The First Lady Almoner: The Appointment, Position, and Findings of Miss Mary Stewart at the Royal Free Hospital, 1895–99

LYNSEY T. CULLEN

Centre for Health, Medicine and Society: Past and Present, Oxford Brookes University,
Headington Campus, Gypsy Lane, Oxford OX3 0BP, UK.
Email: lynsey.cullen@brookes.ac.uk

ABSTRACT This article examines the professional roots of the hospital almoner, a position which has been widely neglected in medical history. The first almoner was Miss Mary Stewart, a former Charity Organization Society employee, appointed at the Royal Free Hospital of central London in 1895. The Royal Free was a charitable hospital which offered free medical treatment to patients considered morally deserving but unable to afford medical care elsewhere. The role expected of Stewart was to means test patients in order to ensure that only those deemed “appropriate” received free medical treatment, and to establish the extent to which the hospital was being abused by those who could afford to contribute toward their medical care. While in office, Stewart continually reshaped the role of almoner. She fashioned the position into that of a medical social worker and undertook such duties as referring patients to other means of medical and charitable assistance, visiting patients’ homes, and training almoners for positions at other voluntary hospitals. Through the examination of Mary Stewart’s *Almoners Report Book*, this article considers the circumstances of her appointment, the role she performed, and the findings of her investigations. **KEYWORDS:** almoner, Mary Stewart, Royal Free Hospital, means test, patient identity.

JOURNAL OF THE HISTORY OF MEDICINE AND ALLIED SCIENCES, Volume 68, Number 4

© The Author 2012. Published by Oxford University Press. All rights reserved.

For permissions, please e-mail: journals.permissions@oup.com

Advance Access publication on April 2, 2012

doi:10.1093/jhmas/jrs020

INTRODUCTION

WITH her appointment to the Royal Free Hospital of London in 1895, Miss Mary Stewart became the first lady almoner in Britain. Almoners are widely recognized to have been the forerunners to the modern-day hospital social worker, though in the pre-NHS era they also acted as financial inquiry officers. The addition of Stewart and subsequent almoners to the staff of voluntary hospitals was a significant step. Though the role would quickly develop, the initial purpose of the almoner was to perform means tests on patients in order to determine if they were eligible to receive free medical treatment. Those found ineligible would either have been ordered to contribute toward the cost of their care, be referred elsewhere, or refused assistance altogether. Both the position and significance of the hospital almoner, however, have been seriously understudied in the current historiography of health and welfare in Britain. In broad hospital histories, the role has been discussed only briefly and the purpose of the almoner often oversimplified. Such histories include those of Steven Cherry, Roy Porter, and Frank Prochaska.¹ Cherry has listed the basic role of the late nineteenth-century almoner as one to “check charitable abuse, filter out patients to the poor law and, later, to assess patients for contributions.”² According to Porter, they were employed in order to ensure that “even the poor paid something towards costs” at public hospitals which were turning themselves into high-prestige diagnostic and surgical centers.³ Similarly, Prochaska has claimed that the increased use of almoners allowed voluntary hospitals to become more selective in their choice of patients, and thus avoid “the accusation of providing treatment free to those who could afford to pay for it.”⁴

The appointment of the first almoner has been discussed in only a few previous histories of British hospitals and studies of social

1. Steven Cherry, *Medical Services and the Hospitals in Britain, 1860–1939* (Cambridge: Cambridge University Press, 1996), 72–74; Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press, 1999), 636–37; Frank K. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund 1897–1990* (Oxford: Clarendon Press, 1992), 55, 74.

2. Cherry, *Medical Services*, 72.

3. Porter, *The Greatest Benefit*, 636–37.

4. Prochaska, *Philanthropy*, 55.

welfare including those of E. Moberley Bell, Lara Marx, and Keir Waddington. The role and training of almoners throughout the twentieth century have been examined by Dorothy Manchée, Phyllis Willmott, Chris Nottingham, and Rona Dougall.⁵ This article, therefore, aims to contribute to this limited historiography by considering the complexity of the almoner's initial role as both an inquiry officer and a social worker. It was the almoner's role to investigate the financial circumstances and moral character of patients in order to determine whether they should contribute toward the cost of their treatment, and to refer patients to other relevant means of charitable assistance beyond the hospital. The almoner therefore acted as an intermediate between the voluntary hospital and a wider network of charity. The actual financial circumstances of the patients and the almoner's conclusions as to whether or not they were their "deserving" of medical charity have so far been neglected by historians. This article will contribute toward our understanding of the origins of hospital almoning by examining Stewart's *Almoners Record Book*; a unique first-hand account of her position and findings until her retirement in 1899.⁶

To begin, this article will examine the appointment of Stewart as the first hospital almoner at the Royal Free Hospital (hereafter RFH), which served to change the dynamics and workings of the general voluntary hospital system in Britain. The general development of London hospitals has attracted historical attention in the last

5. E. Moberley Bell, *The Story of Hospital Almoners: The Birth of a Profession* (London: Faber and Faber, 1961); Dorothy Manchée, *Social Service in a General Hospital* (London: Baillière, Tindall and Cox, 1944); Dorothy Manchée, *Whatever Does the Almoner Do?* (London: Baillière, Tindall and Cox, 1946); Dorothy Manchée, *Textbook for Almoners* (London: Baillière, Tindall and Cox, 1947); Lara C. Marx, "Early Days," *The Almoner*, 1953, 6, 346–59; Chris Nottingham and Rona Dougall, "A Close and Practical Association with the Medical Profession: Scottish Medical Social Workers and Social Medicine, 1940–75," *Med. Hist.*, 2007, 51, 309–36; Andrew Sackville, "Thomas William Cramp, Almoner: The Forgotten Man in a Female Occupation," *Br. J. Soc. Work.*, 1989, 19, 95–109; Angela Simmons, *A Profession and Its Roots: The Lady Almoner* (unpublished spiral bound manuscript, Royal Free Hospital Archives, London, England [hereafter RFHA]); Angela Simmons, "A Profession Takes Root: The Lady Almoner," *Lond. Soc. J.*, 2004, 448, 10–13; Keir Waddington, "Unsuitable Cases: The Debate over Outpatient Admissions: The Medical Profession and Late-Victorian London Hospitals," *Med. Hist.*, 1998, 42, 26–46; and Phyllis Willmott, "1895–1945: The First 50 Years," in *100 Years of Health Related Social Work, 1895–1995: Then–Now–Onwards*, ed. Joan Baraclough, Grace Dedman, Hazel Osborn, and Phyllis Willmott, (Birmingham: BASW Trading Ltd, 1996), 1–20.

6. *Almoners Record Book*, RFH/6/A/1, RFHA.

decade, but much more scholarship is needed on how the system operated.⁷ The introduction of the patient means test highlighted a shift in attitudes toward charitable medicine. Though voluntary hospitals were selective, throughout the nineteenth century, these institutions aimed to offer free healthcare to all those considered “morally deserving.” By the close of the century, however, there was an expectation that those with means should contribute to the cost of their health care.

The article will then turn to an examination of the contents of the *Almoners Report Book* of the first lady almoner, in order to develop our understanding of the functions of early hospital almoners and their interactions with patients. According to the hospital records, on her appointment, Stewart’s primary duties were threefold. First, to prevent the abuse of the hospital by persons able to pay for medical treatment; second, to refer destitute patients already in receipt of parish relief to the Poor Law authorities; and third, to recommend suitable persons to provident dispensaries (the provident system was a form of medical insurance to which members paid a subscription).⁸ Though she could not assess the means of all the patients who sought treatment at the RFH, her presence was believed to act as a deterrent to those who would seek to abuse the system of free medical relief. As this article will demonstrate, the actual daily role and duties of the almoner developed substantially over time. Through her reports, we can gain a valuable insight into the work she performed, the relationships she formed, and the importance of her office in the London voluntary hospital system at the turn of the twentieth century. The relationship between the patient and the hospital was therefore changed by the presence of the almoner.

7. Elsbeth A. Heaman, *St. Mary’s: The History of a London Teaching Hospital* (Liverpool: Liverpool University Press, 2003); Lindsay Granshaw, *St. Mark’s Hospital, London: A Social History of a Specialist Hospital* (London: Distributed for the King’s Fund by Oxford University Press, 1985); Hujohn A. Ripman, *Guy’s Hospital, 1725–1948* (London: Adprint, 1951); Geoffrey Rivett, *The Development of the London Hospital System, 1823–1982* (London: Kings Edward’s Hospital Fund for London, Oxford University Press, 1986); Keir Waddington, *Charity and the London Hospitals, 1850–98* (Woodbridge: Boydell Press, 2000); and Keir Waddington, *Medical Education at St. Bartholomew’s, 1123–1995* (Woodbridge: Boydell Press, 2003).

8. Anon., “Rules and Regulations, 1904–14,” RFH/1/3/6/2, RFHA.

This article will also examine the findings of Stewart's investigations into the financial circumstances of the patients of the RFH. A crucial aspect of her role was to categorize patients based on the findings of a means test. Initially, patients were placed in one of three categories. The first were those who were considered to be in the financial position to contribute toward their medical care through the provident system; the second were those who were unable to make such contributions; and the third were those persons in need of food or other nonmedical charity.⁹ These categories expanded over the course of Stewart's time at the RFH as her understanding of patient poverty and her attitudes toward who was morally deserving of medical charity changed. Moreover, her reports provide a unique insight into the wider identity of voluntary hospital patients. Although full names were not included, in order to protect the patients' privacy, case examples included in the almoner's reports detail the patient's age, occupation, and general living conditions. The current literature contains very little reference to patient identity and thus the almoner's records offer valuable empirical examples of the types of patients who sought free hospital care.

BACKGROUND: THE APPOINTMENT OF THE FIRST LADY ALMONER

The creation of the new role of almoner marked a distinct change in the way the voluntary hospital system in Britain operated, and saw the beginning of an important component of social work, which remains with us today. In order to understand the appointment of Mary Stewart, the state of the voluntary hospital system in Britain at the end of the nineteenth century must first be examined. This will be followed by an overview of the Charity Organization Society (henceforth the COS), which played an important role in the medical charity sector and was subsequently crucial in the establishment of the position of almoner. Finally, the RFH, the setting of Mary Stewart's appointment, will be discussed.

The charitable and voluntary hospital sector of England is credited with having undergone the most impressive growth of all medical institutions during the eighteenth and nineteenth

9. Almoners Record Book, RFH/6/A/1, 2-4, RFHA.

centuries.¹⁰ Digby claims that the number of English voluntary hospitals “had grown from one in 1720 to thirty-three by 1800,” and Prochaska states that this number had increased to 130 by 1861 and to 385 by 1891.¹¹ According to Berridge and Crowther, approximately 18.5 percent of all hospital beds in England and Wales in 1861 were voluntary, and by 1911, this had increased to approximately 22 percent.¹² Cherry estimates that voluntary hospitals provided roughly twelve in-patient beds per thousand population by 1911.¹³ These hospitals were financed primarily by a combination of wealthy upper- and middle-class subscribers, donations, legacies, and the Hospital Sunday and Saturday funds, and were staffed partly by consultant physicians and surgeons who worked for free to serve their community and acquire on-the-job experience.¹⁴ They were typically expected to treat the “respectable” working class poor who, until the late nineteenth century, were primarily admitted as a result of letters of recommendation submitted by either subscribers or governors.¹⁵ Benefactors to charitable hospitals received a number of these letters depending on how much money they donated, which they could then distribute to applicants whom they were willing to recommend for treatment at the respective hospital.¹⁶ Without a letter, patients would only be accepted in cases of emergency.¹⁷

By the late nineteenth century, however, subscribers’ letters were recognized as being an unnecessary aspect of admission, and most

10. Prochaska, *Philanthropy*, 5.

11. Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720–1911* (Cambridge: Cambridge University Press, 1994), 233; Prochaska, *Philanthropy*, 5.

12. Virginia Berridge, “Health and Medicine,” in *The Cambridge Social History of Britain 1750–1950*, ed. Francis M. L. Thompson (Cambridge: Cambridge University Press, 1990), 3: 206, 209; Margaret A. Crowther, *The Workhouse System 1834–1929: The History of an English Social Institution* (London: Batsford Academic and Educational Ltd, 1981), 167.

13. Cherry, *Medical Services*, 24.

14. Cherry, *Medical Services*, 44–45; Bronwyn Croxson, “The Price of Charity to the Middlesex Hospital, 1750–1830,” in *Financing Medicine: The British Experience since 1750*, ed. Martin Gorsky and Sally Sheard (Abingdon: Routledge, 2006), 23–24; Granshaw, *St. Mark’s Hospital*, 3; John Mohan and Martin Gorsky, *Don’t Look Back? Voluntary and Charitable Finance of Hospitals in Britain Past and Present* (London: Office of Health Economics and Association of Chartered Certified Accountants, July 2001), 36.

15. Cherry, *Medical Services*, 72.

16. *Ibid.*, 45.

17. *Ibid.*

voluntary hospitals no longer requested them.¹⁸ At the same time, hospitals were becoming safer places to receive medical treatment, especially after the advent of anesthetics and antiseptics techniques. By the turn of the twentieth century, they could boast new scientific means of medical care such as x-rays, which attracted a higher class of patient, who came hoping to benefit from these new technologies. Consequently, the public perception of voluntary hospitals changed. Once viewed primarily as a charitable institution associated with serving the poor, it was now viewed as a proper center of healthcare with “wider accessibility to their local communities.”¹⁹ This meant that the voluntary hospital was not only embedded in the everyday life of the metropolis, but it was also much easier to access the system. As explained by Waddington, the demand for hospital services began to soar in the later nineteenth century and outpatient departments became seriously overcrowded.²⁰ Concern was expressed by both the medical profession and wider society that outpatient departments were being abused by those who could afford to pay for private treatment.²¹ An article entitled “Hospital Abuses,” printed in *The Times* in 1871, expressed a growing concern on the matter.²² It noted that, “there exists a great abuse of the out departments of hospitals by persons not entitled or needing gratuitous medical attendance and medicine being patients at those departments,” and that, moreover, “the out-patient rooms were so crowded that the medical attention given was often little better than a farce, and that in several respects the out departments of hospitals were often the means of doing harm rather than good.”²³ In response to such concerns, the Select Committee of the House of Lords appointed in 1891 was to investigate and make recommendations on the out-patient departments in the metropolis.²⁴

18. Anne Hardy, *Health and Medicine in Britain since 1860* (Basingstoke: Palgrave, 2001), 15.

19. Ibid.

20. Waddington, “Unsuitable Cases,” 26–46.

21. Ibid.

22. This article was written by physicians after a meeting held at the Royal Medical and Chirurgical Society in April 1871.

23. Anon, “Hospital Abuses,” *The Times*, April 28, 1871, 11.

24. Joan Baraclough, “Stewart, Mary (1862/3–1925),” *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004), available online at: <http://www.oxforddnb.com/view/article/75262> (accessed January 16, 2008); Simmons, “A Profession Takes Root,” 11.

A prominent organization in the ongoing debates surrounding the overcrowding of hospital outpatient departments and the abuse of charity more widely was the Charity Organisation Society (COS). Founded in 1869, the COS argued that indiscriminate charity demoralized those who received it and encouraged habits of laziness and dependence.²⁵ The Society's aim was to establish better efficiency and "a proper costing procedure in the dispensation of charity" by persuading charities to "coordinate and concentrate their considerable resources so that they were distributed systematically to those best able to make use of them."²⁶ It was suggested that relief should only be provided after the case had been "rigorously investigated to ascertain the applicant's worthiness."²⁷ By organizing charity, the COS believed that it could tackle the causes of poverty rather than the effects, and could therefore prevent the poor sliding into pauperism by encouraging "independence, providence, and self-reliance."²⁸ A federation of District Committees that corresponded with the Poor Law divisions of Metropolitan London ran the COS, though they were coordinated by a few paid professional agents at the Central Office. They offered a certification process for relief applicants, who would register their case with the COS, be investigated and if successful, be referred to the appropriate charitable society.²⁹ Middle-class women usually ran these offices on a volunteer basis, as a means of serving their communities or to keep themselves occupied in a period when occupations for such women were limited. Although there were many other newly formed voluntary societies in the late nineteenth century, which sent middle-class women to visit slum areas "bearing with them the religious tract, the sisterly touch, moral certitude and carbolic soap," the COS

25. Robert Humphreys, *Sin, Organized Charity and the Poor Law in Victorian England* (New York: St. Martin's Press, 1995), 4; Charles L. Mowat, "Charity and Casework in Late Victorian London: The Work of the Charity Organisation Society," *Soc. Serv. Rev.*, 1957, 31, 3, 260; Simmons, "A Profession Takes Root," 11.

26. Pat Thane, *Foundations of the Welfare State*, 2nd ed. (London: Longman Press, 1996), 21.

27. Humphreys, *Sin*, 5.

28. Mowat, "Charity and Casework," 260; Thane, *Foundations*, 22.

29. Mowat, "Charity and Casework," 260, 265; Madeline Roof, *A Hundred Years of Family Welfare: A Study of the Family Welfare Association (Formerly Charity Organisation Society) 1869-1969* (London: Michael Joseph Publishing, 1972), 53.

became a particularly respectable force in the field of women's philanthropy due to its investment in training.³⁰

Against this backdrop, Dr. William Marsden founded the Royal Free Hospital in 1828. Unlike other voluntary hospitals of the early nineteenth century, the RFH was established on the principle that subscribers' letters would not be used as the means of admission. Marsden's guiding philosophy was that "*destitution and disease* should alone be the passport for obtaining *free and instant relief*."³¹ Without the use of subscribers' letters, it was the RFH staff who determined which patients deserved free medical treatment based on their apparent moral stature and the severity of their condition, rather than the usual prescreening by governors and benefactors. This system of admission meant that the hospital was hugely popular among the lower classes. As a result, the charity expanded dramatically throughout the century from its origins as a small outpatient dispensary at Hatton Garden to a larger institution (a former barracks) on Gray's Inn Road. This facility could treat hundreds of in-patients at any given time and thousands of outpatients.³² By 1890, the hospital administered to over 30,000 patients annually.³³

The COS worked with a number of hospitals to investigate the abuse of charitable medical relief and in 1874, it conducted a preliminary inquiry into the RFH.³⁴ As the COS did not appoint an official inquiry officer initially, the level of abuse found in the outpatient department must have been low. This is despite the fact that the outpatient department was particularly vulnerable to overcrowding since it did not require a subscriber's letter of admission. Regardless

30. Patricia Hollis, *Ladies Elect: Women in English Local Government, 1865–1914* (Oxford: Clarendon Press, 1987), 11. For details of the wider movement, see Seth Koven, *Slumming: Sexual and Social Politics in Victorian London* (Princeton, New Jersey: Princeton University Press, 2004).

31. Anon., "History of the Royal Free Hospital," R.F.H. Reports, 1848–65, Book A1, January 1849, RFH/1/2/2, vii, RFHA. Although the RFH is an example of an important and pioneering voluntary hospital, it has not been the subject of a systematic study.

32. Lynne A. Amidon, *An Illustrated History of the Royal Free Hospital* (London: Published by the Special Trustees for the Royal Free Hospital, 1996), 16; Anon., "A Brief History of the Royal Free Hospital," R.F.H. Reports 1905–10, Book A13, The Royal Free Hospital Eighty-Third Annual Report, for the Year Ending December 31, 1910, RFHA/1/2/2, 10–11, RFHA; General and Committee Minutes, 1828–39, RFHA/1/2/1/1, 9–11, 192, RFHA.

33. Anon., "Royal Free Hospital Report of the Committee of Management for the Year 1890," R.F.H. Reports 1890–94, RFHA/1/2/2, Book A10, 26, RFHA.

34. Waddington, "Unsuitable Cases," 42.

of the findings of the initial inquiry, fears of abuse and overcrowding did not disappear at the RFH or in the wider medical and charitable communities over the following decade. By the 1890s, the RFH was keen to revise its management structure to include an inquiry official. Cases in which patients who could afford to pay for treatment elsewhere or who dressed down in order to appear to be more destitute and thus receive free treatment, were notorious.³⁵ It was thought that a “gatekeeper” system would be the best way to identify the genuine and reject the unscrupulous.

In the minute-book of the Hospital Board for the year 1894, the Chairman of the Board described the perceived benefits of employing an almoner to assess the patients:

It would put the hospital more in touch with the surrounding dispensaries to which our trivial cases, where the patient can afford to pay a small fee, would be referred, and from which we could receive cases requiring skilled treatment. The Hospital would thus gradually become an institution where the highest skill and largest experience were brought to bear upon serious and difficult medical and surgical cases and the funds contributed by the benevolent would thus be employed to the highest advantage.³⁶

As the RFH was keen to revise its management structure to include such screening, the hospital turned to the government for help in this matter.

As a result, the Select Committee of the House of Lords appointed an inquiry officer at the hospital to eliminate unsuitable patients.³⁷ Revealingly, according to the minutes of the Hospital Board in 1894, “the inquiries take up much time and are necessarily imperfect, because they are conducted by unskilled officers who have no means of testing the truth of the statements made by the patients.”³⁸ While the practice of inquiring into patients’ means was seen as a solution to the problem, the inquiry officer had no training

35. Anon., “Hospital Abuses,” 11; Anon., “Out-Patient Department,” R.FH. Reports 1895–99, Book A11, The Royal Free Hospital Sixty-Ninth Annual Report for the Year Ending December 31, 1896, RFHA/1/2/2, 12, RFHA; Prochaska, *Philanthropy*, 74.

36. Anon., “Memorandum in Reference to the Out-Patients Department,” Presented by Mr Sheppard, Weekly Board Minutes, R.FH.A., July 26, 1894, RFHA/6/A/2, 171, RFHA.

37. Weekly Board Minutes January–July 1895, Almoner Correspondence, RFHA/6/A/2, RFHA.

38. *Ibid.*

or experience in the field. Sir Charles Loch (the Secretary to the COS) sought to ratify this problem by offering to provide a trained female social worker who would act as an inquiry officer to the hospital outpatient department.³⁹ The COS staff members were trained to take the details of the applicant's who entered the office, make inquiries either by post or by visiting and interviewing persons to verify an applicant's statement, and to make visits to the claimants home to check on their progress until the case was closed.⁴⁰ Essentially, the Society trained staff to inquire into the financial and moral standings of charitable applicants. This was the same job description that future almoners would have. Loch felt a trained COS member would therefore be best suited to the role and published a reference guide to aid the work of future almoners entitled *How to Help Cases of Distress: A Handy Reference Book for Almoners and Others*.⁴¹

After a discussion between the COS and the RFH Committee, the hospital appointed Miss Mary Stewart (1862/63–1925) to the position of almoner for a trial period of three months.⁴² All accounts indicate that she was single and childless. She had been employed as Secretary to the North St. Pancras Committee of the Society before being reassigned to the hospital.⁴³ Stewart therefore possessed local knowledge as to the conditions of the poor in London and the training needed to inspect patient's means and refer them to other charitable sources. There appears to be no reference in the minutes, the *Almoners Report Book*, or in the surviving correspondence of the time as to why Stewart in particular was chosen. In the minutes of the Weekly Board for the year 1894, however, Mr. Sheppard (the Chairman of the Board) claimed that the person required for the job must be someone "on whose discretion we could rely and in whom the medical staff had confidence."⁴⁴ Thus, it can only be assumed that Stewart was thought to possess such qualities. At the end of the three-month

39. Marx, "Early Days," 348.

40. Mowat, "Charity and Casework," 266.

41. Charles S. Loch, *How to Help Cases of Distress: A Handy Reference Book for Almoners and Others* (London: Charity Organisation Society and Longmans Green & Co., 1890).

42. Roof, *A Hundred*, 105.

43. Bell, *The Story*, 27–31; Marx, "Early Days," 348.

44. Anon., "Memorandum," July 26, 1894, RFHA/6/A/2, 171, RFHA.

trial period, Stewart returned to work with the COS while the RFH evaluated her performance as almoner. The hospital leadership then decided to appoint her to this position full time. Two members of the COS committee gave half the salary cost of fifty pounds each (twenty-five pounds to the hospital and twenty-five pounds to the society, respectively) to which the hospital added a further twenty-five pounds, making the almoner's total annual salary £125.⁴⁵ This was a very good salary at this time, especially for a woman.⁴⁶

THE ROLE OF THE FIRST ALMONER

The creation of a formal almoner position within the hospital marked two important changes in hospital payment and patient welfare in the era preceding the National Health System Service: the means test and the almoner's network of assistance. This latter included referring the destitute to other means of charitable assistance, poor law authorities, and recommending that suitable patients join the low cost provident dispensaries.⁴⁷ Stewart was to keep a record of all her inquiry work and report back to the Hospital Board two or three times per year. The surviving *Almoners Report Book* well details all of Stewart's varied efforts to prevent any abuse of the department. These include her visits to other hospital outpatient departments for the purpose of comparison, the training of future almoners, details of how patients were interviewed and classified based on their means, home visits to check on their stories and follow-up on their progress, referrals for other means of assistance and finally, the refusal of relief to those considered unworthy.⁴⁸

The arrival of Stewart at the RFH was not, however, met with total co-operation on the part of the medical staff. The office space assigned to her was only a small corner of the outpatient waiting-room partitioned off by screens.⁴⁹ There was no light and if a visitor came they only had the radiator on which to sit.⁵⁰ In her first

45. Baraclough, "Stewart, Mary"; Bell, *The Story*, 31–32.

46. Alison Oram, *Women Teachers and Feminist Politics, 1900–39* (Manchester: Manchester University Press, 1996), 24–25. The annual salaries of women clerks were £45 (in 1911), nurses £55 (in 1913), and assistant women teachers £96 (in 1914). These remunerations were significantly later than the appointment of Miss Stewart in 1895.

47. Baraclough, "Stewart, Mary"; Bell, *The Story*, 28; Marx, "Early Days," 349.

48. *Almoners Record Book*, RFH/6/A/1, 2, RFHA.

49. Bell, *The Story*, 29.

month, no doctor referred any patients to the almoner's office, so she selected patients based on their appearance and gathered "the particulars as to the means and general circumstances of 150 patients" taken at random.⁵¹ As the patients had not been referred to her, the occupations of the heads of the families interviewed were recorded in the first report in order to give "as correct an idea as possible as to the positions of each patient."⁵² Over the next two months of her trial period, the almoner's role was acknowledged and accepted and two doctors began to refer patients to the office, which enabled Stewart to abandon the previous method of random selection.⁵³ The reason why initial objection to the post subsided is not noted in Stewart's reports, but it is likely that the medical staff came to realize that the almoner was not out to challenge their authority. Stewart was hired permanently in October 1895 and the number of patients she interviewed increased steadily each year thereafter.

In order to develop the methods of inquiry and admissions at the RFH, Stewart visited other hospitals in the London area to compare policies and practices.⁵⁴ The outpatient departments of St. Bartholomew's, The London, The Great Northern, and the Great Ormond Street hospitals were all visited.⁵⁵ She found that only at The London Hospital was any method of inquiry into the patients means undertaken. Patients were seen by an inquiry officer "when they first attend and before they are prescribed for by the doctors."⁵⁶ After recording this process, Stewart suggested to the RFH Weekly Board that the hospital should take up the same method of inquiry, as it would not interfere with the patient obtaining first aid, but would make the task of dealing with unsuitable cases much easier. Notably, however, on account of the large number of patients treated at The London, no referrals were made to charitable organizations, demonstrating that the work of Stewart was unique at this time.⁵⁷

50. Ibid.

51. Almoners Record Book, RFH/6/A/1, 2, RFHA; Bell, *The Story*, 29.

52. Almoners Record Book, RFH/6/A/1, 2-4, RFHA.

53. Bell, *The Story*, 30.

54. Almoners Record Book, RFH/6/A/1, 38, RFHA.

55. Ibid.

56. Ibid.

57. Ibid., 39.

By 1897, the success of the almoner's inquiries meant that her work was extended and she began to interview as many casualty patients and in-patients as was required.⁵⁸ The Samaritan Fund Committee began to refer all cases in which in-patients stated that they could not pay for medical devices (such as hernia trusses) or make contributions toward stays in convalescent homes.⁵⁹ In order to cope with this dramatically increased work-load, two assistants were appointed to the almoner's office, Miss Brimmell and Miss Davison, and a new office was allocated to the team.⁶⁰ Stewart trained these women to assist in the role of almoner, and with them developed an index system in order to register all patients referred to their office.⁶¹ By June 1898, Stewart requested a card index from the Hospital Board as the small book, which had been used previously, was full with the details of over five thousand patients.⁶²

Upon her appointment, the main purpose of the almoner was to interview patients wishing to receive treatment at the outpatient department. In May 1895, Stewart commented that few patients objected to giving information, and indeed no complaints were made by patients as to the nature of the questions put to them by the almoner for the duration of her appointment.⁶³ Many patients were pleased to talk about themselves and the position of their families, including their earnings, rent, and children.⁶⁴ Others were less comfortable disclosing personal information, and there are accounts of patients giving false statements as to their means, albeit some unintentionally.⁶⁵ Over the course of Stewart's time at the RFH, the number of patients interviewed each month steadily rose until this number peaked at over six hundred in the report of the first seven months of 1899⁶⁶ (Table 1).

Table 1 shows the total number of patients interviewed each year by the almoner and her team as compared to the total number of

58. Ibid., 54, 68.

59. Ibid., 62.

60. R.F.H. Reports 1895–99, Book A11, Royal Free Hospital, Seventy-First Annual Report for the Year Ending December 31, 1898, RFHA/1/2/2, 12, RFHA; Bell, *The Story*, 32–33.

61. Almoners Record Book, RFH/6/A/1, 77–78, 92, RFHA.

62. Bell, *The Story*, 33.

63. Almoners Record Book, RFH/6/A/1, 21; Bell, *The Story*, 32.

64. Almoners Record Book, RFH/6/A/1, 21, RFHA.

65. Ibid., 21, 26.

66. Ibid., 89.

Table 1. Approximate Number of Patients Interviewed versus Total Number of Outpatients.

outpatients at the hospital (although in-patients and casualty patients were also interviewed on occasion, the numbers were so small, they have not been included in this table).⁶⁷ While those interviewed clearly do not make up the majority of total outpatients, we can see the numbers gradually increasing. In the almoner's first year in office, she interviewed close to 2,500 outpatients, out of over 21,600.⁶⁸ The number of patients interviewed grew by approximately one thousand in each of the two following years, but between 1897–98 and 1898–99 this number grew by over 1,700 patients, to a total of over 6,300 patients interviewed during Stewart's last year.⁶⁹

67. Data collected from: Almoners Record Book, RFH/6/A/1, 47, 51, 52, 60, 66, 72, 76, 82, 89, RFHA; R.E.H. Reports 1895–99, Book A11, 1898, RFHA/1/2/2, 19; Anon., "Memorandum Respecting the Almoner's Work during 1898," in R.E.H. Reports 1895–99, Book A11, 1898, RFHA/1/2/2, 19. These findings do not include those of the almoner's trial period, and are approximate as Miss Stewart took up the position of Almoner in October 1895, meaning the table columns represent October 1, 1895–September 30, 1896, and October 1, 1896–September 30, 1897, but after this date, the Almoner's findings are recorded from January 1897 to December 1898, meaning the following two columns represent October 1, 1897–December 30, 1898, and January 1, 1898–December 31, 1899.

68. Almoners Record Book, RFH/6/A/1, 52, RFHA; Anon., "Medical Report," in R.E.H. Reports 1895–99, Book A11, 1896, RFH/1/2/2, 18, RFHA.

69. Almoners Record Book, RFH/6/A/1, 60, 66, 72, 76, 82; Anon., "Memorandum," 1898, 19; Anon., "Memorandum," 1899, 19.

This increase can at least in part be attributed to the expansion of the almoner's office and the assistance of Miss Brimmell and Miss Davison after 1897. Overall, with the number of patients interviewed having steadily increased while the total number of outpatients decreased, the almoner and her team went from interviewing approximately 11 percent of outpatients by the end of 1896, to 39 percent by 1899.⁷⁰ This is an impressive increase in workload over the course of only four years, and with claimant numbers dropping exponentially, the almoner's office was clearly offering value for money. The annual reports of the Hospital Board attribute the drop in the total number of outpatients largely to the almoner and her team acting as a deterrent to potential abusers of the free treatment available at the hospital.⁷¹

Perhaps even more importantly, the almoner gained an understanding of the patients' financial circumstances through the practice of visiting patients at home.⁷² Stewart first described the practice of visiting in her second report, in which she claims to have visited patients in order to inquire into how many had joined their local provident dispensary after promising her that they would.⁷³ By 1898, Stewart had made agreements with both the COS and members of the provident system that much home visiting would be carried out on behalf of the almoner by contacts she had established within these groups.⁷⁴ This agreement was later extended to all trained almoners.⁷⁵ Visiting also allowed for the information given by patients to be checked in order to make a fair decision as to whether or not they were deserving of free treatment. In Stewart's third report, a patient was visited after one of the referees cited by the patient was found to have no knowledge of the patient, and the other referee listed was no longer alive.⁷⁶

70. Percentages based on 21,660 total outpatients vs. 2475 patients interviewed in 1896 and 16,012 total outpatients vs. 6316 interviewed in 1899. Figures taken from Almoners Record Book, RFH/ 6/A/1, 52, RFHA; Anon., "Medical Report," in R.F.H. Reports 1895-99, Book A11, 1896, RFHA/1/2/2, 18, RFHA; and Anon., "Memorandum," 1899, 19, 26.

71. For example, see Anon., "Memorandum," 1899, 19.

72. Almoners Record Book, RFH/ 6/A/1, 38, RFHA; Koven, *Slumming*, 191 and 225, for details of the wider home-visiting system in London.

73. *Ibid.*, 13.

74. Marx, "Early Days," 349.

75. *Ibid.*

76. *Ibid.*, 26.

PATIENT IDENTITY

Although the main aim of Stewart and her team was to inquire into the financial standings of those wishing to receive treatment at the hospital, their investigations also give a wider insight into the lifestyles of the patients. The *Almoners Report Book* contains information on the occupation, earnings, addresses, and living conditions of thousands of patients interviewed at the hospital. The reports are also revealing of Stewart's perception of patients and of her opinion as to the amount of abuse in the system. Although she does not record the age and sex of the patients interviewed (except in case examples), her findings remain crucial in understanding the quality of life of those people who attended the RFH for medical assistance. Even in cases where the almoner refused to assist the patient, the reports still provide an insight into people's lives.

The patients referred to the almoner's office were primarily local residents, living within two or three miles of the RFH.⁷⁷ This suggests that most patients used the hospital because it was convenient. The almoner kept records as to the patients' residences so that she could refer them to other local means of assistance, such as the relevant COS office or to a local provident dispensary. The hospital was located on Gray's Inn Road, close to King's Cross Railway Station, with most of the patients coming from neighboring Islington, Holloway, Bloomsbury, and King's Cross districts.⁷⁸ As the hospital annual report of 1899 reported, "it is, perhaps, not generally realised that the neighbourhood of the Royal Free Hospital is one of the poorest and most densely crowded districts in London. In 'The Labour and Life of the People,' Mr. Charles Booth shows that it contains 61 percent of the poorest classes, and 297 persons to the acre."⁷⁹ Other patients traveled further distances in order to receive treatment, such as in the case of "a labourer, aged 23, married," who had applied to the Battersea office of the COS for assistance while his wife and child were situated in the Wandsworth

77. For example, see, *Almoners Record Book*, RFH/6/A/1, 52, RFHA.

78. *Ibid.*, 30.

79. Anon., "Medical Reports," in R.F.H. Reports 1895-99, Book A11, Royal Free Hospital, Seventy-Second Annual Report for the Year Ending December 31, 1899, RFHA/1/2/2, 15, RFHA.

workhouse.⁸⁰ Given that these areas of London are approximately five miles from the RFH, it appears that some patients went out of their way to attend the hospital for treatment, perhaps after having been recommended or referred to see a specific physician or surgeon.

The age of patients investigated by the almoner's office ranged from newborns to the elderly. As the patient's family was expected to be the initial means of help, the almoner carefully recorded the occupations and earnings of family members. For example, in the case of "N. C, patient boy of 12 years," the record book reveals that his father was a horse keeper and the joint earnings of all of his family members was twenty-two shillings per week.⁸¹ The occupations compiled by the almoner provide an insight into the financial and social circumstances of families who requested medical assistance from the RFH. Of the eighty occupations listed in the first report, the two most common were laborer and domestic servant.⁸² The almoner was therefore dealing largely with members of lower working-class families, who were likely to fall into absolute poverty when sick. Most domestic servants were unmarried women who lacked kinship ties where they worked and had no one to rely on financially at times of ill-health. Many single women are presented throughout the reports, such as the "widow, aged 43, cloakroom attendant," who earned 18 shillings per week "when well" and paid five shillings rent.⁸³ The almoner only considered the case eligible for free care when the patient had no family or their needs outstripped the assistance any family could provide.

The almoner's reports also reveal much about the living conditions of patients. Case examples often recorded both the rents patients paid and a description of their lodgings. In one case, Stewart reported that "four adults and one child are living and sleeping in one room!"⁸⁴ She noted that another family was living in "a deplorable state of things," as the father, mother, and six children were all found to be living in one room.⁸⁵ To make matters worse,

80. Almoners Record Book, RFH/6/A/1, 18, RFHA.

81. *Ibid.*, 22.

82. *Ibid.*, 3.

83. *Ibid.*, 10.

84. *Ibid.*, 17.

85. *Ibid.*

the room was “dirty and bare of furniture.”⁸⁶ It is not surprising that the almoner took note of the bad living conditions of the poorer patients, as such cases were believed by middle-class observers to be more prone to social evils like sex outside of marriage and incest, often associated with people of uncertain moral character such as the idle, drunkards, and criminals.⁸⁷ Not all patients lived in such bad conditions, however, as shown by the tidy home kept by the “respectable looking” mother of a child patient recorded in the third report.⁸⁸ The attitudes and appearance of patients and the conditions in which they lived were important factors in the almoner’s decision as to who “deserved” medical charity. Those who lived in cramped and overcrowded conditions but found to have kept a tidy home in spite of poverty were assisted by the almoner, as she judged them to be of good moral character.⁸⁹

Overall, the patients investigated through the almoner’s office were generally members of the lower working-class who lived in the local community of the RFH. Though most appear to have been in work, they often could not afford to pay for medical treatment at times of ill-health and thus relied on the assistance of medical charity. Of course, one aspect of the almoner’s role was to determine if the financial information provided by the patient was accurate. She feared that some “undeserving” patients lied about aspects of their identity and circumstances in order to receive free medical attention. Who the almoner considered “deserving” of charity will be discussed further when the findings of her inquiries are examined later.

PATIENT CLASSIFICATION

Stewart used the statements of the patients interviewed to create a system of classification that documented how many patients were considered truly eligible for medical treatment at the RFH. The initial categories of patients appear to stem from those used by the COS and so reflected Stewart’s training with them. The COS classified patients as those who were dismissed, those who were referred,

86. Ibid.

87. Ginger S. Frost, *Living in Sin: Cohabiting as Husband and Wife in Nineteenth-Century England* (Manchester: Manchester University Press, 2008), 52–53, 124–25.

88. Almoners Record Book, RFH/6/A/1, 21, RFHA.

89. Ibid., 17.

and those who were assisted.⁹⁰ It is clear, however, that Stewart updated and developed the classifications of patients throughout her time as almoner, and she gave numerous examples throughout her reports in order to clarify why cases had been placed in each category. In her first report, Stewart divided the patients interviewed into three categories: those who could provide within the provident system, those who were unable to make such provision, and those who were not in need of medical assistance but could be helped by either private charity or the Poor Law.⁹¹ Stewart found no serious cases of abuse among these patients and classified them as follows:⁹²

Roughly speaking the 150 patients may be classified under three heads:

Class	I. able to provide for their own medical care on the Provident System	40
	II. Unable to make such provision	91
	III. Persons needed food etc;	
	a. Those who can be helped by private charity	
	b. Those who should be helped by Poor Law.	19
	Total	150.

By the second report, these classifications were already changing as a reflection of the larger number of patients interviewed.⁹³ Those who would usually pay a private practitioner but needed special advice available only at the RFH were included in the updated classifications, as were active members of the Metropolitan Provident Medical Association (henceforth PMA) and members of other provident associations.⁹⁴ By the almoner's sixth report (covering June–September 1896), the classifications had changed again.⁹⁵ The almoner now classified patients as those who had been referred to the PMA, who could probably join a provident dispensary, who were sent away as they were able to pay for treatment privately, who were issued certificates, who

90. Mowat, "Charity and Casework," 266.

91. Almoners Record Book, RFH/6/A/1, 8, RFHA.

92. Ibid.

93. Ibid., 12.

94. Ibid.

95. Ibid., 51.

were referred to the Poor Law, and where no action had been taken.⁹⁶ These classifications remained constant throughout the remainder of Stewart's reports. The almoner's role was therefore not simply to fit the patients into predetermined categories based on their financial circumstances, but to understand the plight of the patients and help them through means other than the RFH if necessary.

THE FINDINGS OF PATIENT INQUIRIES

Stewart and her team detailed their findings in fourteen reports published in the *Almoners Report Book* between the years 1895 and 1899.⁹⁷ Each account recalled between one and several months work and was presented to a weekly board meeting at the RFH. This article does not examine each of the fourteen reports individually, but instead reports on the total annual findings of the almoner for each of the four years she worked at the hospital (Table 2).

Table 2 shows the main categories that patients were divided into based on their financial standings.⁹⁸ We find that regardless of the constant annual increase in the number of patients interviewed, the percentages of patients placed into each category of the total number interviewed were always nearly identical. The almoner placed the majority of patients in the "no action taken, except where charitable assistance was required" category. These patients were those which Stewart and her team did not refer elsewhere for medical treatment as they were considered suitable and appropriate patients to receive medical charity at the RFH. Significantly, the almoner team also referred many of these patients to nonmedical charitable assistance outside of the RFH. The almoner had to work with many different organizations, institutions, and private individuals on a daily basis, including the COS and religious groups. Stewart

96. Ibid.

97. Ibid.

98. Data collected from: Almoners Record Book, RFH/6/A/1, 47, 51, 52, 60, 66, 72, 76, 82, 89, RFHA; R.FH. Reports 1895–99, Book A11, 1898, RFHA/1/2/2, 19; Anon., "Memorandum," 1899, 19. These findings do not include those of the almoner's trial period, and are approximate as Miss Stewart took up the position of Almoner in October 1895, meaning the table columns represent October 1, 1895–September 30, 1896, and October 1, 1896–September 30, 1897, but after this date, the Almoner's findings are recorded from January 1897 to December 1898, meaning the following two columns represent October 1, 1897–December 30, 1898 and January 1, 1898–December 31, 1899.

Table 2. Patient Classification.

continually sought new contacts to add to the network of assistance upon which the almoner relied, in order to increase opportunities to help indigent patients. This was a new role in the hospital system and the network brought the hospital and the wider medical market fundamentally closer while helping to ensure that patients received appropriate care. The relationship held between different means of medical assistance is often overlooked by historians, and thus the manner by which a network was maintained and utilized by almoners has also been neglected.

The COS was pivotal to the almoner's network of patient assistance. Warm clothing, shelter, food, money for necessities, and free doctors visits were all often reported to have been given by various branches of the Society to patients referred to them from the almoner. In one case, a general servant of twenty-five years of age "was provided with clothing to enable her to take a situation which she had found."⁹⁹ It was also common for the COS to refer patients to nursing and convalescent homes. Children would typically be sent to a nursing home in cases of illnesses such as rickets.¹⁰⁰ Adults were likely to be sent for up to a month, such as in the case of "J. L, a Railway Porter, single, aged 24," whom Dr. Carr diagnosed as

99. Almoners Record Book, RFH/6/A/1, 25, RFHA.

100. *Ibid.*, 15.

being on the verge of consumption.¹⁰¹ The Society also sent people to the seaside to improve their health, most often to the south coast. There are cases of the almoner sending patients to the sea, but usually it was the COS that would search for a vacancy in a suitable home (such as St. Andrews at Folkestone or All Saints at Eastbourne).¹⁰² Other reports reveal rare and obscure forms of help being given to patients, such as a waterbed being lent to a woman suffering from phthisis.¹⁰³ As Stewart previously worked for the COS, it is no surprise that she relied on their help in her daily work.¹⁰⁴ She would have been aware of the services which they could provide and would presumably have already had contacts in various Society offices sympathetic to her cause. Although the almoner's office worked independently, it is clear that on many occasions, the work of the almoner relied on the Society to help locate and organize forms of charitable assistance for patients. Stewart's findings as almoner were also often reported at COS conferences, which highlights their close relationship and the integrated nature of their work.¹⁰⁵

The almoner's office also referred patients to various religious groups for nonmedical charitable assistance. The clergymen of the parish were often consulted in cases where the patient was in need of money to pay for nourishment when out of work due to ill health.¹⁰⁶ This form of help often overlapped with other means of assistance, as for example in the case of that woman who received a bed and doctor's visits from the COS, and food and help with housework from the clergy's funds.¹⁰⁷ The almoner also called on various religious groups to provide shelter for patients in need. In 1895, Stewart organized for "T. C, a single aged 61, homeless" who was suffering from starvation to be given shelter by the Sisters of the Church at Kilburn.¹⁰⁸ As of 1898, she sought assistance from the Church Army, the Jewish Board of Guardians, and the "Reform

101. *Ibid.*, 14.

102. *Ibid.*, 16.

103. *Ibid.*, 24.

104. Rooff, *A Hundred*, 104.

105. Reports of the almoner given at C.O.S. conferences were recorded: Almoners Record Book, RFH/6/A/1, 69, RFHA.

106. *Ibid.*, 43.

107. *Ibid.*, 24.

108. *Ibid.*, 28–29.

and Refuge Mission” for patients in need.¹⁰⁹ The almoner’s contacts included various other institutions, as well. Patients were sent to Parish Infirmaries such as Whitechapel to receive medical care when they were considered unsuitable for further treatment at the RFH, or they were sent to specialist institutions such as the Middlesex Cancer Ward.¹¹⁰ Others were discharged to nursing homes, convalescent homes, and dental hospices.¹¹¹ The office of almoner was thus an important clearing-house for directing the indigent to a wide support network of charities in the capital. The Samaritan Fund of the RFH also allowed for the hospital itself to provide medical and nonmedical assistance to those who appeared of good character. The money of the Fund was usually used to pay for the patient to attend a convalescent home.¹¹² Finally, the reports occasionally reveal that often unnamed private individuals were crucial in helping those in need.¹¹³ The almoner herself helped in some situations. As one example, she obtained spectacles for a patient.¹¹⁴

Overall, in both 1895–96 and 1896–97, Stewart and her team placed 69 percent of all patients interviewed into the “no action taken” category, while in the following two years, this percentage fluctuated from 64 percent in 1897–98 to 76 percent in 1898–99.¹¹⁵ This meant that each year, the vast majority of patients interviewed gained access to free medical treatment at the RFH, and in some cases also became eligible for help via the charitable network established through the almoner’s office. From these figures, we can draw out two important points. First, that the majority of patients applying for cost-free medical assistance through the almoner were considered appropriate recipients, both in terms of their poor financial circumstance and their good moral character. Secondly, that the almoner’s office acted as an invaluable clearing-house for practical medical help in the makeshift economy of the poor, by organizing further charitable medical help for many of the same patients who had already been granted free treatment at the hospital.

109. *Ibid.*, 32.

110. *Ibid.*, 43, 90.

111. *Ibid.*, 90.

112. *Ibid.*, 43.

113. *Ibid.*, 48.

114. *Ibid.*, 43.

115. Almoners Record Book, RFH/6/A/1, 47, 51, 52, 60, 66, 72, 76, 82, 89, RFHA; Anon., “Memorandum,” 1898, 19; Anon., “Memorandum,” 1899, 19.

The second largest category was made up of those patients who were advised to join the PMA.¹¹⁶ Throughout all of the reports, Stewart placed a large amount of focus on the provident system, by which she referred to the medical insurance schemes run through provident dispensaries. These were becoming more common throughout the nineteenth century as emphasis on self-help and campaigns to limit free medical attention increased.¹¹⁷ These dispensaries worked as friendly societies or sick clubs, whereby individuals usually made a weekly or monthly contribution in order that they and their dependants were covered in the event that they could not pay for medical care.¹¹⁸ The PMA was established in 1880 for the purpose of providing efficient medical relief for the lower classes, whose wage-earners fell between those who could afford to pay the ordinary medical fees and those who were fit recipients of the medical relief provided by the Poor Law.¹¹⁹ PMA dispensaries were established across London in working-class districts, to which the lowest paid workers were encouraged to subscribe. The subscription was six pence a month for a single person, ten pence for married people, and six pence extra for a family with children.¹²⁰ Thus, theoretically, for sixteen shillings a year, the whole family were insured against ill-health.¹²¹

From the first report, Stewart classified patients based on whether they could join the provident system, but interviewing proved that “by far the larger number had never heard of the Association.”¹²² In 1897, while reporting on the number of patients who had joined the PMA, Stewart noted that “the last returns are undoubtedly disappointing.”¹²³ Thus, it became the almoner’s role to recommend the system to as many patients as possible.¹²⁴ In every report, the number of patients referred to the PMA far exceeded the numbers referred to other means of help.¹²⁵ Theoretically, the more people

116. Ibid.

117. Cherry, *Medical Services*, 43.

118. Ibid.

119. Anon, “Metropolitan Provident Medical Association,” *The Times*, June 10, 1886, 4.

120. Ibid.

121. Ibid.

122. Almoners Record Book, RFH/6/A/1, 8, 12, RFHA.

123. Ibid., 67.

124. Ibid., 7.

125. Ibid., 47, 51, 52, 60, 66, 72, 76, 82, 89.

who joined the Association meant fewer patients would rely on the RFH. The main problem Stewart faced when persuading patients to join the PMA or other sick clubs, however, was that hospital treatment at the RFH was free.¹²⁶ Cost-free treatments meant that most patients did not see the need to pay for hypothetical medical treatment through insurance.¹²⁷ Moreover, there was always the concern that provident dispensaries, or any other friendly societies, could go broke. The poorest patients would have been reluctant to spend money they might not be able to reclaim when needed. Although many did not go on to join the Association, these patients were considered able to make contributions to a medical insurer, and so were considered financially fit to be refused cost-free medical care. Over the course of Stewart's time as almoner, patients placed in this category always made up between 22 percent and 31 percent of the total annual patients interviewed.¹²⁸ These figures are slightly higher than the membership levels given by Smith, who claims that provident societies nominally covered about one-quarter of the population by the 1890s.¹²⁹ This suggests that more patients were considered "able" to join such societies.

The smallest numbers of patients were always those referred to the Poor Law for nonmedical treatment, and those refused treatment on the grounds that they were considered able to afford private medical treatment elsewhere.¹³⁰ Some patients were referred to the St. Pancras Workhouse to be admitted to the asylum there.¹³¹ Patients referred to the Poor Law each year made up no more than 5 percent of the total number of patients interviewed, while patients refused treatment made up even less of the overall total.¹³² The small number of patients referred to the Poor Law could be explained by the general relaxation of medical relief in the Poor Law system after it experienced democracy for the first time in the

126. *Ibid.*, 12.

127. Bell, *The Story*, 30.

128. Almoners Record Book, RFH/6/A/1, 47, 51, 52, 60, 66, 72, 76, 82, 89, RFHA; Anon., "Memorandum," 1898, 19; Anon., "Memorandum," 1899, 19.

129. Francis B. Smith, *The People's Health, 1830-1910* (London: Weidenfeld and Nicolson, 1979), 320.

130. Almoners Record Book, RFH/6/A/1, 47, 51, 52, 60, 66, 72, 76, 82, 89, RFHA; Anon., "Memorandum," 1898, 19; Anon., "Memorandum," 1899, 19.

131. Almoners Record Book, RFH/6/A/1, 43, RFHA; Crowther, *The Workhouse System*, 3.

132. Almoners Record Book, RFH/6/A/1, 43, RFHA.

1890s.¹³³ It was possible that the poorest who needed medical relief got it inside the New Poor Law system after this date, meaning that only a small number of such patients applied to the RFH for treatment based on reasons of convenience (such as they lived nearby) or in cases of emergencies.

While Stewart worked with many organizations to help as many patients as possible, it was also an important part of her role to refuse treatment to those patients considered unworthy of free medical aid. The number of cases seen each month in which patients were deemed able to pay for private medical assistance and thus refused treatment was always the minority. Being poor enough, however, did not necessarily ensure that patients would receive free medical treatment. Those thought to be “deserving” of charity were also evaluated on their moral character, which Stewart judged based on her training with the COS. As previously discussed, the Society believed that the only way to tackle poverty was by encouraging attitudes and methods of self-help.¹³⁴ Those who worked hard and kept a tidy home were deemed to be of a respectable character, while those who were not employed and neglected their appearance or home were considered “undeserving” of charity. The details of those patients considered of bad moral character were often used to explain why they did not receive assistance. After having inquired into “E. A, a labourer, aged 23,” for example, Stewart was left in “no doubt as to the patient being idle and of intemperate habits; the wife dirty and but little better than her husband.”¹³⁵ In another case, in 1895, the mother of a child patient was visited after not reporting to the Islington COS office as she promised.¹³⁶ The visiting agent found the mother “very dirty and untidy, and gossiping in the street.”¹³⁷ Gossiping was not considered appropriate behavior for a good woman and thus explains why the mother and her family were not considered suitable for assistance. On other occasions, the almoner refused to assist patients she felt would be better suited for treatment elsewhere, such as by refusing to give milk to an infant (which was a

133. Elizabeth T. Hurren, *Protesting about Pauperism* (Woodbridge: Boydell Press, 2007), 184–88 and Chapter 9.

134. Mowat, “Charity and Casework,” 260; Thane, *Foundations*, 22.

135. Almoners Record Book, RFH/6/A/1, 43, 18, RFHA.

136. *Ibid.*, 18–19.

137. *Ibid.*, 18–19.

common aspect of treatment for those who suffered from rickets) and instead referred the family to the parish medical officer.¹³⁸

Other patients were refused treatment when found to be attempting to defraud the RFH by giving false information to the hospital staff. One patient is reported to have been sent to the almoner's office by a doctor for nourishment as he gave the "impression that he was without means."¹³⁹ After further inquiry, however, it was found that the patient was in receipt of "18/- a week from his Sick Club and Trade Union."¹⁴⁰ In other cases, the almoner found that while patients were unable to join the PMA due to constant ill-health, other members of the family were in the position to support their relation. In these cases, patients were often refused treatment, such as in the case of "W. W, labourer, 58 years of age" whose sons were found to be capable of providing the relief he required.¹⁴¹ If the patient's family members refused to join the PMA, pressure was brought to bear on them to do so, in order that "the habit would not be acquired of attending hospitals for every trifling ailment."¹⁴² In the cases where assistance had been granted, further help could be refused in the instances where "money was not used for the purpose for which it was given."¹⁴³ One case of false information having been provided, although not of intentional abuse, gives an insight into the relationships held within the applicant's family. In 1895, a woman applied for assistance for her nine-month-old child, only to withdraw her application in finding that her husband earned more money than he had led her to believe.¹⁴⁴ Though the application was withdrawn, Stewart commented that "at least it was good for something!"¹⁴⁵

While the *Almoners Report Book* contains examples of patients considered to be of immoral character, the almoner did on other occasions hold a positive opinion of some of the patients she interviewed. The patient "J. L, a Railway Porter" was sent to a

138. Ibid., 14, 17, 55.

139. Ibid., 27.

140. Ibid.

141. Ibid., 26–27.

142. Ibid., 13.

143. Ibid., 16.

144. Ibid., 14–15.

145. Ibid., 15.

convalescent home as a reward for being of “excellent character.”¹⁴⁶ In another case, a family was considered to have had a good character even though they were heavily criticized for living in poor conditions.¹⁴⁷ Stewart also made note of those patients who appreciated the help they received. One married woman suffering from phthisis was reportedly “touchingly grateful” for the assistance she received through the almoner’s office.¹⁴⁸ This case has been previously discussed; the patient received free visits from a doctor, a water bed from the COS, a neighbor to do all the housework, and had a visit to the seaside.¹⁴⁹ It was rare for one patient to receive such a large amount of care at once. Stewart seemed to have considered it necessary therefore, to include the patient’s thanks in her report by way of justification.

Overall, these results indicate that only the smallest section of those patients investigated were considered to be deliberately abusing the system of free medical treatment at the RFH. Stewart reported that little “intentional” abuse on the part of the patient appeared to have taken place as many who applied for help were unaware of the alternative means of assistance, such as the PMA.¹⁵⁰ She considered these patients misguided rather than of bad moral character. The vast majority of patients who sought treatment at the RFH were therefore considered suitable recipients of medical charity. There was, however, a striking similarity in the percentages of patients placed into each category per annum, as mentioned earlier.¹⁵¹ Approximately 30 percent of all patients were referred to provident dispensaries between 1895 and 1898, while on average around 70 percent of patients interviewed were always allowed to receive treatment at the RFH. On the one hand, this trend may accurately represent the consistency in the financial position of patients applying for outpatient relief at the RFH. If it were the case that these numbers were manipulated, we would expect to find a higher percentage of patients refused treatment, since one of the main objectives of the almoner’s role was to reduce the amount of

146. *Ibid.*, 14.

147. *Ibid.*, 17.

148. *Ibid.*, 24–25.

149. *Ibid.*, 24.

150. *Ibid.*, 21.

151. Almoners Record Book, RFH/6/A/1, 43, 52, RFHA; Anon., “Memorandum,” 1899, 19.

abuse the hospital suffered at the hands of those able to afford private medical treatment. On the other, it may indicate that the almoner and her team had established an acceptable proportion of patients to admit or to refer elsewhere, based on background poverty conditions and patient profiles. This unofficial quota could not have allowed for too many patients to have been rejected, as it would have been bad for the hospital's image as a center of charity. By allowing the majority of patients to receive free treatment and by referring others to the provident system instead of the Poor Law, the almoner appears to have been both fulfilling her duties as a gatekeeper, while not deterring patients from the RFH altogether.

CONCLUSION

By examining the *Almoners Report Book*, this article has attempted to advance our understanding of how the almoning profession was established and shaped by the early work of Miss Mary Stewart. As discussed in the introduction, hospital almoners have been relatively neglected in the current historiography and thus Stewart's reports contribute toward filling this gap. While her appointment was the result of the anxiety and distrust surrounding the suspected abuse of outpatient departments, the reports reveal the complex and developing nature of the role in the initial years, as well as the findings of her investigations into patient circumstances. The decision to create the position of almoner represented a shift in the attitude of wider society toward the provision of charity, as it was expected that where possible, patients should have contributed toward their medical treatment. The means test and the resulting system of patient classification recorded in the almoners reports therefore provides a unique and valuable insight into attitudes toward who was "deserving" of free medical aid and how it was determined in practice. Crucially, the reports show that despite the reasons for her appointment, Stewart allowed the majority of patients to continue receiving cost-free treatment at the RFH and only turned very few away.

The position therefore changed the working of the RFH and other hospitals that subsequently appointed a lady almoner. The hospital had to navigate its administrative transition from a strict voluntary system to a large teaching institution in which patients were consumers rather than objects of charity. The place of the RFH in the wider medical community would have developed as it became a

viable consumer choice for paying patients, but simultaneously continued to offer free medical treatment to those patients considered appropriate. According to Stewart's reports, it was typically local, lower working-class residents who relied on the hospital for cost-free medical care. The majority of these patients or their families were in low-paid work, meaning that while they were not considered to be destitute (and therefore not referred to the Poor Law), they could not afford to make contributions toward medical insurance. It is for this reason that the network of assistance established by the almoner and her team was so important to the long-term welfare of the patients. By having referred many to other institutions, religious groups, and the COS, the almoner connected patients to the wider charitable sector.

The almoner's office therefore acted both as a gatekeeper to free medical treatment and as a clearing-house and mediator for both medical and nonmedical needs, networked into charities and hospital systems across London and beyond. The role was therefore important in the makeshift economies of the laboring poor and as a part of the complex mixed economy of welfare available across London. Its importance cannot be over-stated, nor should it be under-estimated in the lives of those living just above and below the threshold of relative to absolute pauperism. In some respects, the poorest were simply shuffled around that complex network of charity-providers, encouraged at every stage to practice self-help in-line with the COS vision. In other ways, the almoner was sifting patients to ensure their medical and nonmedical needs were served by the most appropriate agencies. As long as the almoner worked within the approval of the Hospital Board and any patient who needed it received first aid before being referred elsewhere, she had the authority to decide how to best assist those patients referred to her and to refuse assistance to those she felt would be better suited to other means of help. The office of almoner was thus discretionary and important in the makeshift economies of the sick poor who attended the hospital. Its neglect is therefore significant in the historical literature, as the position of the almoner as a gatekeeper to the hospital would have served to determine its patient base, and consequently shape its future as a center of medical and surgical treatment.

Overall, it was thanks to the efforts of Stewart and her team that the position of almoner became synonymous with the voluntary

hospital system of the early twentieth century. The increased workload of the almoner's office (having interviewed 11 percent of patients in 1896 and 39 percent in 1899) demonstrates the growing importance of the office over the course of only its first four years. The organization of bigger premises for the almoner and her team as of 1897 indicates that the role was considered to be both significant and permanent to the RFH and other voluntary hospitals more generally.¹⁵² This is supported by the fact that only two years after Stewart was appointed, the Hospital Sunday Fund recommended that all hospitals appoint an almoner.¹⁵³ Moreover, the training of future almoners (including Miss Mudd, who was to become the almoner at St. Georges Hospital) conducted by Stewart and her team was crucial to the long-term success of the position as a staple role in voluntary hospitals of the early twentieth century.¹⁵⁴ Stewart and her team were therefore crucial in establishing a profession which would be an alternative route for women to take into health-care and welfare management in the sphere of philanthropy. More research is now needed to track how the profession developed beyond the work of Stewart and her team at the RFH to become firmly established in the voluntary hospital system of twentieth-century London and beyond.¹⁵⁵

ACKNOWLEDGMENTS

I would like to thank Professor Steve King (University of Leicester) and Dr. Elizabeth Hurren (University of Leicester) for their guidance and support during the completion of this article.

FUNDING

Wellcome Trust Doctoral Studentship entitled "Patient Case Records of the Royal Free Hospital, 1902–12." Award number: 086218.

152. Almoners Record Book, RFH/6/A/1, 43, 70, RFHA.

153. Anon., "Out-Patients," in R.F.H. Reports 1895–99, Book A11, Royal Free Hospital, Seventieth Annual Report for the Year Ending December 31, 1897, RFHA/1/2/2, 12, RFHA.

154. Anon., "Memorandum," 1899, 19.

155. Marx, "Early Days," 348; Simmons, "A Profession," 10–13.