

It Won't Do Any Harm: Practice and People at the London Homoeopathic Hospital, 1889–1923

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Introduction

HOMOEOPATHIC PRACTICE within the London Homoeopathic Hospital during the years 1889–1923 is examined in this paper with the focus on the role of hospital treatment in the framework of homoeopathic practice in Britain in the late nineteenth and early twentieth centuries. The history of the London Homoeopathic Hospital (LHH) during that period, its patients and professional workers are analysed,¹ recognising that such an approach has to be used with caution given the advantages and disadvantages of using hospital case notes² and hospital-published statistics,³ but it does supply fresh perspective and new evidence. The surviving LHH records are of particular importance because they cover the period when prescribing changed from 'pathological' to 'constitutional'. It has been possible to understand what these methods meant in practice, and the magnitude of the change. In addition, these records give an insight into general medical and nursing practice at the turn of the century, of surgical and anaesthetic techniques and the laboratory investigations available. They also provide information about the patients who attended the hospital. After an overview of the beginnings of homoeopathic practice in Britain in the nineteenth century, a brief summary of chronological developments of the London Homoeopathic

Hospital at the turn of the century is presented. The remaining analysis is thematic as the hospital's patients, their diagnoses and treatment, the medical and nursing staff and the management of the hospital are examined. Finally a detailed analysis of the homoeopathic practice at the hospital is presented.

The growth of homoeopathy seems to have reflected social forces as well as conversion to belief in its methods. It was part of a developing Victorian service economy and benefited from links with royalty and large houses employing numerous domestic servants. The use of homoeopathy reflected status and ensured a genteel environment for treatment. Its main hospital was located in one of London's most beautiful eighteenth-century streets far in spirit from the poor urban areas where most of the voluntary hospitals were located. It was oddly appropriate that a daughter of one of homoeopathy's best known practitioners, Dr Compton Burnett, should have become one of England's best known novelists in realistic, even mordant, depiction of class relationships. Ivy Compton Burnett was indeed a fitting daughter of homoeopathy. Homoeopathy gained from affinity as well as from status. It reflected the growing interest in psychology and holistic medicine, as well as admiration for German culture and science. Its physicians, although not always its surgeons, showed concern for personality and motivation of patients as well as for treatment of disease. The success of homoeopathy reflected a particular time and place, for it declined as society changed but once again its fortunes are rising.

Homoeopathic Practice in Britain in the Nineteenth and Early Twentieth Centuries

THE FATHER OF HOMOEOPATHY IN BRITAIN was Dr Frederic Hervey Foster Quin who was born in 1799 and qualified in medicine at Edinburgh in 1820. He was regarded for many years as the illegitimate son of Lady Betty Foster (nee Hervey) who became the second wife of the fifth Duke of Devonshire. This was certainly untrue, but Quin was accepted in society and had the entree to all the great houses. In fact, he was possibly a relative of an Irish peer and probably the Duchess's godson, being her personal physician for four years. Thus, at its beginning homoeopathy was linked to status. After her death in 1824, he met Dr Neckar, a prominent homoeopath in Rome and became sufficiently interested in homoeopathy to study it in Germany. After practising both systems in Naples he became physician to Prince Leopold, later King of Belgium. Finally, convinced of the merits of homoeopathy, he resigned after two years in order to visit Hahnemann. He practised

homoeopathy successfully in Germany during the cholera epidemic of 1831 and in Paris. Quin returned to London in 1832 to set up the first homoeopathic practice in the country where, with his aristocratic connections, he was quickly established among the well known and wealthy. Quin counted the Dukes of Edinburgh and of Beaufort among his patients and became physician to the household of the Duchess of Cambridge. He was a friend of Dickens and of Landseer and, in later life, the regular dinner guest of Edward Prince of Wales.

Royal interest in homoeopathy appears to have started with Queen Adelaide, wife of King William IV (1830–1837) who was a patient of Doctor Stapf, one of Hahnemann's close associates. This seems to have had political repercussions and Sir Henry Halford, the President of the Royal College of Physicians, bemoaned the influence of the new system:

Dear Dr. Turner,

I am exceedingly annoyed at the Queen's not commanding my professional attendance, as it would give me an excellent opportunity of playing an important political game at this crisis. The last accounts I have received from the Pavilion mention that her Majesty is still persevering in the homoeopathic system and she supposes she has derived advantage from it...Her Majesty's confidence in the absurd system arose from one of her maids being put under it when they were in Germany. Her brother, the Duke, sends her these invisible pills from Germany and they are such atoms that a quill filled with them lasts her Majesty a couple of months.

Her Majesty has also an extraordinary bottle which she smells whenever she wants a movement in her royal bowels and my correspondent tells me that the effect of smelling the bottle is so immediate that her Majesty is obliged to leave the room at a moments notice. H.H.⁴

Neither Queen Victoria nor King Edward VII received homoeopathic treatment, although minor royalty such as the Dukes of Edinburgh and of Cambridge were patients of Quin.

Opening of the Homoeopathic Hospital

QUIN HAD A SOCIETY PRACTICE but he attempted also to open a dispensary for the poor and when this project failed he turned to the idea of a hospital. He founded the British Homoeopathic Association, a predecessor of the present Association, as a medical and lay organisation which was responsible for raising the necessary funds particularly from many aristocratic supporters. In 1849 he was able to purchase a house at 32 Golden Square, Soho and its first 25 patients were admitted on 10th April 1850,

Hahnemann's birthday. There were 156 in-patients and over 1500 out-patients treated in the first year.⁵ This was an important decade in which British homoeopathic practice became more stable within a legislative framework which allowed a diversity of approaches in medical practice.⁶ The progress of homoeopathy in England was seen as 'slow but sure'.⁷ The following decades were characterised by continuous additions to the hospital premises and in 1853 two branches for out-patients were opened. The hospital worked successfully, particularly during the cholera epidemic of 1854, but the premises in Golden Square, as the only homoeopathic hospital in London, quickly proved inadequate to meet the need. In nine years 24,894 patients were treated. Quin, therefore, once more sought finance from his supporters and, in 1859, he was able to purchase three houses, Nos. 51, 52, and 53, Great Ormond Street, at what is the site of the present hospital, providing beds for 50 in-patients, at a total cost of £10,339.⁸ The principal supporters of the hospital, until Quin's death in 1878, were members of the aristocracy; thereafter it was the upper middle classes, self-made millionaires and figures in the 'City'. 'Homoeopathic' families played an important part. Sir Henry Tyler, for example, was Chairman of the Board and a major contributor; his wife chaired the Lady's Guild while their daughter, Margaret, was a physician at the hospital. Similarly, the Epps family held management appointments while Dr. Washington Epps was also a staff physician.

By 1885 275,083 patients had been treated at the hospital.⁹ In the 1880s a new male ward was opened and an associated convalescent home at Eastbourne was established. It became obvious that a new purpose-built replacement was essential and a special appeal in 1890 raised £30,000. The foundation stone for an ultra-modern 100 bed hospital was laid by the Duchess of Teck and her daughter the Duchess of York (later Queen Mary) in June 1893 which opened in July 1895 at a total cost of £55,868. A new wing was opened in 1911 with some accommodation for private patients; previously all in-patients had been treated free of charge. In 1919 the hospital was described as 'the largest homoeopathic hospital in Europe and indeed the whole world.'¹⁰ Demand for homoeopathic treatment was growing, and 'frequent applications [were] received from different districts for homoeopathic practitioners and complaints [were] being made of the unavoidable necessity for calling in ordinary practitioners...'¹¹ Although specialising in homoeopathy, the LHH was a general hospital, open to patients with all types of ailments. In 1899 there was medical and surgical treatment available for 'the diseases of women, girls and children, and those of men and boys' which were all receiving 'equal attention.' In addition,

'diseases of the nervous system, diseases peculiar to women, diseases of the eye, of the skin, of the ear and throat and dental cases are all submitted to special practitioners.'¹² By the 1920s further expansion was planned 'to improve the health of the nation', including an ante-natal department and a department for 'mentally defective' children.¹³

Medical Staff and Education

THERE WERE TWENTY FOUR APPOINTMENTS, by 1899, from consultants to resident medical officers. In addition to the usual specialties, there was one surgeon dentist, one physician in charge of the electrical department and a pathologist. However, by the 1920s some posts were vacant and numbers were unchanged; specialisation had not been fully developed and several medical officers held posts in more than one specialty. The paediatrician, for example, was also an anaesthetist. All medical staff, except for the residents, gave their services to the hospital free, gaining experience and building a reputation which helped their private practice.

In 1877 a School of Homoeopathy was established in connection with the hospital amalgamating with the hospital in 1883 under the name of London Homoeopathic Hospital and Medical School. Clinical assistants, physicians and surgeons were appointed to the hospital half-yearly. Although training included homoeopathic practice, it did not vary greatly from that at other hospitals. Medical officers could hold office for 12 months, during which time they were expected to acquire 'a good knowledge of homeopathic therapy, whilst at the same time gaining considerable experience in general medicine and surgery.'¹⁴ There were many educational opportunities as wards and the out-patients department were 'thrown open daily for the purpose of clinical instruction'¹⁵ to any medical men and students. It was also possible to attend operations which were performed once a week. Special lectures were delivered at regular intervals. There were also travelling scholarships available 'for the purpose of enabling young qualified men or women to study homoeopathy.'¹⁶ As the hospital's fame was international, it had many visitors 'from the Continent, America and Colonies.'¹⁷ A Missionary School of Medicine was attached to the hospital in 1903 to give training in medicine, surgery, first aid and other health-related subjects to foreign missionaries. By 1920 it had about 300 students. The hospital Board recognised it as providing good publicity 'as there are few better methods of spreading the benefits of homeopathy.'¹⁸

Nurse Management and Education

NURSING WAS ADVANCING RAPIDLY in the late nineteenth and early twentieth centuries, resulting from reforms both in the voluntary and Poor Law hospital sectors, distancing itself from the historical image of being 'overworked and underpaid, bewildered and disparaged, unfit for all the duties required...'¹⁹ At the LHH the Medical Staff Committee recommended in March 1891 that nurses should undergo a three year training programme and this was accepted by the Board of Management in May.²⁰ The need for such training was reiterated in 1894, especially for 'external nurses', and the lack of formal training remained a cause for concern to the medical staff even as late as 1897. Nursing certificates were issued on the recommendation of the Nursing Committee. No nurse served on this committee although the Matron was allowed to give advice. A blurring of the line between nursing and domestic duties continued as exemplified in 1919 when a joint 'Nurses and Domestic Staff's Peace Party' was celebrated, showing social contact as well as the overlap of duties.²¹

In 1899 there were 58 nurses of whom 37 were 'more or less regularly employed on the wards.'²² In addition, 21 were available for private nursing. The nurses trained on the wards were 'in constant request for private work' and they were sent to all parts of the United Kingdom and abroad. They had a very high reputation and were employed by both allopathic and homoeopathic practitioners. Complaints were frequent that they were not available when needed, such was the demand. Ten additional nurses in 1919, making a total of sixty eight on average, saw sixty nurses on duty per day with eight away on holiday or sick leave all being under the supervision of the matron, assistant matron and sister housekeeper. Twenty five probationer nurses entered training; their ages were relatively high as the limits were 22-30 years. In the post-war period arrangements were made 'for the fourth year of training to be remitted in the case of suitable candidates who have had not less than two years nursing VAD (Red Cross) experience in a recognised military hospital of not less than 100 beds.'²³ Probationers received lectures in medicine and surgery from the doctors on the staff and examinations included written papers and oral and practical sections. In 1919 ten nurses passed the examination, and twenty four passed the junior examination; a gold medal being presented each year to the best examination candidates. In addition, twelve nurses qualified in invalid cooking, instruction being provided by the London County Council. The nurses were highly regarded, as 'to them and to their care of the patients much of the success of the hospital is due.' Patients attested 'to their

gratitude for the care and good nursing they received.' Despite this, salaries were regarded merely as pocket money as probationers received £17 per year, rising to £28 in the fourth year together with free board lodging, laundry and uniform.²⁴ It would appear that homoeopathy did not make any very distinctive contribution to nursing.

The Patients

THE LONDON HOMOEOPATHIC HOSPITAL was, like most of the major voluntary hospitals in London, supported by contributions from individual benefactors. Its prime purpose was to provide homoeopathic medical attention for the 'working poor'. Direct insight into patient characteristics during the late nineteenth and early twentieth centuries is provided through the data available in approximately 300 volumes of manuscript clinical notes from 1889–1923. Initial analysis of selected records from the years 1889, 1891, 1892, 1895 and 1896 reveals patient characteristics which can be compared to those noted in later records from the years 1919–1920.

Age and Sex

More women than men were admitted, which suggests a non-discriminatory attitude to female members of the 'working poor' and the large number of 'housewives' who were granted treatment. Most patients were in the 15–69 age group with very few aged over 70 years. A sizeable number of children, from the youngest to the age of 14 were treated. Most of the children, although not all, had not yet entered the labour market. By the 1920s women still outnumbered men and the majority of patients were within the 14–69 age group but there was a higher number of patients over 70.

Occupations

The five most common occupations were those of a servant, housewife, house or parlour maid, labourer, laundress, cab/car or coach driver. There were many patients in domestic service for one of the obvious advantages of being a contributor was that the contributor's employees could be removed to hospital for free treatment when ill. The list includes examples of unusual or now extinct occupations such as: lace worker, lacquerer, fancy stationer, bamboo worker, fancy box maker, leather cutter, surgical instrument maker and ostrich feather worker. By the 1920s many occupations previously mentioned had disappeared and there was a marked decrease in those employed in domestic service. Lower middle class patients were becoming

more common, with occupations such as clerk, office worker and probation officer, being recorded.

Length of hospital stay

Most patients stayed from two to five weeks, four weeks being common, but stays of four or five months were not uncommon. Patients who were admitted for only one or two days were usually either so seriously ill that they died or required transfer elsewhere. In 1919 and 1920 the average length of stay had not changed remarkably. Of twenty two patients who remained in hospital for less than a week, twelve died and one was transferred to a Fever Hospital. Some children stayed only one or two days, often because parents were not prepared to part with them. For others, it became obvious soon after admission that nothing could be done to help them and they were discharged.

Diagnosis

The most frequent diagnoses were infections and their sequelae. These included tuberculosis/phthisis, tonsillitis, bronchitis and pneumonia, diphtheria, pleurisy, rheumatism and morbus cordis. Other common conditions were gastric ulcer and gastritis, anaemia and eczema. It was noted that non life threatening illnesses such as dermatitis could result in long periods of in-patient treatment. Patients with tuberculosis often reported several relatives as having died of the disease. The number of admissions for tuberculosis was reduced in the latter part of the period which may have been due to the advent of sanatorium treatment rather than any change of incidence of the disease. In 1919–1920 the incidence of tuberculous disease had fallen remarkably, possibly due to admission policy, but influenza, bronchitis and pneumonia remained common reasons for hospital admission.

Clinical Investigations

Regular recording of temperature, pulse and respiration rates were not routinely practised or recorded; only about a sixth of the analysed records included such graphs. Even when high temperature rates (102–104 degrees Fahrenheit) were recorded in the notes, they did not merit routine recording. Marey's sphygmograph, a research device for tracing the pulse, had been modified and reduced in size for clinical use by Dr Dudgeon.²⁵ Tracings by this machine, utilising a stylus on to smoked paper, are included in a number of the late nineteenth-century case notes. Post-mortem reports were included for fifteen out of thirty-five patients studied and who died at the hospital.

Patient Profiles

THE 1899 ANNUAL REPORT provides further descriptive information about the hospital patients and their origins. Those admitted or seen in the out-patients department were 'sent direct from various parts of the country [and] certain proportion [of in-patients] were transferred from the outpatients' department.' Direct referrals came from medical practitioners in places such as Reading, Croydon, Norwich, Tunbridge Wells, Ramsgate and Camberwell. It was not unusual for many patients to come to the homoeopathic hospital as the last resort, having sought relief from symptoms unsuccessfully elsewhere. Unexpectedly, most patients were described as relatively healthy before developing conditions for which they were treated at the LHH. A typical example of past medical history is seen in a description of a 42-year old patient, who 'excepting a slight attack of variola at sixteen years had never had a day's illness', or of a 60 year old patient whose 'general health was good until eight months before.'²⁶ Some patients' histories show great robustness, such as a three year old girl from Eastbourne who survived measles, whooping cough and influenza. Attention was paid to the psychological profiles of patients as well as to their general appearance. A fourteen year old girl from Hampshire was recorded, for example, as being 'a very stout, well developed girl, with fair, straight hair, pale skin and obviously lymphatic temperament, shown especially in a listless manner and cold flabby hands.' A twenty year old domestic servant was described as 'a tall, well-nourished girl of sanguine temperament... She had a fresh healthy colour, though she conveyed the impression of being a neurotic subject.' A child suffering from tubercle was 'a most delicate child with thin scanty hair, dry skin of an earthy tint; with veins marbling the forehead... Her tongue was matted and pale, expression listless.'²⁷

One section of the 1899 Annual report dedicated to the diseases of women was prepared by Edwin Neatby, the assistant physician for diseases of women at the hospital, and later a consultant. Strong emphasis is placed on patients' subjective experience of illness and his notes are very characteristic of the specific way of history taking in homoeopathic practice being rich descriptions of patients' feelings and everyday lives. As an example, a patient called Kate V. was 42 years of age. She had a house on Hampstead Heath, was married for twenty years and never pregnant. She dated her illness 'to the eating of a mutton chop late in the evening of March 30' in 1895. 'Next day her abdomen began to swell and to be painful [...] Since April she had been to two hospitals and her abdomen had been thrice tapped.' On examination (at LHH) in July, the abdomen was 'found to be full of free fluid

[...] The diagnosis of pelvic and abdominal carcinoma was made, and no operation advised. More tappings and perforations were necessary, on average once a month'. Initially the patient remained 'cheerful and hopeful' but soon she 'lost ground and became emaciated and nervous, and had a bad cough; she dreaded the repeated tapping.' In order 'to obviate these' Dr Neatby has devised 'a special short cannula [...] just long enough to pass through the abdominal wall [...] with the plug removable by the patient at will [...] She did this every three days.' The tube was of 'much comfort to the patient, and by being under her own control saved her much distress from the anticipation of repeated tapping.' In March 1896 the patient went to the country for two months and returned to London 'decidedly improved.' Nevertheless, after this she was seen by Dr Neatby only once because of her sudden death in August 1896 'after a short illness brought on by a railway journey to London.[...] Her mother reported that until a week before death she was enjoying the country and seemed comparatively well. Then she began to have much abdominal pain [...] and she expressed a wish to go home. On the 19th she drove seven miles to Rugby, changed at Willesden and travelled on to Hampstead Heath, and walked downstairs in her house. She then became very ill and was carried up to bed. In the night [...] she was seized with excruciating pain, which caused her to draw up her legs. About 5 am the pain left her and she felt quite comfortable. She died at 7 am, being conscious up to the last.'²⁸

This case study is very informative for not only are there many details about the patient's life, but also, importantly, the doctor tries to see the illness from the patient perspective and empathises with her. He is not afraid to 'empower' the patient by designing a device which would give her control over her symptoms. This was not common at the time when scientific medicine was just gaining ground by increasing its power over patients' bodies. It is noteworthy that the patient was treated by a physician for the diseases of women, while her abdominal tappings involved obvious surgical skills. Although Edwin Neatby was paying considerable attention to the experiences of his patients, he managed to follow the trend of his time in his scientific inquiries into the mysteries of the human body. He was keen to report any pathological changes to the anatomy as seen either during surgery or at the post-mortem examination. His descriptions of internal parts of the body are outstandingly vivid and colourful. For example, the appearance of the peritoneum of one of his patients 'was most striking, and I have never seen anything else quite like it. It at once suggested to my mind the appearance of being coated over with a layer of raspberry jam. The injected base resembled in colour the deep purple-red of the jam, dotted over with the

white seeds.' His concern for patients combined with pathological curiosity can also be seen in this description. Although the outcome of treatment was seen as 'the most satisfactory case from the patient's point of view [...] the tumour itself was of great interest from a pathologico-clinical point of view. The lower part of it [...] was] whitish-pink and firm on section, and almost non-vascular to the unaided eye. The upper distal portion was of a brilliantly variegated appearance of pattern and colouring, reds, yellows, and purples being prominent. Some of these dashes of colour represented obvious blood-vessels, showing active growth in marked contrast to the pale quiescent appearance of the fibroma.'²⁹ These descriptions of pathological lesions can be seen as a classic example of an intellectual and cognitive conflict experienced by many doctors when medicine was entering into a new paradigm and acquiring scientific status. Cool clinical descriptions with their laborious vocabulary were intermingled with more emotive portrayals of visual perceptions. Here the intellect of new science was fighting the old romance of medicine as art. This conflict was probably even more striking for homoeopathic doctors, who found themselves with many contradictory clinical models – those of the old medicine, new science and specific homoeopathic practice.

Hospital Statistics

IN 1899 THE HOSPITAL HAD OVER 100 BEDS of which about three quarters were in medical wards and more than a thousand in-patients were treated. The out-patients department was well attended with over thirty five thousand consultations. By 1919 there were 173 beds including 13 for private patients. Half of the free beds were medical, including 24 for children. There were 31 adult and 10 children's surgical beds. The remainder were 18 beds for gynaecological diseases, 6 for patients with ophthalmic conditions, 6 beds for patients undergoing ear, nose and throat (ENT) treatment, 6 for patients with nervous diseases and 3 for those with skin problems. 1509 people were treated as in-patients, with 109 as the average daily number of patients treated and the average length of stay being 27 days. Each bed was occupied, on average, by nine patients per year. There were 52,209 attendances at the out-patients department which admitted ten and a half thousand new patients.

649 operations were performed in 1919. Ninety seven per cent of the patients recovered, the remaining three per cent died. The recovery rate varied only slightly between specialties, with 100% recovery rate for ENT patients, 97% for gynaecology and 95% for general surgery patients. The

largest group of admissions in 1919 was for alimentary disease – 343 patients were treated of which 65% were ‘cured’, 20% improved and 5% died. Of 165 gynaecological inpatients 74% were cured and 19% were improved. Three patients died (2%). 138 patients were classified as suffering from general diseases. 52% were cured, 30% improved and 9% died. The recovery rate for operations varied from 95% to 97%. The mortality rate for pneumonia in children was claimed to be half that in other hospitals.³⁰ In the dental department, 2866 patients were advised and 6321 extractions were performed, mostly with the help of gas.³¹ By 1919 the hospital had its own electro-therapeutic and x-ray department and there were 836 ‘radiogram and screened cases’, 59 new ‘electro-therapeutic’ cases and 1579 attendances. There was also the ‘mechano-therapeutic department’ which consisted of the ‘gymnasium, fitted with the necessary appliances’, and the hospital’s own laboratories engaging in ‘chemical, histological and bacteriological examinations and preparation of therapeutic agents.’³²

Finance

THE HOSPITAL WAS FINANCED by voluntary contribution and, even at its peak around 1899, expenditure was in excess of income. The finances of the hospital after the first world war became ‘fraught with difficulties’ and great efforts were ‘required to restore the finances of the hospital’.³³ Provisions were rationed and the strictest economy was exercised in all departments. A deficit had to be financed by increasing donations. At the same time the hospital expanded its income from private patients and from those who were covered by the provisions of the National Insurance Act of 1911. After 15 January 1913 all patients had to state whether they were insured, ‘but the treatment of the really necessitous poor who are not insured remain as at present.’³⁴

The financial situation of the hospital was not helped by the First World War. Staff were granted leave to go on active service and the War Office and Admiralty were offered beds for the wounded. The first convoy of ‘sick and wounded sailors’ arrived on October 28th 1915 and the last naval patient, most of whom returned to the service, left the hospital in November 1919, by which date over 2000 had been treated. The actual daily cost of each naval patient exceeded the sum received from the Admiralty, Charitable Funds making up the difference. The hospital managed also entered into an agreement with the London War Pensions Committee for the treatment of discharged disabled men, upon a payment, both as in- and out-patients.³⁵

A Lady Almoner was appointed in 1919 to assess the ability of individual patients to pay for their care. This was a further reversal of past policy where the 'working poor' were recognised as deserving of charitable care. Now all patients were to be treated in the same way subject to a means test of their income. 'The Board feel that the time has come for doing away with that individual, unfair, and ill-defined distinction of a certain section of the public which is considered to be entitled to treatment on a charitable basis – the public will, the Board feel sure, maintain the Hospital if the institution is managed on democratic lines – supported by all for the benefit of all – wherein each patient contributes in accordance with his means.'³⁶ Patients who required a letter of recommendation were examined for 'suitability for admission', with the exception of the accident and emergency cases who were admitted at any time of the day or night without recommendation. Patients had to have their own change of linen, soap, towel, brush, comb, and flannel as well as supplies of tea, sugar and butter. In addition, a deposit was required against breakages. Visiting was restricted and no information could be obtained about patients by telephone.

The financial position of all hospitals led to discussions at the Ministry of Health about possible government funding. The Board of the London Homoeopathic Hospital took the view that supporters could be 'assured that the idea of rate-supported hospitals in place of the voluntary system is neither feasible nor contemplated. The financial burden now being borne by the State makes it unlikely that anything will be done in the future to supersede the voluntary system, but there is little doubt that the responsibilities of the voluntary hospital boards will be increased or widened.'³⁷ The American system was taken as an ideal model of health care provision, where, it was claimed that 'the humblest citizen gets as good medical treatment and nursing as can be obtained by any millionaire, and each patient pays according to his income for exactly similar benefits.'³⁸ Thus, the hospital's finances reflect the changing trends, fashion and custom and found great difficulty after 1918 in financing the built legacy of past success.

Homoeopathic Prescribing Methods

BRITISH HOMOEOPATHS LED BY Robert Dudgeon and Richard Hughes were 'pathological prescribers', their ideas contrasting with those of Frederic Quin who was probably the only British homoeopath who had met Hahnemann. 'He very seldom used tinctures. Most medicines he gave in high dilutions and very seldom had occasion to descend. Some medicines he

prescribed in lower attenuations. Thus, in gonorrhoea he gave Cannabis in globules saturated with the Mother Tincture and he never prescribed higher than 3. But Nux Vomica, Bryonia, Belladonna and the antipsorics he gave in the 30th and he had no reason to be displeased with the results of his practice.³⁹ Hughes recognised the need to reduce the dose of powerful poisons and that many eminent practitioners used high dilutions and praised their efficacy. Yet, 'We seem, therefore to have effected all reasonable ends, even with the most potent poisons when we have reached the thousandths and millionths of which I have hitherto spoken. Unless some evidence should be brought before us to prove that we actually develop power as we go on attenuating after the Hahnemannian method, reason must certainly frown upon the higher potencies.'⁴⁰

Early in the twentieth century the opinions of James Tyler Kent dominated with an emphasis upon mental symptoms and the use of high potencies. They first appeared when Dr Octavia Lewin presented a paper entitled 'Cases Illustrating Constitutional Treatment' in 1903.⁴¹ She was a London graduate who had obtained a MD in Chicago who raised the possibility of curing a patient by studying the generals rather than the particulars; in only one of the five cases she reported were the mentals mentioned. All the patients were treated with M potencies. Dudgeon, who was present at the meeting, raged against the whole idea for as far as he was concerned the very high potencies were not what was claimed. Others present, encouraged by J.H.C. Clarke welcomed the new ideas, although there was some discussion on the nature of a 'Constitution'. This paper supported Clarke whose own ideas were very far from those of Hughes. He had been the outsider who used the 30th and 200th potency. In spite of his seniority, he had held no post within the British Homoeopathic Society but now he was to be vindicated.

Homoeopathic Prescribing Methods at LHH

THIS ACCOUNT IS NOT UNFAMILIAR but there was little knowledge of the prescribing methods prior to the advent of Kentian ideas. Patients, during their stay, could receive five, ten or even twenty different remedies. Some of these are explicable as treatment for inter-current episodes, but it is difficult to avoid the first impression that remedies were prescribed on an arbitrary basis. There is no evidence that a repertory of any kind was used in pre-Kentian days. The choice of remedy was limited to no more than two dozen.⁴²

By far the most common remedy was *Bryonia alba*, the next being

Arsenicum album and Arsenicum iodatum. Others were Belladonna, Aconitum napellus, China officinalis, Ignatia amara, Chamomilla, Nitric acid and Nux vomica, Veratrum both Album and Viride, Hydrastis canadensis, Antimonium tartaricum, Rhus toxicodendron and Berberis vulgaris. All of these were prescribed in low potency, usually 1x or 3x but mother tinctures were used regularly. These were given at short intervals of one to four hours, two being the most frequent. High potencies were not used at all though, occasionally, a 30th was given, particularly of Sulphur given repeatedly rather than in the single split dose of modern times. No other C potencies were prescribed and it is noticeable that remedies requiring high potency for effect, such as Natrum muriaticum, were seldom prescribed. Quantity seems to have had importance for if a remedy was ineffective the dose might be increased rather than the remedy or the potency changed. Many medicines were given in liquid form in three or five minim doses. Alternation of remedies was commonplace particularly Bryonia alba which was usually prescribed two hourly, alternating with Arsenicum album or Aconitum napellus. Conventional medicines were used freely with or instead of homoeopathic remedies. Iron was given for anaemia although sometimes as a 1x potency. Potassium iodide, a common medicine of the time, was prescribed although its purpose is not obvious. Morphine was used for pain relief in one case when there appeared to have been no attempt to relieve the symptoms homoeopathically.

By 1910 there was a complete change from the prescription of 90% material doses to 70% or more of high potencies. The notes of patients under the care of Dr Washington Epps cover the first decade of the century. In 1902 his patients received the treatments described above, but by the end of the decade Kent and his followers appear to have had a strong influence. Remedies were now prescribed in single doses and almost always in the 200th potency. Low potencies seem to have been reserved for gross pathological conditions and alternation had virtually disappeared. The choice of remedy did not alter substantially although it is noticeable that Bryonia was only prescribed twice for thirty-six patients. Perhaps old habits died hard and the importance of the mental symptoms had not yet been fully appreciated thereby limiting the choice of remedy. Although admissions covered most diagnoses, Dr Epps seems to have specialised in rheumatic fever and its sequelae so that indicated remedies tended to be the same in several cases.

Surgery played a major part in the activities of the hospital and the techniques used appear to have been similar to those in other hospitals. Although most of the surgeons were homoeopathic practitioners, they do

not seem to have used potencies to alleviate the effects of surgery itself. While Hepar Sulphuris might be given for sepsis, or Belladonna in fever, no attempt seems to have been made to prescribe Arnica montana or Staphisagria to promote wound healing. In fact, many patients admitted for surgery received no homoeopathy at all.

An understanding can be gained of how certain specific diseases such as diphtheria and tuberculosis were treated.

Diphtheria

The first homeopathic article on diphtheria, a major killer of children, is that of Francis Black which dates from 1858.⁴³ At first the recommendations for treatment appear to have been derived from the therapy used for tonsillitis viz. Belladonna, Mercurius vivus, Rhus toxicodendron, Lachesis, Capsicum. Mercurius vivus, Nitricum acidum, Sulphuricum acidum, Kali bichromicum were recommended for ulceration of the tonsils. If the throat was dark coloured then Mercurius corrosivus, Mercurius iodatus, Arsenicum album, Ammonium carbonicum, Nitricum acidum were considered appropriate. Chlorate of potash was regarded as a specific. Later in the century, mercurial salts became popular, at first Mercurius iodatus but this gave way to Mercurius cyanatus. According to Dr Byres Moir, physician at the LHH, 'it gives far better results than any of the other drugs I have mentioned.'⁴⁴

There was some improvement as a result of use of a new serum. The death rate from diphtheria before the introduction of antitoxin could be more than 50% and averaged 33%. The serum produced a steady decrease in the number of deaths, so that by 1913 the British death rate had been reduced to 6.4%; a similar reduction in mortality was recorded world wide. The number of patients with diphtheria admitted to the London Homoeopathic Hospital increased steadily between 1880 and 1900, replacing typhoid fever as the common diagnosis in the infectious ward. Serum was not used in the hospital until November 22, 1896. The first patient was admitted under Dr Moir having been given the serum the day before by Dr. Roberson Day, the hospital paediatrician. She was a 21 year old woman who had membrane affecting the larynx and trachea who was cyanosed when first seen and coughing up membrane. Recovery was complete. Cases were admitted under Drs Blackley, Clarke, Epps, and Moir. One patient, aged 5 years, treated by Dr Clarke in 1896, was apparently given a potency of the serum by mouth. 10 minims were diluted with 5 minims of water and 5 globules prepared from this were given four times daily. The patient was in hospital for 54 days and developed nephritis. Treatment started with Mercurius cyanatus 6 and was followed by Bacillinum

100 as a single dose. The antitoxin was administered a week later. The last medicine was *Cantharis* 3 commencing six days later for the nephritis. The patient recovered. Between October 1896 and October 1897 thirty cases were treated with three deaths. Of these seventeen received antitoxin of whom one died (5.8%) and thirteen did not with two deaths (15.3%).⁴⁵ The number of cases is too small to make a statistically significant comparison of antitoxin alone and antitoxin plus homoeopathy, but there is a suggestion that the latter was more effective. Many homoeopaths expressed the belief that the serum had little or no effect. In 1900 Dr F.S. Arnold summarised the evidence for this view in a paper presented to the Liverpool branch of the British Homoeopathic Society.⁴⁶ One problem in assessing efficacy was the difficulty of diagnosis. Arnold quoted the results of Dr Hague in 119 cases of 'post-scarlatinal diphtheria', demonstrating that even by then the separation between diphtheria and scarlet fever was not complete. In contrast, Roberson Day, the homoeopathic enthusiast for antitoxin, insisted on bacteriological examination in all cases.⁴⁷ While he did not publish results in sufficient numbers to be statistically significant, he established the idea that a firm diagnosis was essential if conclusions were to be drawn for in a paper of 1892 he had drawn attention to the different manifestations of the disease.⁴⁸ At the same time, he suggested that carers exposed to infection should take *Belladonna* and *Merc sol* as a preventative. In addition, he produced evidence to support the growing conclusion that the earlier the antitoxin was administered the lower the mortality. Laryngeal diphtheria was particularly serious. Goodall gave figures demonstrating the efficacy of antitoxin.⁴⁹ Before antitoxin, of 3,275 cases of laryngeal diphtheria 1008 recovered, a mortality rate of 66.2 per cent; with antitoxin given to 3,275 cases mortality was reduced to 27.7%. Once signs of respiratory distress developed, due to the membrane obstructing the larynx, relief of that obstruction was a matter of urgency. Prior to antitoxin treatment tracheotomy was the method of choice. Even then there was a risk that the membrane would block the tracheotomy tube and this often resulted in death.⁵⁰ Homoeopathy, however, appeared to have an effect, although the doctors realised that, in a small number of cases of a self limiting disease, no definite claims could be made. In one patient paralysis of the palate which had been present for some days, disappeared immediately after the administration of *Causticum*. Farrington reported a severe case which recovered under *Gelsemium sempervirens*. In Calcutta a diphtheritic paralysis of the cervical muscles recovered more quickly than with a spontaneous recovery with *Lycopodium*, based on the symptom 'weakness of neck muscles' in *Chronic Diseases*. Moir reported a case where *Belladonna*

1x appeared to have a favourable effect on bulbar palsy. It also seemed useful in heart disease.⁵¹

Tuberculosis

There were patients with pulmonary disease, with glandular disease and with bone and joint conditions. Homoeopathy made a distinctive contribution to thinking on tuberculosis. Many patients were treated surgically by the removal of glands or the drainage of abscesses. Medical treatment tended to be limited to that necessary to deal with secondary infection or some other acute episode and when this had settled the patient would be discharged as 'cured'.

In 1895 Compton Burnett published his book *Five Years of Experience in the New Cure of Consumption by its own virus*.⁵² This coincided with the introduction of Koch's Tuberculin as a treatment but Burnett claimed to have been experimenting for fifteen years previously. Burnett's Bacillinum was prepared from nummular sputum whereas Koch's preparation was made from cultures of the bacillus. Bacillinum was given in potency, Tuberculinum by injection. Burnett found Bacillinum useful for glandular and joint tuberculosis as well as for early lung disease. It proved ineffective for advanced lung disease and he suggested Psoricum instead. However, the method was only slowly adopted at the Homoeopathic Hospital; Dr. Galley Blackley, for example, made no change in his method of managing tuberculosis. J.H.C. Clarke, who had a more classical approach, started to utilise Bacillinum immediately. It was an acceptable means of treatment as for homoeopaths the only explanation for the operation of Tuberculin was the Law of Similars. By 1914 most homoeopathic doctors used both Bacillinum and Tuberculin.⁵³ Tuberculin was being given, as a matter of routine, in potency but if all else failed could be given by injection. Charles Wheeler pointed out that prescription was based upon the finding of tubercle bacilli.⁵⁴ He thought the importance of inter-current infection was being underestimated and that Bacillinum was indicated where there was such infection. Where there was no definite symptom match he suggested the use of non-human tuberculinum such as Tuberculinum bovinum. This was a preparation that was not evident before 1920–21 when both Wheeler and John Weir were prescribing it as the only form. Burnett recommended the prescription of high potencies because even the 30th could cause severe reactions but, in practice, all potencies were used. It is noted that the 100c potency was popular for Tuberculinums although it does not appear to have been prescribed for any other remedy. Bacillinum was not used alone as many remedies were prescribed with it; Burnett frequently justified Thuja on the

basis of failed vaccination. Other popular remedies were *Arsenicum iodatum*, *Phosphorus* and *Silicaea*. Koch's tuberculin treatment was a failure, despite efforts to improve results, first by increasing and later by reducing dosage and it disappeared gradually to be replaced by open air sanatorium treatment. Tuberculinum therapy of tuberculosis also ceased possibly because patients were referred directly to sanatoria and were no longer admitted to the Homoeopathic Hospital.

Treatment Outcomes

THE EFFICACY OF THE THERAPY would be difficult to establish requiring comparisons with conventional results. Most patients were discharged with the letters 'VMI', very much improved, though in many cases it is far from clear what this meant. There were no miracles; heart murmurs did not disappear with one high potency dose as was claimed in some of the nineteenth-century literature. Nevertheless, deaths were infrequent, for example, Dr Moir in 1889 had only one death out of 74 patients. Many deaths seem to have been inevitable where causes included heart failure, the last stages of TB, bronchiolitis in an infant and carcinoma.

Conclusions

THE LONDON HOMOEOPATHIC HOSPITAL was a small, voluntary institution in Central London which was unique in that it specialised in homoeopathy, introduced to Britain by Quin. At the beginning of the period there were homoeopathic hospitals, clinics and practitioners throughout the country and the method presented a real threat to conventional medicine. Homoeopathy represented a real threat to doctors' reputation and income and a possibility of becoming the 'conventional' method. The period ends when homoeopathy was becoming an idiosyncrasy espoused by a minority of doctors and of little interest, except to a limited number of supporters who remained a faithful clientele despite the declining popularity of this practice. Homoeopathy faced a growing struggle both for funding and for professional credibility.

Once the threat of homoeopathy to the medical orthodoxy was removed, the establishment lost interest and the constant attacks in the press ceased.⁵⁵ One of the reasons for these changes was the alteration in prescribing methods following the substitution of Kent's philosophy for that of Hughes and the change of attitude towards scientific medicine. A detailed study of the two methods has been given, although it has not proved possible

to compare the efficacy of 'pathological' with 'constitutional' prescribing. Finally, there were radical changes in the financing of health and social care, which occurred during the early twentieth century and affected the Hospital, including the 1911 National Insurance Act. The growing availability of 'free' health care based on 'scientific' medicine weakened the hospital's ability to attract patients. Expansion ceased and, for many years, homoeopathy in Britain survived on the medical fringe. Now, at the end of the twentieth century, 'customer-led' rejuvenation of interest in homoeopathic ideas and practice could see another phase of expansion.

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Notes

- 1 There are no previous wider studies of homoeopathy in Britain, except the work by P. Nicholls, which deals mainly with the professional and organisational background. Phillip Nicholls, *Homoeopathy and the Medical Profession* (London, 1988). Information presented in this chapter has been gathered during on-going research into the history of the LHH. We undertook detailed analysis of the primary source documents concerned with the hospital: Minutes of Board Meetings, Minutes of Governors and Subscribers Meetings, Minutes of the LHH Staff Committee and the Medical Staff Committee, Annual Reports and a selection of clinical notes, over three hundred volumes of which were discovered in the basement of the hospital in 1992.
- 2 Guenter Risse & John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine* 5 (1992), 183–205.
- 3 Brian Abel-Smith, *The Hospitals 1800–1948* (London, 1964).
- 4 Henry Halford, *The Lancet*, 29 (Nov. 29, 1834), 359.
- 5 The London Homoeopathic Hospital, *The Annual Report*, 1899.
- 6 When the Act for Regulating the Practice of Medicine for 1858 was being debated, Lord Ebury, a great supporter of the LHH, intervened in the House of Lords to expunge a clause calculated to make the practice of homoeopathy impossible, and substituted one which made any attempt of any examining body to disqualify students on the ground of adherence to any particular theory of medicine, illegal.
- 7 LHH *Annual Report*, 1899.
- 8 LHH *Annual Report*, 1919
- 9 *ibid.*
- 10 *ibid.* The building included the present offices on the ground floor and the Board Room. The out-patients department was expanded and wards were added on the four floors above. This building remains as the base in which the now Royal London Homoeopathic Hospital Trust operates within the National Health Service.
- 11 LHH *Annual Report* 1899
- 12 LHH *Annual Report* 1899
- 13 LHH *Annual Report* 1919 At the end of the nineteenth century there were eight other homoeopathic hospitals in England, and consulting staff from London were contributing to some of these hospitals. There were also many homoeopathic dispensaries in various parts of the UK.
- 14 *ibid.*
- 15 *ibid.*
- 16 *ibid.*
- 17 *ibid.*

- 18 LHH *Annual Report* 1919. The school existed until 1995 in Powis Place, near the hospital, in the offices of the Faculty of Homeopathy.
- 19 Guenter Risse, *Hospital Life in Enlightenment Scotland: Care and Teaching at the Royal Infirmary in Edinburgh* (Cambridge, 1986).
- 20 LHH, *Minutes of the Board of Management and Medical Staff Committee*, March 1891.
- 21 LHH, *Minutes of the Board Meeting*, June 18, 1919.
- 22 LHH, *Annual Report* 1899. Although information is available on nurse education and management there is little on the nursing procedures used.
- 23 LHH *Annual Report* 1919.
- 24 *ibid.*
- 25 Dudgeon was a physician at the LHH. He was a polymath who edited the *Journal of Homoeopathy* for forty years and wrote innumerable articles himself. In addition, he invented such items as spectacles for seeing under water. He reduced the size of Marey's sphygmograph to make it usable in the consulting room.
- 26 LHH *Annual Report* 1899.
- 27 *ibid.*
- 28 *ibid.*
- 29 *ibid.*
- 30 *Report of the 13th Annual Meeting of the Children's Homoeopathic Dispensary*, 1927.
- 31 LHH *Annual Report* 1919.
- 32 *ibid.*
- 33 *ibid.*
- 34 *ibid.*
- 35 *ibid.*
- 36 *ibid.*
- 37 *ibid.*
- 38 *ibid.*
- 39 *Minutes of the British Homoeopathic Society*, 1846.
- 40 Richard Hughes, *Manual of Pharmacodynamics* (New Delhi, re-print 1980), p. 99.
- 41 Octavia Lewin, 'Constitutional Prescribing', *Journal of British Homoeopathic Society*, 11, vol. 2 (1903), 139.
- 42 LHH, *Manuscript Clinical Notes*, 1889–1923.
- 43 Frederick Black, 'Remarks on Diphtheria', *British Journal of Homoeopathy*, 41 (1858), 633.
- 44 Byres Moir, 'On the General Medical Treatment of Diphtheria', *Journal of British Homoeopathic Society*, 6 (1898), 124.

- 45 J. Roberson Day, 'The Serum Treatment of Diphtheria', *Journal of the British Homoeopathic Society*, 6 (1898), 122.
- 46 F.S. Arnold, 'Inoculation Therapy in Tetanus, Plague and Diphtheria', *Journal of the British Homoeopathic Society*, 8 (1900), 231.
- 47 J. Roberson Day, 'The Serum Treatment of Diphtheria', *Journal of the British Homoeopathic Society*, 6 (1898), 117.
- 48 J. Roberson Day, 'The Polymorphous Manifestations of Diphtheria – A Contribution', *The London Homoeopathic Hospital Reports* (1892), 77–90.
- 49 Goodall, *Serum, Vaccines and Toxins* (London, 1916), p. 113.
- 50 LHH *Manuscript Clinical Notes*, 1889–1923.
- 51 Byres Moir, 'On the General Medical Treatment of Diphtheria', *Journal of British Homoeopathic Society*, (1898).
- 52 John Compton Burnett, 'Five Years of Experience in the New Cure of Consumption by its Own Virus' (1895).
- 53 George F. Goldsborough, 'The use of Tuberculin by Homoeopathic Practitioners Based on a Collective Investigation', *British Homoeopathic Journal*, 4, 9 (1914), 387–437.
- 54 Charles E. Wheeler, 'Summary of Clinical Evidence on the use of Tuberculin', *British Homoeopathic Journal*, 9 (1914), 437–47.
- 55 Phillip Nicholls, *Homoeopathy...*, op. cit. Only in the past decade, when a threat again seems to be developing, have the attacks recommenced.

End note

Extensive use has been made of the Manuscript Clinical Notes (1889–1923) in providing supporting data throughout this paper. This has not always been acknowledged in foot notes, to avoid repetitious referencing. The aggregated data were drawn upon extensively in analysing prescribing patterns, diagnostic and clinical practice/innovation and patient profiles in terms of both socio-economic and clinical characteristics.

