clearly, there is a sense of fatalism here and of a melancholy born of sheer exhaustion from the rigours of hard army life on meagre pay. His correspondence shows however that he did everything in his power to preserve his children’s lives, as it seems likely the majority would have done. There was however a persistent suspicion amongst the Victorian middle class that fatalism bred wilful neglect and ‘the increasing overall concern for social welfare led to infanticide becoming a subject of greater public interest at mid-century’.<sup>89</sup> Infanticide was the subject of what would now be termed a ‘moral panic’, each court case producing sensationalist and lurid reporting that fuelled a fresh moral outcry. Anti-Poor Law campaigners blamed the so-called ‘bastardy clauses’ in the Poor Law Amendment Act of 1834 and others the practice of enrolling

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<sup>86</sup> Strange J.-M. *Death, Grief and Poverty in Britain, 1870-1914*. Cambridge University Press, Cambridge, 2005, p.65.

<sup>87</sup> Letter from Edward Bradley to his sister [Mary Ann Dudfield] dated 18<sup>th</sup> August 1870, *op. cit.*

<sup>88</sup> Letter dated 23<sup>rd</sup> March 1868. *Ibid.*

<sup>89</sup> Sauer, R. Infanticide and Abortion in Nineteenth-Century Britain *Population Studies*, Vol. 32 No.1 (March 1978), p.92.

infants into burial clubs, for providing the financial incentive for the crime. As Sauer's work discovered however, hard evidence is difficult to come by. Thompson was probably close to the truth when he argued that:

'...the chances of a baby surviving were not so slim as to make it likely that some rational calculation about emotional investment or expenditure would override maternal or parental feeling among parents who possessed the personalities and dispositions to display such feelings at all'.<sup>90</sup>

Recorded instances of infanticide were low and its true extent will never be known. Its prevalence was almost certainly overestimated and there is no convincing evidence to support the suspicion that working class fatalism toward the death of a child translated, other than with extreme rarity, into murderous intent.

In reality, there was likely a diversity of responses to the death of a child amongst the working classes, who, it must be emphasised, were a far from homogenous entity. The labour aristocracy of skilled manual workers seem to have held views not dissimilar from the middle class on the sanctity of childhood. Neither were they entirely unknown amongst the families of the poorest unskilled workers. Some Victorians recognised this, the artist Frank Holl, for example with his sympathetic portrayal of infant death in a working class home; *Hush and Hushed* (1877).

Financial circumstances were obviously critical to a family's ability to care for a family member with a life threatening illness and to the standard of care they could provide. This does not mean however that the wealthy always provided excellent care or the poor were incapable of doing so. Other factors were involved; the strength of family bonds, the duration and nature of the illness, the ability and willingness of extended family to help with care, for example. If the breadwinner was ill, the poor had reason to invest a greater proportion of their resources into attempting to find a cure, as death would often mean destitution and the workhouse for those left behind.

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<sup>90</sup> Thompson, F.M.L. *The Rise of Respectable Society: A Social History of Victorian Britain, 1830-1900*. Fontana Press, London, 1988, p.124.



Frank Holl *Hush* 1877<sup>92</sup>



Frank Holl *Hushed* 1877<sup>93</sup>

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<sup>92</sup> Source: [Online] Available from: <http://www.tate.org.uk/servlet/ArtistWorks?cgroupid=999999961&artistid=267&page=1> [Accessed 20<sup>th</sup> December 2010].

Unfortunately, evidence is too rare a commodity to build a clear picture of end of life care in working class homes. It is probably fair to say however that in the homes of the working class elite; the skilled artisans, the standard of care and the aspirations of carers were similar to those of the middle class. It was among the unskilled and poor, with their often cramped, unsanitary, living conditions that care differed substantially, but even here can be found individual families that struggled against the odds to keep a clean and 'respectable' home in which to care for their dying. Lack of financial resources obviously compromised the level of care that could be provided on a practical level, but this does not necessarily mean the poor were unable to invest the same levels of emotional energy into caring for their dying as the middle classes.

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<sup>93</sup> Source: [Online] Available from: <http://www.tate.org.uk/servlet/ArtistWorks?cgroupid=999999961&artistid=267&page=1> [Accessed 20<sup>th</sup> December 2010].

## CONCLUSIONS

This study has attempted to understand the beliefs, motivations and influences that shaped end of life care in the Victorian home. It has introduced important new archival material together with published sources not previously explored in relation to this subject. Drawing upon this evidence, it has shown how the interaction between professionals (in the form of clergymen, doctors and nurses) and the family worked in practice to inform and shape end of life care. The study has also attempted to identify the currents of change that would transform care of the dying in the Victorian period and sow the seeds of twentieth century practice. In so doing, it has focussed upon those areas of Victorian end of life care that may provide useful lessons and relevant examples for palliative care practice today. Finally, it has sought to challenge the notion of a Victorian 'obsession' with death.

The Victorian age was one of social, economic and political transition, from which emerged a Britain that is largely recognisable to us today. Industrial revolution and the resultant urbanisation of many parts of the country created a public health crisis on an unprecedented scale. Disease was the inevitable consequence of urban overcrowding and poverty, with infections (particularly tuberculosis) the biggest killers. From the epidemics of cholera, typhoid, and smallpox, and the fear and disruption they caused, emerged the modern concept of public health, which despite hesitant beginnings and being initially premised in the flawed miasma theory of disease transmission, eventually contributed to steadily, if unevenly, reducing mortality rates. The result of this fall was that death became less frequent and familiar: people began to die later (with the important exception of the very young) and more often from the chronic illnesses of old age familiar today.

In many ways the Victorian era was unique: it saw the last great flowering of Christian renewal, but this was rapidly followed by decline and an emergent secular, and increasingly individualistic, consumer society. At the same time advances in housing and sanitation within the home were starting to transform the sickroom, starting in the wealthiest homes but working steadily downwards, as slums were cleared and piped water introduced. Care of the dying in the Victorian home must be considered against this backdrop, where local communities were still tight-knit, self-reliant and supportive

of the dying and their carers, but where at the same time grinding poverty, inequality and squalor remained rife.

The foundations of the practice of end of life care in the Victorian period lay in Christian faith, which continued to provide language and ritual through which the majority articulated their feelings about death. Although the Evangelical revival faded in the 1850s and belief went into long-term decline, the Christian influence over the deathbed was tenacious and it brought many consolations. Christian belief meant care was focussed on spiritual preparation for the afterlife before comfort of the physical body. This emphasis on death as a spiritual encounter placed the dying in a privileged position within the family and community, conferring a dignity upon them (in recognition of their nearness to the Almighty) that has often been cited as lacking in modern secular British society. Christianity made sense of death as a divine act of merciful release from a sinful world, tempering grief with hope. It also provided some consolation for the agonies of dying before the advent of effective pain management, giving pain purpose as being both redemptive and an opportunity to demonstrate strength of faith. However, this study found no evidence of devout Christians spurning pain relief when it was available. It seems rather that Christians hoped and prayed for a death free from pain, but drew upon their Christian belief in its value when unable to avoid it. The Victorians may have been assailed by religious doubt, but many continued to cling tenaciously to the consolations of religion in death. In the twentieth century secularisation and industrialised warfare would sweep away these consolations without providing obvious alternatives.

Christian influence over the deathbed had a darker side however: it could be judgemental and exclusionary, stigmatising those who, often through no fault of their own, or by bitter twist of fate, could not 'die well'. The close association between outward displays of piety and 'respectability' bred hypocrisy and snobbery that have tarnished the image of the many thousands of Christians who engaged in genuinely well-meaning philanthropic care for the dying in their communities. As a result, the many instances of visiting the sick and dying that were appreciated and brought comfort and material aid to the dying and their families have subsequently been dismissed as patronising 'do-gooding'.

Ideas about what constituted a 'good death' changed significantly during the Victorian period, from being primarily concerned with the need for spiritual preparation to being as free as possible from bodily suffering. As pain relief became more effective,

freedom for pain became increasingly important to a 'good death'. At the same time religious belief was declining and, in consequence, the focus on spiritual preparation gave way to management of the illness. With this change the roles of the family, the clergy and the medical profession also changed, with power and influence shifting toward the doctor and away from the clergy and the family.

The missionary zeal that drove Christian women to call upon the sick also declined with the waning of belief and with it a valuable source of emotional and practical support for the dying and their families. The emergence of the Victorian middle class as 'the most home-centred group in British history' made death into an increasingly private family event, to be enacted out of the view of the rest of the community.<sup>1</sup> These changes were also apparent amongst the working class, where improved housing and living standards made it possible for the first time to create private space within the home. This allowed the family to regulate contact with the dying. The depopulation of the countryside, and the speed and ease of modern communications and travel, eroded the traditions of rural communities and here to communal responses to death withered away. English society changed radically in the Victorian period and with these changes a new age of medicalised, hospital centred, end of life care was dawning.

However, this study has sought to show that medical power over the Victorian deathbed was limited. It has questioned the extent to which Michel Foucault's theories about the rise of medical power disseminated through the regime of the hospital can be applied in the context of end of life care located in the home. The limitations of medical power in this specific circumstance have been demonstrated in three key areas. Firstly, in arriving at a diagnosis and breaking bad news, where the patient narrative and 'bedside manner' remained of crucial importance in the GPs relationship with the patient and their family, and the imposition of a categorising, controlling and disempowering medicalised discourse was neither practicable nor appropriate. Secondly, in the frequent recourse to second opinions, which not only demonstrate the readiness of families to question doctors' assessments of the case, but suggest that educated Victorians were not easily overawed by medical discourse. Finally, in the constraints that the limited effectiveness of treatment placed upon the doctors ability to demonstrate their expertise and curative powers.

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<sup>1</sup> Thompson, F.M.L. *The Rise of Respectable Society: A Social History of Victorian Britain, 1830-1900*. Fontana Press, London, 1988, p.152.



Throughout the nineteenth century an important competitive discourse to conventional medicine came from an array of alternative approaches and from the purveyors of patented medicines. These factors all suggest that outside of the hospital, medical authority was limited and medical discourse was not completely ascendant, even at the end of the Victorian age, despite dramatic improvements in the social and professional status of doctors and nurses, and the not inconsiderable advances made in medical science.

However, this study also argues that two key developments did eventually allow medicine to assume ascendancy over end of life care, although this would not be fully achieved until well into the following century. The first factor was medicine's ability to control pain, which improved rapidly from the 1860s onwards and eventually made the doctor indispensable to end of life care. The second factor was a change in perceptions of hospitals, combined with an increase in their number and their willingness to accept 'incurable' cases. The advent of anti-sepsis and asepsis, together with the development of effective anaesthesia, started to remove the public's dread of hospitals as places of pain, filth and disease. At the same time increasingly complex therapeutic technology that could only be accessed through the hospital, and the creation of professional nursing standards, started to create a perception of hospitals as centres of expertise and of excellence in care and, as such, as an appropriate place to die.

The eventual relocation of death away from the home had many benefits, but it also eventually dispossessed the family of their central role in providing end of life care, and its female members (who, as has been shown, exercised considerable autonomy and enjoyed a decision making role earlier in the century) were eventually 'excluded from the social organization of death'.<sup>2</sup>

The comfort of a home death to the dying and the grieving is clearly apparent in the accounts covered by this study. The care of the dying brought a concerted response from the family, who drew together to provide mutual support and comfort. Advances in communications meant that absent family members and friends could, for the first time, have an important role in supporting carers at the bedside. This location of dying within the home, with the family having a central role in providing care, supported by

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<sup>2</sup> Bradbury, M. *Representations of Death: A Social Psychological Perspective*. Routledge, London, 1999, p.13.

the local community, it is argued, prevented the 'social death' of the dying that is so prevalent today.<sup>3</sup> A death in the community elicited demonstrations of communal respect and solidarity, such as the drawing of curtains and bowing of heads as a funeral cortege passed, and the regular visiting of the bereaved by friends and neighbours.<sup>4</sup> That this seems so far away now is a symptom of the wholesale retreat from public to private space that became a defining feature of English society by the late twentieth century. It is perhaps in this area that the Victorian middle-class experience can provide some useful insights for modern palliative care practice.

The dying had an accepted place in the Victorian family home and carers' roles were both well-defined and prepared for from an early age. Consequently, the Victorians encountered in this study were able to maintain communication with dying family members without obvious signs of awkwardness, embarrassment or fear. The dying were, as long as they remained able, involved in decisions about their care and in the daily life of the household around them. In fact, in what was still a largely religious society, their perceived proximity to their Maker appears to have conferred upon them a certain dignity and respectful interest from the family, friends, neighbours and professionals involved in supporting them.

Clearly such dignity and attention is sadly lacking from the care provided by professionals in many hospitals and nursing homes in Britain today.<sup>5</sup> Even though Britain is now a predominantly secular society, the Victorian experience of end of life care, which placed the family at the heart of the decision making process, the dying in familiar surroundings, and care in the hands of concerned family, friends and neighbours, may provide clues as to how to this seemingly intractable situation may be improved in the future (as also does the example of de-institutionalised hospice care).

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<sup>3</sup> Social death being 'the cessation of the individual person as an active agent in others lives' which precedes physical death – see Mulkay, M. Social death in Britain In: Clark, D. (ed.) *The Sociology of Death: theory, culture, practice*. Blackwell, Oxford, 1993, p.33.

<sup>4</sup> Interesting, recently seen again in the people of Wootton Bassett's spontaneous tributes to the passing corteges of war-dead returning from Afghanistan and Iraq.

<sup>5</sup> See, for example: Campbell, D. and Meikle, J. 'Half of NHS hospitals failing to care for elderly' *The Guardian* (London), Thursday, October 13th 2011 [Online] Available from: <http://www.guardian.co.uk/society/2011/oct/13/nhs-hospitals-care-of-elderly> [Accessed 12 November 2011] and Care Quality Commission *Dignity and nutrition inspection programme: National overview*. CQC, London, 2011.

This study has argued against assuming that the Victorians were obsessed with death. The sentimentality of the Victorian treatment of death in literature and art has contributed to this perception, along with the ostentation of Victorian funerary display and the prolonged and rigid mourning practices of the time. However, it is argued, such sentimentality was the product of the enduring Victorian fascination with Romanticism and funerary ostentation and prominent public display of mourning had more to do a Victorian obsession with status and 'respectability' than with death itself. The evidence presented in this study suggests that most Victorians reacted with emotions and behaviours entirely recognisable today when confronted by the death of a loved one.

A final thought: what the Victorians encountered in this study have demonstrated, through their diaries and personal correspondence in the most testing of circumstances, is not only their indefatigable courage, but their compassion and their humanity. There was nothing intrinsically alien in the feelings, thoughts, hopes and fears of the Allens, the Hales, of Sarah Thomas, Louisa Baldwin, or in the 'solemn parting after a union [of] 35 years' of her mother Hannah MacDonald and her beloved husband.<sup>6</sup> The resilience of these families in the face of personal tragedy, and the strength they drew from the support of each other, their faith and the communities in which they lived, leaves a sense that in all of the fabulous improvements in palliative care in the hundred and ten years since Victoria's death, something that the Victorians had and that will always be needed was lost somewhere in the transference of end of life care from the home and the family to the institution and the professional. If these Victorian people were not underneath as strange and different as has been so often imagined, perhaps then it is timely and appropriate to pay more attention to how they cared for their dying: they may have much to teach us.

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<sup>6</sup> Diary of Hannah MacDonald, 13<sup>th</sup> November 1868. Baldwin papers 705/8229/13 (ii). Worcestershire Record Office.

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## ***On-line Resources***

<http://www.edinphoto.org.uk>

<http://www.quilthistory.com/VMC.htm>.

[www.socresoline.org.uk](http://www.socresoline.org.uk)

<http://www.tate.org.uk/collection/>

[http://www.vam.ac.uk/collections/prints\\_books/victorian\\_sentiment/death/index.html](http://www.vam.ac.uk/collections/prints_books/victorian_sentiment/death/index.html)

<http://www.victorianlondon.org/>

<http://www.victorianresearch.org/>

<http://www.victorianweb.org/history/sochistov.html>

<http://images.wellcome.ac.uk/>

<http://www.workhouses.org.uk/>

<http://www.york.ac.uk/inst/chp/crg/esrc-crg.htm>

## APPENDIX A

### ***'How to avoid the cholera being Plain directions for poor people by Dr Challice of Bermondsey':***

*Whatever may be the cause of Cholera, this much is certain, that hitherto, almost without exception, this pestilence has been the portion of the poor, and we know that those who are in want of food and clothing most readily fall the victims of this disease. Let therefore the working man, the head of a family, reflect, that by idleness or drunkenness, he not only exposes himself, but in all probability his wife and his children, to the attacks of Cholera, by depriving them of the comforts and the necessaries of life.*

1. Good health, good spirits, and industry, are the best preservatives. If you are ill, send for a doctor.
2. Keep the whole of the body clean; do not spare soap and water; rub the skin well after washing. Cholera is food of *filth*. Parents apply this rule to your children.
3. Live plainly, and avoid all excesses. Go early to bed; the hardworking man requires rest, not excitement, after his days work. Drunkenness and late hours are great friends of the Cholera.
4. Sleep as few in the same room, or in the same bed, as possible; make every shift, rather than be crowded at night.
5. Early in the morning remove all dirty or offensive matter, open your windows and doors, turn down the bed-clothes to let the fresh air pass over them.
6. Do not take your meals in the bedroom; if you cannot help yourselves in this respect there is still greater necessity for cleanliness and fresh air.
7. Washing or drying clothes in the bed-room is always bas, and, in times of sickness, very dangerous.
8. EAT ONLY OF GOOD FOOD. Half a pound of good meat is better than one pound of bad. One good loaf is better than two bad ones. Cyder and [?] or bard beer are injurious. Let not your children stuff themselves with apples, plums pears or sweet stuff. Rice, tapioca, barley and oatmeal are cheap, nourishing, and wholesome.
9. Clean out, and thoroughly scour, your water butts and cisterns; boil the water before you drink it or give it to your children. Impure water is the cause of many diseases.
10. If there be offensive smells in your house from sewers or cesspools, complain to your landlord; if he takes no steps for removing the nuisance, complain to the parish authorities; if they don't assist you, apply to the magistrates. The *law* now protects you from *poison* as well as starvation.
11. If you get wet, change your clothes as soon as you can; warm and dry clothing, however homely or course, will do much to keep off Cholera. Flannel sound be worn next to the skin round the body, and the feet kept dry and warm with worsted stockings.
12. Go out, and take your children, into the fresh air as often as you can; pure air and wholesome exercise may keep off Cholera, as well as Fever.
13. Take no *strong physic*, as Epsom salts, [?] &c. If opening medicine is wanted, a small teaspoon of powdered rhubarb, with a little ginger and carbonate of soda, or a small wine-glass of the compound tincture of rhubarb, or the compound rhubarb pill (which may be bought for 4d or 6d per dozen) may either be taken with advantage. For children, nothing is better than rhubarb with magnesia, in small doses, repeated every four hours till the proper effect is produced.
14. If you have bowel complaint, leave off work. Rest and lying in bed are most necessary; many a working man has lost his life by neglect of this rule. Get this mixture, for which a druggist ought not to charge a poor man more than sixpence.

1 drachm of      Aromatic Confection

1	“	Prepared chalk
1	“	Sal [?]
[?]	“	Laudenum
[?]	“	Tincture of [?]
[?]	“	Tincture of [?]
3 [?]		of Cinnamon water

A table-spoonful to be taken every two hours until the relaxation is stopped. A child under 10 years, half the dose; and from there to five years old, a fourth part only. For infants it is not suitable. Broths and hot tea are injurious and increase the relaxation of the bowels. Arrowroot, or rice boiled in milk, or gruel, with some grated ginger or cinnamon powder, should be taken, and these not hot, but nearly cold.

15. Should the cholera, however, attack you, or any in your house, don't be alarmed – it is not catching – the disease is better understood than heretofore; mild cases are easily cured, and the worst cases are not always fatal.
16. Neighbours and friends have a bad custom of crowding a sickroom. Where there is *Cholera*, it makes the disease more dangerous; therefore, don't do it.
17. As a measure of precaution, every family should, if possible, have a pound of the best mustard, one quart of vinegar, half a pint of brandy (which must be close corked and sealed,) and two pounds of salt, in the house; also, the fire laid ready for lighting at a moment's notice, with a large kettle of water on the hob. Then, in case of sudden attack before a doctor can be fetched, apply a vinegar and mustard poultice over the entire belly, as long as it can be borne, or at least for twenty minutes, and let the arms, feet, and legs be constantly rubbed with flannels dipped in hot vinegar. Constant friction in this manner may have many a life. The body of the sufferer becomes in the same state as one nearly dead from drowning or suffocation, and everyone knows how often life is restored in such cases by persevering exertion for *hours*. Two of these pills should be taken at once, with a table-spoonful of brandy, and one pill with a table-spoonful of brandy-and-water, cold, every half hour. But don't delay in getting a doctor.

Cayenne pepper.....12 grains

Camphor .....12 “

Calomel .....12 “

Aromatic confection sufficient to make into twelve pills.

Brandy is certainly most valuable in Cholera to those who have not been in the habit of spirit-drinking: those who have constantly taken it, derive little or no good from it.

Lastly, it cannot be too often repeated, that bad bread or bad vegetables, unsound meat or stale fish, tend most powerfully to derange the stomach and bowels, and to bring on Cholera. Let the *dealers* in these staple commodities of life reflect on their very serious responsibility at the present moment, and on the public indignation which will most justly fall upon them should *human life* be sacrificed by the sale of

unwholesome food – a too common practice, and a wicked imposition on the poorer classes.”<sup>1</sup>

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<sup>1</sup> Anonymous *How to avoid the cholera being Plain directions for poor people by Dr Challice of Bermondsey* Henry Renshaw, London [undated] [Online] Available from: <http://images.wellcome.ac.uk/> [Accessed 1 September 2010]

## APPENDIX B

### Thomas Arnold "Judgments and Chastisements" (1832)

And David said, I am, in a great strait: let us fall now into the hands of the Lord; for His mercies are great: and let me not fall into the hand of man. — 2 Samuel xxiv.14

We are all familiar with these words of David, his answer to the prophet who came to him from God with a choice of one of three heavy judgments, the pestilence, famine, or war. And the choice which he made is one which we feel was wisely made. He preferred any of those evils which are directly from the hand of God acting upon natural causes, to those which are produced by the evil passions of men. He thought it, better to suffer three days' pestilence, or three years' famine, rather than to taste all the miseries of unsuccessful war in a three months' flight before an invading enemy.

Now the evils by which this country is threatened [87/88] at this time are of both these kinds; both natural — that is to say, such as befall us without being in any degree caused by other men — and moral evils, by which I mean evils that are occasioned by the fault of men, whether ourselves or others. The prayers which have been appointed for this day's service allude chiefly to the former class of evils; not that they are by any means the greatest, but because, with regard to these, people are all of the same mind; whereas when we speak of moral evils, or those caused by the fault of man, there is a very great difference of opinion about them, and these differences are very apt to excite angry feelings. Still the opportunities afforded by this day would be greatly wasted, if, while turning our minds towards the evils which assail or threaten the country, we were to omit those from which we have infinitely the most to fear, and from which we may, with a far stronger assurance of faith, pray to God to deliver us.

First, however, I will say a few words on the natural evils which are besetting us; that is, on the [new and fatal disease](#) which has appeared in several parts of the kingdom, and which is likely to spread itself over the whole of it. It is a very old remark, that new and alarming dangers are apt to breed a great deal of folly and superstition. Men's minds become highly excited, and their feelings far outrun their judgment. All sorts of exaggerated notions [88/89] therefore have been entertained about the present disorder, and in particular it has been represented as a punishment sent by God for our great and universal sinfulness. Undoubtedly our sins are great, and it would be a most false and mischievous representation which should endeavour to palliate them. But the aspect of the present disease seems to me by no means that of a judgment of God upon our sins. Of course no one could dare to speak of it as a judgment in the cases of individuals; we know that it would be equally false and uncharitable to think that they whom it carried off were greater sinners than those whom it spared. And with regard to the nation, it has not hitherto been in any degree so destructive as to weaken the power or diminish the resources of the country; in fact, nationally speaking, it has been no more felt than the ordinary diseases of every common season. On the contrary, far from regarding it as a judgment of God in His anger, it seems to me to bear far more of the character of a chastening given in His mercy. Both to individuals and publicly, it is capable of being most profitable, and has in fact in a great many instances actually been so. As I said on a former occasion, it has warned them most usefully of the uncertainty of life, while it has encouraged temperance, and called forth a considerable exertion of active charity. It has been a timely interruption to political violence, and has given men a subject of [89/90] common interest, on which not only they could not quarrel, but which placed them towards each other in relations of mutual kindness; and though, like all other chastisement, it "seemeth for the present not to be joyous, but grievous," and though we may lawfully pray to be delivered from it, as from all other visitations of pain and suffering; yet we must feel at the same time that we cannot certainly know whether it is best for us that our prayer should be answered; and assuredly if it be not answered, we may be certain that the refusal does not proceed from God's anger, but from his fatherly love.

How is it then, it may be asked, that we read so often in the Old Testament of pestilence sent as a judgment for sins past, not as a chastisement to warn from sins to come? There are several answers to be made to this question. In the first place, the visitations there spoken of differ from the present case in some important particulars. The destruction was very much greater, and more instantaneous; that is, it did not offer an opportunity for the exercise of those virtues which have been called forth by the present danger. The sight of seventy thousand persons cut off in three days, as on the occasion to which the text relates, was likely to make men overwhelmed with fear, or hardened by desperation; while the evil came in such a moment that there was no time for any wholesome preparation to meet it profitably, or to take any measures for lessening [90/91] its dangers. But the great distinction between the visitations of pestilence under the old dispensation and under the new, may be best understood by reading the prayer of Hezekiah, composed by him in a dangerous sickness; and by observing how little it could be the language of a good Christian now. Hezekiah earnestly prays against death, because it would cut him off from God: "The grave cannot praise Thee," he says, "death cannot celebrate Thee: they that go down into the pit cannot hope for Thy truth." Compare this with St. Paul's language: "Whilst we are at home in the body, we are absent from the Lord; and we are willing rather to be absent from the body, and to be present with the Lord." It is manifest that a grievous disease falling upon a people whose promises were earthly, was a very different thing, as marking God's disposition towards them, from the same disease falling upon a people whose promises are heavenly. What was in the one case a sentence of death, is in the other a removal to glory. Then, if a parent saw his whole family dying around him, his wife expiring by his side, while he felt his own life ebbing fast within him, would he not have regarded himself as suffering the very last extremity of God's judgments, in not only cutting off himself, but all his hopes of posterity also; so that his name and race would be utterly put out? But suppose the same case in a Christian family, — Christian, I mean, [91/92] not in name only, but in deed and in power, — and what before was the extremity of judgment becomes the utmost perfection of mercy. It is a grief for a parent to leave young children behind him, when he cannot but fear that the promise of their early years may in after life, when he can no longer watch over them, be wrecked for all eternity. But to be called to his Saviour with all those whom he most loves; to be released at once from all earthly care; to have done with earth not only for himself, but for his wife and children also; to have reached his home in safety with all his treasures, not only with none to mourn as lost, but with none to fear for as yet in danger; the fondest range of hope could go no farther than to imagine such a rich abundance of blessing.

Or to come to our own experience. We know with what an unusual degree of sickness we in this place are at this moment visited; that there are now four persons lying dead in this town, all of whom one fortnight ago were in no more danger of death than any of us here assembled. Are we to call this a judgment of God in His anger? God forbid! Much rather is it a dispensation most mercifully designed, — would that it might be received by us in an answering spirit! It warns us indeed with a striking voice, to become Christians in earnest with all speed; to put on Christ, and to put off all our sinful reflections. If we do not listen to it, be [92/93] assured that our continued health and prosperity is one of the most awful judgments of all. No sentence is so dreadful as that when God says of the sinner, "Let him alone." The pestilence may cut him off in the midst of his sin; but better even so than to be year after year hardened and encouraged in it, and thus to be daily swelling its amount. But if we do become Christians indeed, then the voice which was so solemn is but the gracious call of a loving Saviour. The servants who were ready, busily employed in preparing for their Lord's coming, zealously assisting one another, and looking forward for the hour when he would visit them, they assuredly felt nothing but a bounding joy when, at whatever hour, in the deepest midnight, or the full noon day, they heard the signal of His presence.

If this day leads us to consider all this, to hear both in the sickly season immediately around us, and in the disease which is prevailing elsewhere, nothing but God's warning and earnest call, the chastening of His love, not the judgment of His anger, then indeed it will be blessed to us. But it will be vain, and worse than vain, if with hearts full of worldly fear and spiritual hardness, trembling at the thought of pain and sickness and death, careless of sin and of eternal judgment, we pour out our unholy prayers to be delivered merely from worldly

sufferings. And should God hear such prayers so [93/94] offered? Nay, verily, the worst scorn with which unbelievers regard this day's solemnities, would be deserved by us, and more than deserved, if our devotion be no more than cowardice, if our desire be for worldly and not for spiritual deliverance.

But the evil of disease is neither the only, nor by any means the worst evil which at this moment threatens our country. In this there are even to the actual sufferers, — the friends, I mean, of those whom it carries off, — many circumstances of great comfort; and to society at large it will be, and indeed has been already, as I said before, the means of calling forth a larger measure of mutual kindness and charity. But the other evils have nothing whatever to palliate them; they are bad, and merely bad from the beginning to the end. I speak of those violent passions, that impatience, and pride, and covetousness, and revenge, and brute ignorance, and hatred of law and authority, and selfish indifference to the degraded state of our brethren, and insolence, and extortion, and oppression, which becoming more aggravated every hour, must inevitably ere long lead to the destruction of our prosperity at once nationally and individually, at once as far as regards this world, and as far as regards the world to come. All these different kinds of wickedness, not existing of course in the same persons, but according to the party or class of society to which we belong, — some being the [94/95] besetting sins in one case, and others in another, — are yet all conspiring together to bring about the same ruin. And together with all these, or rather as the very fountain from which they all spring, there is the bitter root of ungodliness; existing not exactly under the same form, but with the same fatal power, in the unprincipled and wicked of both parties; showing itself on one side in a bitter hatred of all the forms of religion, because they may sometimes be accompanied with the spirit also; attended on the other with a great semblance of attachment to these same forms, because experience has shown, that they do not necessarily ensure the spirit; and so long as they do not do this, bad men on one side find them politically convenient, just as bad men on the other hold them to be a political evil. We find on one side, the blasphemy occasioned by worldly discontent and distress, as when Job was advised to curse God and die; and on the other, the inward blasphemy of the gay and luxurious, who say in their hearts, "Tush, the Lord shall not see, neither doth the God of Jacob regard it." All this evil is so great and so prevalent, that we may almost use the words of the prophet, "I looked, and there was none to help: I wondered that there was none to uphold."

But the difficulty of turning this to profit on occasions like the present, arises from the mixed nature of our common congregations; and from the absolute harm which is done to either side, or class, [95/96] or party, by dwelling in their hearing upon the faults of the other. One is restrained, therefore, from going into the particulars of the evil on either side so fully as we might do, because the other side would hear it with pleasure, and would but be confirmed in their own faults the more. Here, however, the congregation consists so much of one particular class in society, the higher or richer class, that their faults may be safely dwelt upon; not that the poor have not theirs also, but because it does *us* nothing but harm to think of these, is it seems to afford a sanction to our own. Every one must have noticed the delight with which they who want an excuse for selfishness and a grudging spirit lay hold of any alleged instance of ingratitude or improvidence on the part of the poor. The faults of the poor, the sins of the avowed enemies of religion and of our national institutions, however great they may be, do not concern us; our true business is with our own. I have before, in this place and elsewhere, noticed our great sin, — *ours*, that is, as belonging to the richer classes, — that we measure ourselves by one rule and our neighbours by another; we think that a very little will do for others, while for ourselves we think we can never have enough; and this is the case with intellectual enjoyments as well as with bodily; a very little knowledge, a very scanty measure of social enjoyment, very little show of civility, and next to [96/97] none of respect and attention to their feelings, are while for ourselves, sea and land are ransacked, the utmost ingenuity of man is exercised, to furnish us with new "information, with new excitement, to carry to the utmost possible perfection the polish and refinement of our own social intercourse. And this spirit infects us all more than we are aware of; it is a habit gained in childhood, and it goes on with us in after life, in many instances without our being aware of it. I have known good and kind-hearted persons speak so coldly and behave so distantly to those of an inferior station, that a



foreigner, not acquainted with our manners, nor with the character of the individuals, would have ascribed it at once to insolence and pride. But though the excuses for individuals doing this are many, from the cause that I have mentioned, namely, that they do it from habit, and without thinking of it; yet it is no less wrong in itself, and like all other wrong things tends to produce evil to society at large. This manner is practised unintentionally on one side, and received as a matter of course on the other; but even while it breeds no ill will, it effectually checks any feelings of positive regard; and when in process of time tills cold and neutral state of feeling comes to be tampered with by those who wish to change it into active hatred, they find it but too easy a ground to work upon. Then the reserve and distance [97/98] which had before only prevented cordiality, comes to be looked upon as an actual insult, and as such awakens resentment; nor is the length of time which it has lasted considered in any other light. than as swelling the amount of the wrong, and therefore adding to the violence of their hoped for vengeance.

True it is that manner is but an outward thing, and does not always show the state of the heart. But when our notice is called to it, it is at least a good ground for examining a little anxiously whether indeed all is right and sound within. I cannot but think, that if we really possessed a true Christian love of our brethren, if we felt towards them as brethren, not as towards what are called, and most sadly miscalled, objects of charity, that we should insensibly assume towards them a very different outward manner also. At any rate this is certain, that the national evil produced by the behaviour I have been speaking of, is most enormous. It is a folly to think that any money given away in alms can at all make up for the want of kindness. He is in fact doing a double mischief to the poor, who, while he alienates their hearts by his pride, makes himself useful to their necessities by his money; he is doing what he can to degrade them, to make them wear an outward show of respect and gratitude and dependence towards one whom in their hearts they can neither esteem nor love. But on the other [98/99] hand, kindness without money may do very much indeed; and the comfort is, that there is no one amongst us who cannot be kind, however small may be his ability to give alms. There is no one among us who may not make his daily intercourse with every one in a poorer station, a means of increasing mutual charity, instead of exciting mutual aversion. You know full well the vexations which you are sometimes guilty of towards some of our neighbours; not of any serious amount, and still less purposely inflicted; but still galling and annoying, and tending to perpetuate what is unkind between one class and another, rather than what is friendly. I am sure that you are not aware of the full extent of the mischief created by these apparent trifles; but when you think of the number of schools in England; and that in the neighbourhood of each of them something of the same thing is going on, it is easy to imagine, that the effect on the whole may be felt even nationally. But at any rate, whether the effect be more or less, the mischief to our own hearts is the same; opportunities for kindness are kept out; and a careless and insulting habit finds its way into them.

In other places there are other matters on which I might have dwelt with propriety in addition to this; but I know of none where this could have been rightly omitted. And now in conclusion, the sum and substance of this day's solemnity is to [99/100] nourish in us feelings of love towards God and man. Whether we fear disease, love towards God in Christ, and an unwearied kindness towards one another, will take away its sting, and turn it into a blessing; or if we fear civil commotions and revolution, love to God and man is again the only oil that can appease the raging waters; the one love enkindling the other, till, if for no other reason, yet for this alone, because of our strong sense of our common brotherhood in Christ Jesus, because God so loved us, we also should all love one another.

RUGBY CHAPEL, March 21st, 1832. (General Fast Day.)<sup>1</sup>

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<sup>1</sup> Arnold, M. (ed) *Thomas Arnold "Judgments and Chastisements" (1832) Sermons chiefly on the Interpretation of Scripture*. 4th ed. London: T. Fellowes, 1859. [Online] Available from: <http://www.victorianweb.org/religion/sermons/arnold1.html> [Accessed: 26th August 2010].

## APPENDIX C

### **Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick, c.1860**

'Dearly beloved, when God visits us with trouble of any kind, it is our duty to bear it with patience and without murmuring. For, in the first place, our sins deserve that we should be afflicted on account of them, and the actual pain or uneasiness, which we are called to endure when God visits us, is not so great as we have justly merited. Were He to deal with His creatures according to the measure of their sins and shortcomings, they would soon be utterly crushed by the weight of His hand. But the troubles He sends us are but light, in comparison with our deserts, and this is one reason, why we ought to bear them with patient thankfulness and submission.

Secondly, it will alleviate our trials, if we accept them with a patient mind. We cannot, it is clear, resist the Will of God. We are in His hands, and whether we are willing or not, we must bear the inflictions which He sees fit to lay upon us; nor can any attempt to rebel against His dispensations have any other result, than the increase of our own pain and discomfort. Those, therefore, who under sickness are impatient, cross-tempered, and hasty in complaining, may be compared to the horse and the mule, which have no understanding, and whose efforts to shake off the bit and bridle only cause their master to tighten, instead of slacken, the reins. If you are inclined to murmur, therefore, under God's hand, consider that such a course is both most unreasonable, and will serve no other end, than that of making your trouble greater and heavier to bear, than it already is.

But thirdly, it is part of God's design in afflicting His creatures, that they should be taught the lesson of patient endurance under suffering. This lesson is a very necessary one for their happiness and comfort in life; nor can they be good disciples of Christ, who have not already learned it. It would seem ordained, that sickness should be the season, when this lesson is best learned; for in the pains and discomforts and helplessness of a sick bed. Men are more tried, perhaps than in any other form of affliction, and have more need, therefore of exercising patience and resignation. Submit, therefore, to your present trouble, with a calm and tranquil mind.'<sup>1</sup>

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<sup>1</sup> Anonymous *Handbook for the Sick: containing a Series of Addresses with Prayers, a Form of Prayer for Use in an Hospital and a Litany for the Sick*. Society for Promoting Christian Knowledge, No.1168, London, c.1860, pp.69-70.

## APPENDIX D

### Diary of Sarah Thomas, 26<sup>th</sup> May 1860

'They arrived an hour later than arranged and after Dr Evans had warmed his hands at the fire we all went to the sick room and he made Kate tell her own tale. The two doctors went downstairs to consult privately then returned to tell the treatment. Dr Evans said that she was appearing to have a succession of small blisters on the tender part of the bowels. By no means was she to take aperient medicine, but a little salad oil or lemon juice when necessary. She was not to let the bowels go over two days without moving and to use an enema with ½ pint of linseed oil at night. She was to lie much in bed and if she gets up then to lie on the sofa, but by no means to walk until fully recovered. If she felt strong enough to go out and the weather was fine then she must ride in the carriage or be drawn out in a chair. No meat was allowed but light nourishing meals. Milk mixed with water, soda water or brandy and water were advised for drinking. As they were leaving I asked the fee, and it was £10. Dr Evans said he charged a guinea for every two miles beyond the railway...He admitted it was a critical case but he has reason to hope that Kate will be restored to health if she will be careful, but an internal complaint like that kind is very difficult to get at or to know exactly what is going on inside. The worst feature is that she has had it for so long. He couldn't but say there is danger in the case and it often breaks out again after it is supposed to be cured and that it often leads to consumption. He examined her lungs and they are perfectly good now, but the bowels and liver both being disordered, irritated one another. It was after 8 o'clock when they left. I was far more excited than dear Kitty was and I spent the interval of their delay in coming in prayer, imploring God to bestow a blessing upon the doctor that he might have wisdom and skill to prescribe that which would conduce her recovery'.<sup>1</sup>

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<sup>1</sup> Lewis, J. (ed.) *The Secret Diary of Sarah Thomas, 1860-1865*. The Windrush Press, Moreton-in-Marsh, 1994, pp.29-30.

## APPENDIX E

### Letter to Martha Porter from E.C. Backlen dated 8th May 1818

“Knowing you all wish to hear all the particulars about poor Watson, Monday after the Basket was gone her speech came to her and pain left her for sometime during the day but at night it came back on in her arm so bad that she quite moved up in the bed. I ad [sic] asked Mr Boston in the day if he thought anything would happen in the night for I was thinking she might go off abote [sic] the time she was taken ill he said he could not say but if anything should happen I was to let him know I sopose [sic] that was to prevent his coming again - ~I did not know what to do I thought if she should go off in the night and I ad [sic] never been with a [?] person and the others no more experience than myself – I said to have as you are so poorly I think it would be better to have somebody to sit up with us tonight she did not seem against it but sais [sic] she should not like anyone but Betty Willis I sent to her and asked her she sat up on Monday night with Betty and I went to Bed in my own Bed that I might be ready to get up in a minit [sic] she dos [sic] not like anybody to do any thing for her but me she is so helpless and so heavy now that I am obliged to get one of the maids to help me – since then we have not sat up taken it by turns one sits up half the night the other lays on my Bed. I am never without one of them in the room of a night she ad [sic] but a very indifferent Night but very quiet which is a great mercy for herself and us...<sup>1</sup>

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<sup>1</sup> Letter dated 8<sup>th</sup> May 1818. Porter family of Burlingham. 705: 262/3940/60/iii Worcestershire Record Office.