



University
of Glasgow

Cronin, Jenny (2003) *The origins and development of Scottish convalescent homes, 1860-1939*. PhD thesis.

<http://theses.gla.ac.uk/2316/>

Copyright and moral rights for this thesis are retained by the author

A copy can be downloaded for personal non-commercial research or study, without prior permission or charge

This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the Author

The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the Author

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given

The Origins and Development of Scottish Convalescent Homes, 1860-1939

JENNY CRONIN

Submitted for the Degree of Doctor of Philosophy
University of Glasgow
Centre for the History of Medicine and
Department of Economic and Social History

June 2003

© 2003 by Jenny Cronin

ACKNOWLEDGEMENTS

First of all, I would like to express my gratitude to my primary supervisor, Dr Marguerite Dupree, for supporting my decision to undertake this study and for imparting her considerable enthusiasm for the history of medicine, alongside careful and sustained guidance. My second supervisor, Dr Eleanor Gordon, joined the project at a later stage and her skilful direction threw a new and invaluable light on the subject of convalescent homes. I also thank Dr Alastair Durie for his assistance in selecting a research topic and his supervision during the initial period of study, and the University of Glasgow for a scholarship that allowed three years of full time study.

In addition, I am extremely appreciative of the advice and support offered on numerous occasions by Dr Malcolm Nicolson, Professor Mike French and Dr Bridget Fowler, and the encouragement given by Professor Anne Crowther, especially during the latter stages of the project. My fellow doctoral students and 'support group', Lindsay Reid, Anne Cameron and Sibylle Naglis listened, laughed (quite a lot sometimes), and advised throughout, and I am grateful to them not only for reading and commenting on various drafts but also for several years' worth of lunchtime discussions. These not only put the world to rights but inspired numerous ideas on a diverse range of health topics, past and present, including the convalescent homes. I am also immensely grateful for the support of past postgraduate students at the Centre for the History of Medicine, in particular Gayle Davis, Debbie Nicholson, Matt Egan and Catriona MacDonald, who sustained and cheered me on through the good and bad times. Further thanks are due to current doctoral students at the Centre, especially David Sutton, Roberta Shoafenge, Ian Carthy and Paula Summerly, and to previous students – now staff – Rose Elliott and Mark Freeman for their interest in my subject. My relatively new office-mates, Lawrence Wilson and Tine Van Bortel's congenial company made the last nine months of writing up a very pleasant experience. Also, a big thank you to the Centre Administrator and Secretary, Ann Mullholland and Rae McBain, who make life so much easier for all staff and students, myself included. I am indebted to the encouragement and support over many years from Campbell Lloyd. Also, to Andrew Hull for sharing his thoughts and wisdom about convalescence and especially for reading and commenting on Chapter Three. Thank you also to other colleagues, Jane Gow, Brenda White, Edna Robertson, Anne-Marie O'Donnell and Rona Ferguson for their support and for directing me towards interesting and relevant material. Many thanks also to the 'unipals', Anne Kegg, Janice Forsyth and Alan Watts, for their unflagging interest in the progress of this thesis, and to my former colleagues at NRIS, Glasgow Caledonian University, especially Professor Joan Curzio and Dr Marion Brady.

My archival research was greatly assisted by Alastair Tough and George Gardner of Greater Glasgow NHS Board Archives, Fiona Watson of Northern Health Services Archives, Dr Mike Barfoot of Lothian Health Services Archives, Anna Forrest, former Librarian of the Royal College of Physicians and Surgeons of Glasgow, and

Murdo MacDonald of Argyle and Bute District Archives. I also acknowledge the assistance offered by the staff of Special Collections at Glasgow University Library, Glasgow University Archives, the Mitchell Library, Glasgow City Archives, the National Archives of Scotland, the National Library of Scotland, the Library of the Scottish Mining Museum, the Central Libraries at Edinburgh, Dundee and Aberdeen, the Public Libraries at Dunoon, Helensburgh, Ardrossan and Bearsden, and the William Patrick Library in Kirkintilloch. I would like to thank Catherine Heckman for helpful communications on various issues relating to nursing convalescent patients, Irene Paterson for discussions on aspects of occupational therapy and the Astley Ainslie Institution and Dr Bridget Towers for sharing her knowledge of convalescent homes in England. I also express my gratitude to all the people who brought the convalescent homes to life by writing or talking to me about their experiences of these institutions, past and present.

Finally, I owe a truly enormous debt of gratitude for the moral and practical support given by all my family, but particularly my husband Gerry, who has supported me throughout. Also my children - David, for the intensive proof reading of several drafts, and Sean and Anna for their constant good humour and insight into the process of writing a PhD thesis - and other family members, who have tolerated my absence while working on this thesis.

ABSTRACT

Scottish convalescent homes, established between 1860 and 1939, provided short-term care for around two to three weeks for patients recovering from trauma, surgery, or illness either at home or in hospital. In 1870, there were just seven convalescent homes, mainly in the West of Scotland, with an annual admission rate of 4000 patients. By the 1930s this had risen to over sixty convalescent homes that cared for more than 34,000 people annually. Despite the massive growth of Scottish convalescent homes, lack of accurate data about the topic has led to a variety of misunderstandings over their origins, purpose, function and development. This thesis reclaims the hitherto forgotten or misunderstood history of the convalescent homes in Scotland between 1860 and 1939.

An extensive survey of the convalescent homes uncovered a wide diversity of individuals and organisations involved in their sponsorship. This ranged from independent promoters, hospitals, religious and temperance organisations, to Co-operative and friendly societies. The survey also revealed considerable geographical and chronological diversity in the extent of overall convalescent home provision. During the nineteenth century, few doubted their purpose was to return the deserving sick poor to health and productive life. Confusion over their definition arose during the twentieth century when various mutual assurance organisations began to sponsor homes. The mutual assurance societies were less willing to associate their convalescent homes with institutions for the poor. They were also more flexible in their admission policies and admitted patients for both rest and recuperation from illness. Sponsors of new children's convalescent homes during the twentieth century were also reluctant to differentiate between those in convalescence and ailing children needing a country break. An association thus developed between holidays and time spent in convalescent homes. Although there were similarities between the experience of a holiday and the regime of a convalescent home, such as the focus on fresh air, healthy diet, recreation and exercise, in other respects they were quite different. The structured routine provided by most convalescent homes centred on a return to health whereas holidays stressed freedom and recreation.

The association of convalescent homes with holidays and lack of adoption of the new scientifically based therapies, developed during and after the First World War, challenged their status as medical institutions. This failure to align themselves with the new scientific rehabilitation revered by the medical profession, led to suggestions that some convalescent homes might be reclassified from a type of medical institution to recuperative holiday homes. Despite the attempts to demedicalise traditional convalescent homes during the twentieth century, the increased numbers of willing patients indicates that they were one of the more successful legacies from the nineteenth century.

CONTENTS

<i>ABBREVIATIONS</i>	...	i
<i>TABLES</i>	...	ii
<i>FIGURES</i>	...	iii
<i>MAPS</i>	...	iii
<i>ILLUSTRATIONS</i>	...	iii
INTRODUCTION	...	1
CHAPTER ONE: Vital Statistics	...	18
Growth and Development	...	22
<i>Hospital CHs</i>	...	23
<i>Independent CHs</i>	...	31
<i>Religious/Temperance CHs</i>	...	32
<i>Mutual Assurance CHs</i>	...	36
Extent of Provision	...	37
Geographical Distribution	...	40
Age and Gender of Patients	...	43
Closure of Convalescent Homes	...	45
Conclusion	...	48
CHAPTER TWO: Origin, Influence and Sponsorship in the Nineteenth Century	...	50
Institutions Providing Convalescence before 1860	...	52
Major Influences	...	54
Raising Funds	...	67
<i>Hospitals CHs</i>	...	68
<i>Independent CHs</i>	...	75
<i>Religious and Temperance CHs</i>	...	79
Financial Maintenance	...	82
Case study of Corstorphine House Finances	...	89
Conclusion	...	92
CHAPTER THREE: Development and Consolidation during the Twentieth Century	...	94
Perspectives and Change in Existing Convalescent Homes	...	99
Welfare of Children and Mothers of Young Children	...	101
Support and Sponsorship through Mutual Assurance Schemes	...	111
<i>Occupational CHs</i>	...	115
<i>Co-operative Society CHs</i>	...	120
<i>Friendly Society CHs</i>	...	123
The First World War and the Development of Scientific Convalescence	...	125
Government Reports	...	130
Re-interpretation of Convalescent Homes	...	139
Conclusion	...	142

CHAPTER FOUR:	Illnesses	...	144
	Interpreting Convalescence	...	147
	Patients/type of Illnesses excluded from Convalescent Homes	...	148
	Deaths in Convalescent Homes	...	154
	Non-Convalescent Patients	...	157
	Overall Patterns of Illness	...	158
	Tuberculosis Patients	...	166
	Conclusion	...	174
CHAPTER FIVE:	Regime	...	177
	Orthodox Treatment of Convalescence	...	179
	Therapy	...	184
	<i>Location</i>	...	184
	<i>Air</i>	...	186
	<i>Diet – Robust or Refined?</i>	...	190
	<i>Occupation as Therapy</i>	...	198
	<i>Recreation</i>	...	201
	<i>Physical Exercise</i>	...	203
	<i>Heliotherapy</i>	...	205
	<i>Hydrotherapy</i>	...	207
	Comparison between Therapies at the Astley Ainslie and Traditional Convalescent Homes	...	210
	Comparison between Holidays and Convalescent Homes	...	211
	Control	...	215
	Conclusion	...	224
CHAPTER SIX:	Doctors, Domestic and Nurses	...	226
	Doctors	...	230
	<i>Appointment of Medical Officers</i>	...	230
	<i>Corstorphine House</i>	...	233
	<i>The Glasgow Convalescent Home</i>	...	238
	<i>Doctors in other Convalescent Homes</i>	...	241
	<i>Doctors as Managers</i>	...	242
	Domestics and Nurses	...	245
	<i>Matrons</i>	...	245
	<i>Nurses and Domestic</i>	...	252
	Conclusion	...	259
CONCLUSION:		...	262
APPENDICES:		...	275
	A Explanation of database design	...	276
	B Convalescent homes in Scotland established between 1860 to 1939	...	279
	C Other names for convalescent homes	...	282
	D Board of Management at the GCH	...	287
BIBLIOGRAPHY:		...	289

ABBREVIATIONS

AAI	Astley Ainslie Institution
BMJ	British Medical Journal
BMA	British Medical Association
CH	Convalescent Home
COS	Charity Organisation Society
EMJ	Edinburgh Medical Journal
EMS	Emergency Medical Service
EMMS	Edinburgh Medical Missionary Society
GCA	Glasgow City Archives
GCH	Glasgow Convalescent Home
GMJ	Glasgow Medical Journal
GRHB	Grampian Regional Health Board
GRI	Glasgow Royal Infirmary
GGHB	Greater Glasgow Health Board
LHB	Lothian Health Board
ML	Mitchell Library
NAS	National Archives of Scotland
NHS	National Health Service
NLS	National Library of Scotland
OCC	Occupational
PID	Personal identification number
PW	Post War
RAMC	Royal Army Medical Corps
REL/TEMP	Religious/Temperance
RIE	Royal Infirmary of Edinburgh
YMCA	Young Men's Christian Association

TABLES

1.1.	Categorisation of convalescent homes by type of sponsor	...	19
1.2	Convalescent homes linked to hospitals	...	23
1.3	Children's convalescent homes established between 1880 and 1939	...	29
1.4	Convalescent homes sponsored by independent individuals or organisations between 1860 and 1939	...	31
1.5	Convalescent homes founded by religious organisations between 1860-1895	...	33
1.6	Annual admission rates of patients to convalescent homes between 1871-1934 (eight to twelve year intervals)	...	38
1.7	Comparison of annual numbers of patients in hospital convalescent homes with Dunoon Homes	...	39
1.8	Population of Glasgow, Edinburgh, Dundee and Aberdeen 1861-1931	...	40
1.9	Comparison between the general population and annual number of patients from four major Scottish cities admitted to convalescent homes in 1871 and 1934	...	41
1.10	Age ranges of patients at GCH and Dunoon Homes between 1881-1939	...	43
1.11	Convalescent homes that closed before the Second World War	...	46
2.1	'Abstract of Accounts' for 1866 at the GCH	...	77
2.2	Annual income and expenditure of Convalescent homes in 1897 and 1930	...	82
2.3	Income and expenditure per patient in 1897 and 1930	...	83
2.4	Expenditure in 1936 at GCH and 1938 Corstorphine House	...	84
3.1	Major differences between occupational, Co-operative and friendly society convalescent homes	...	113
4.1	Main types of illnesses/disorders at Corstorphine House and the Dunoon Homes in 1883/5	...	160
6.1	Medical Officers at the GCH between 1865-1936	...	233
6.2	Medical Officers at Corstorphine House between 1869-1939	...	234
6.3	Resident Staff at Corstorphine House, GCH and Dunoon Homes, 1871, 1881	...	254
6.4	Reason for probationers leaving Corstorphine House between 1910 and 1921	...	257
6.5	Paternal occupation of probationer nurses at Corstorphine House between 1910 and 1921	...	258
6.6	Nursing and domestic staff at Corstorphine House in selected years between 1871-1929	...	259

FIGURES

1.1	Establishment of new convalescent homes in sponsorship groups between 1860 and 1939	...	21
1.2	Sponsors of new convalescent homes between 1869 and 1939	...	22
1.3	Growth in the annual number of patients during of 8 to 12 years between 1871 and 1934	...	39
1.4	Variation in gender at Corstorphine House between 1869 and 1939	...	45

MAPS

1.	Distribution of convalescent homes in Scotland in 1870	...	42
2.	Distribution of convalescent homes in Scotland in 1890	...	42
3.	Distribution of convalescent homes in Scotland in 1939	...	42

ILLUSTRATIONS

1.	Corstorphine House, Edinburgh, 1912	...	70
2.	Dundee Convalescent Home, Broughty Ferry, 1898	...	70
3.	Schaw Convalescent Home, (n.d.)	...	70
4.	Glasgow Convalescent Home, Lenzie, c.1905	...	70
5.	Kilmun Convalescent Home, 2000	...	70
6.	Newhills Convalescent Home, c.1900	...	70
7.	Muirfield Children's Convalescent Home, Gullane c.1909	...	72
8.	Aberdeen Convalescent Hospital, 1897	...	72

Introduction

A house of one room (or even a house of two rooms) made domestic life, as it was known to the middle-classes, impossible. There was no privacy, no play space, no workspace or place to get out of the tensions of family life, to think, to relax or sulk. There was not even space to die.¹

Under these circumstances, neither was there space for illness or convalescence.

In the mid-nineteenth century, an innovative type of medical institution, most commonly known as a 'convalescent home', appeared in various parts of Scotland.² During this period, pollution, overcrowding and unsanitary living conditions, often complemented by long hours of work at a relentless pace, within a dangerous environment not only exacerbated ill health amongst the poor but often impeded the recovery process of survivors.³ The provision of convalescent homes was one ameliorative response to these appalling social and environmental circumstances. Their main objective was to provide the sick poor, recovering from illness, trauma or surgery, with a short period of institutionalised convalescent care in a healthy therapeutic environment for around two to three weeks.

¹ T. C. Smout, *A Century of the Scottish People* (London, 1987), p. 34.

² Convalescent homes were also sometimes called 'convalescent hospitals' or 'convalescent houses'. The Aberdeen Convalescent Hospital is one example of a convalescent home referred to as a 'convalescent hospital'.

³ For example: R. A. Cage, 'Health in Glasgow', in R. A. Cage, ed., *The Working Class in Glasgow 1750-1914* (London, 1987), pp. 56-76; M. A. Crowther, 'Poverty, Health and Welfare', in H. Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990), pp. 265-289; T. Fergusson, *Scottish Social Welfare, 1864-1914* (Edinburgh & London, 1958), pp. 155-204; B. Leneman, *An Economic History of Modern Scotland* (London, 1977), pp. 201-205; I. Levitt, *Poverty and Welfare in Scotland, 1890-1948* (Edinburgh, 1988), pp. 22-43; D. Hamilton, *The Healers* (Edinburgh, 1987), pp. 146-147; A. Hardy, *Health and Medicine in Britain since 1860* (Basingstoke, 2001), p. 13; A. J. McIvor, *A History of Work in Britain 1880-1950* (Basingstoke, 2001), pp. 111-147; Smout, *Century of the Scottish People* (London, 1987), pp. 32-57; P. Weindling, 'Linking Self Help and Medical Science: The Social History of Occupational Health', in Paul Weindling, ed., *The Social History of Occupational Health* (Beckenham, 1985), pp. 6-11.

Following the introduction of the first Scottish convalescent institution in 1860, their number increased rapidly.⁴ However, they were not alone but formed part of a far wider movement that established similar institutions in many other Western countries.⁵ For example, the Metropolitan Convalescent Institution, the first English convalescent home, opened at Walton-on-Thames in 1840. In France, the first modern convalescent institution, the Convalescent Hospital of Vincennes, opened slightly later in 1859.⁶ As in Scotland, this movement was a response to the effects of the urban decay that followed the rapid industrialization of many European countries during the mid-nineteenth century. In Britain, 'shock' cities such as Manchester, Liverpool and Glasgow emerged.⁷ Despite government economic policies of 'laissez faire', the 'better off' gradually, but often reluctantly, accepted some responsibility for health care amongst the poor. Although their concern for the sick was often rooted in religious or moral obligation, the middle classes were also well aware that disease in the slums could not be contained and infectious diseases frequently spread to their new, expensive suburbs. The Victorians often used containment within an institution as the solution to a social problem. Thus, the remedy for sickness, particularly amongst the working classes, involved a range of

⁴ The first convalescent home in Scotland was the Dundee Convalescent Hospital, established in Dundee by Bishop Alexander Penrose Forbes and Lady Jane Ogilvy. See pages 34, 53, 284 of this thesis.

⁵ E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), pp. 30-34; J. Pickstone, *Medicine and Industrial Society* (Manchester, 1985), pp. 101, 129, 147, for development of convalescent homes in the Manchester area.

⁶ J. Bryant, *Convalescence, Historical and Practical* (New York, 1927), pp. 12-26.

⁷ R. H. Campbell, *Scotland Since 1707. The Rise of an Industrial Society* (Edinburgh, 1985), pp. 66-163; B. I. Coleman, *The Idea of the City* (London and Boston, 1973), pp. 1-21; B. Dicks, 'Choice and Constraint: Further Perspectives on Socio-Residential Segregation in Nineteenth-Century Glasgow with Particular Reference to the West End,' in George Gordon, ed., *Perspectives of the Scottish City* (Aberdeen, 1985), pp. 92-93; H. J. Dyos, *Exploring the Urban Past* (Cambridge, 1982), pp. 3-56; G. M. Howe, *People, Environment, Disease and Death* (Cardiff, 1997), pp. 143-182; P. Lawers and F. Brown, *Urban Growth in Britain* (London, 1986), pp. 1-69; Levitt, *Poverty and Welfare*, pp. 22-43; R. J. Morris, 'Structure, Culture and Society in British Towns', in M. Daunton, ed., *The Cambridge Urban History of Britain, Vol III 1840-1950* (Cambridge, 2000), pp 395-426; R. J. Morris, 'Urbanisation and Scotland' in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. III, 1830-1914* (Edinburgh, 1990), pp. 73-102; J. Pickstone, *Medicine and Industrial Society* (Manchester, 1985), pp. 78-138; Smout, *Century of the Scottish People*, pp. 32-57; J. H. Treble, *Urban Poverty in Britain* (London, 1979), pp. 5-12, 149-183, 185-189.

medical institutions, including various types of hospitals, asylums and convalescent homes.⁸

Olive Checkland estimated that by 1899, there were 1,070 beds in twenty-three convalescent homes in Scotland.⁹ Despite this apparently substantial number of people using convalescent homes, their history is a neglected area of research, reflected in the paucity of literature on the topic. Checkland's half chapter in *Scottish Philanthropy in Victorian Scotland* is the only study of Scottish convalescent homes extending beyond a few paragraphs. Although Checkland's work is a useful overview, the scope is limited because it focuses on convalescent homes established during the nineteenth century. In a broader study, John Bryant's, *Convalescence, Historical and Practical*, discusses both convalescence and convalescent institutions in Britain, Europe and the USA. However, the publication date of 1927 inevitably excluded any discussion on convalescent homes established after this time. Neither did it mention Scottish convalescent homes.¹⁰ Similarly, a study of British convalescent homes during the 1930s by Elizabeth Gardiner also excluded convalescent homes in Scotland.¹¹ Catherine Heckman is the only author to undertake a historical study of convalescent homes covering the whole period from the mid-nineteenth century through to the Second World War. However, Heckman has confined her study to English convalescent homes, particularly those in the London area.¹² It is nevertheless useful for the purpose of this project since Scottish convalescent homes had many parallels with those in England.

Although references to convalescent homes appear in other areas of literature, they are mostly scant and tangential. For instance, hospital histories that comment on convalescent homes rarely extend their remarks beyond two pages. Two examples that provide only spasmodic references to their convalescent homes are *Victoria*

⁸ See Chapter 2, pp. 52-54 for further discussion on the background to the convalescent homes.

⁹ O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p. 214. Estimates given in Chapter Two suggests that the number of convalescent homes was higher than Checkland's estimate.

¹⁰ Bryant, *Convalescence, Historical and Practical*.

¹¹ Gardiner, *Convalescent Care in Great Britain*.

¹² C. Heckman, *Convalescence*, Unpublished MA Dissertation, (Kings College, 1995).

Infirmary of Glasgow by S. Slater and D. Dow and *The Royal* by J. Jenkinson, M. Moss and I. Russell.¹³ Similarly, A. Kerr and L. MacQueen in the *History of the Western Infirmery*, allocate only two pages of discussion on the Lady Hozier Home, the convalescent home attached to the Western Infirmery.¹⁴ Yet these examples are generous compared to Dow's *Paisley Hospitals* that devotes only one paragraph to the topic of their convalescent home.¹⁵ Likewise, Douglas Guthrie's history of *the Royal Edinburgh Hospital for Sick Children 1860-1960* assigns less than one page to two convalescent homes attached to the hospital.¹⁶ Further examples of hospital histories with only brief references to their convalescent homes are H. C. Gibson's, *Dundee Royal Infirmery*, W. G. Harrington's *Stirling Royal Infirmery 1874-1974* and I. Levack and H. Dudley's *Aberdeen Royal Infirmery*.¹⁷

A hospital history that does have some relevance to convalescent homes is Elaine Thomson's thesis on *Women in Medicine in Late Nineteenth and Early Twentieth Century Edinburgh*. She focuses on the medical practice of women doctors in Edinburgh, much of which took place in the Edinburgh women's hospitals, where she found many of the patients admitted were suffering from overwork, inadequate diet and generalised physical neglect. She examines the physiology of rest, which underpinned treatment that involved rest and adequate nutrition that the doctors offered at the Edinburgh women's hospitals. The same ideas about rest formed the basis for the natural therapies of rest and nutrition used in the convalescent homes.¹⁸

¹³ S. Slater and D. Dow, *The Victoria Infirmery of Glasgow 1890-1990* (Glasgow, 1990), p. 245; J. Jenkinson, M. Moss and I. Russell, *The Royal* (Glasgow, 1994), pp. 148-149, 165.

¹⁴ A. Kerr and L. McQueen, *The Western Infirmery in Glasgow, 1874-1974* (Glasgow, 1974), pp. 16-17; H. C. Gibson, *Dundee Royal Infirmery 1798 to 1948* (1948), p. 47; W. G. Harrington, *Stirling Royal Infirmery 1874-1974* (Stirling, 1974), pp. 15-16.

¹⁵ D. A. Dow, *Paisley Hospitals, The Royal Alexandra Infirmery and Allied Institutions 1786-1986* (Glasgow, 1988), p. 25.

¹⁶ D. Guthrie, *The Royal Edinburgh Hospital for Sick Children, 1860 –1960* (Edinburgh, 1960), p. 30.

¹⁷ H. C. Gibson, *Dundee Royal Infirmery 1798 to 1948* (1948); W. G. Harrington, *Stirling Royal Infirmery 1874-1974* (Stirling, 1974); I. Levack and H. Dudley, *Aberdeen Royal Infirmery* (London, 1992), p. 39.

¹⁸ E. Thomson, *Women in Medicine in the Late Nineteenth and Early Twentieth-Century Edinburgh: a Case Study*, Unpublished PhD thesis, (University of Edinburgh, 1998).

Lack of attention to the history of convalescent homes is also apparent in more extensive studies of hospitals or health. For example, although Brian Abel-Smith in his classic work, *The Hospitals* and Elizabeth Lomax in *Small and Special: The Development of Hospitals for Children in Victorian Britain*, both comment on aspects of convalescent homes, the total amount is only a few lines.¹⁹ Similarly, Rona Gaffney, in her PhD thesis on *The Development of Hospital Provision in Glasgow*, includes just a short paragraph of discussion on the topic of convalescent homes.²⁰ *The Book of Aberdeen*, describing hospitals and medical institutions in and around Aberdeen, provides three pages of discussion on the Newhills Convalescent Home, yet neglects to mention the Aberdeen Convalescent Hospital, the convalescent home of the Aberdeen Royal Infirmary.²¹

Although there are also a few written accounts of the history of individual convalescent homes that provide a basis for further study, their authors often write from an internal perspective. For example, Robert Hillhouse bases his history of the West of Scotland Seaside Convalescent Homes (Dunoon Homes), published early in the twentieth century, upon his reminiscences as the Secretary of this home.²² A more recent example is the history of the Astley Ainslie Institute (AAI) by C. Smith titled, *Between the Streamlet and the Town*.²³ Although Smith provides useful and interesting background information on regime at the AAI and individuals involved in the foundation, he does not develop the discussion within the wider perspective of convalescent homes. Despite a promising title, *The Unfinished History of the Railway Convalescent Home*, John Whitehouse also focuses on the managers and

¹⁹ B. Abel-Smith, *The Hospitals* (London, 1964), pp. 133, 254, 265, 395; E. Lomax, 'Small and Special: The Development of Hospitals for Children in Victorian Britain', *Medical History, Supplement No 16* (1996), pp. 12, 14, 33, 34, 55, 85, 110, 173; Other examples include: J. Kinnaird, 'The Hospitals' in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987), p. 219; S. Cherry, *Medical Services and the Hospitals in Britain 1860-1939* (Cambridge, 1996), pp. 47, 61, 75.

²⁰ R. Gaffney, *Development of Hospital Provision in Glasgow between 1867 and 1897*, Unpublished PhD Thesis, (University of Glasgow, 1983), p. 25. Rona Gaffney did not include convalescent homes in her thesis because she believed they did not offer treatment to patients.

²¹ D. Rorie, ed., *The Book of Aberdeen* (Aberdeen, 1939), pp. 94-96.

²² R. Hillhouse, *Bygone years of the West of Scotland Convalescent Seaside Homes, Dunoon* (Glasgow, 1909). Another example is D. Stewart and M. Burnett, *100 years of the Convalescent Home, Nairn* (Nairn, 1993).

²³ C. Smith, *Between the Streamlet and the Town* (Edinburgh, 1989).

sponsors rather than the social background of patients, the staff or the regime of the railway convalescent homes. The book also only assigns one page to Ascog Mansion, the Scottish Railway Convalescent Home situated at Rothesay on the Island of Bute.²⁴ Local histories, such as T. Watson's, *Kirkintilloch: Town and Parish*, also occasionally mention convalescent homes, but it is difficult to establish their reliability because they frequently lack references to their original sources.²⁵

Some of the literature focuses on one particular aspect of convalescent homes. Harriet Richardson, for instance, devotes a short chapter to the topic of convalescent homes in her book on English hospital architecture.²⁶ However, the chapter mainly concerns their design and describes convalescent homes in England rather than Scotland. Another example of a specific approach to the study of convalescent homes is W. G. Macpherson's *History of the Medical Services of the First World War*. This study refers only to the military convalescent homes established during the First World War.²⁷ Comments on convalescent homes discussed in the context of a particular theme are also found in Norma Davies Logan's, *Drink and Society in Scotland, 1870-1914*. In this thesis Norma Logan mentions convalescent homes organised by the Rechabites as a service for their members.²⁸ Similarly, W. Maxwell briefly describes the development of convalescent homes run by the Co-operative Society in *History of Co-operation in Scotland. It's Inception and it's Leaders*.²⁹

²⁴ J. Whitehouse, *The Unfinished History of the Railway Homes* (Portsmouth, 1986), pp. 19, 40.

²⁵ T. Watson, *Kirkintilloch: Town and Parish* (Glasgow, 1894), pp. 131-133; Other examples of references to Scottish convalescent homes in local histories are in: R. and M. McSherry, *Old Saltcoats* (Ochiltree, 1995), p. 36; S. Wyllie and J. Wilson, *Troon in Old Picture Postcards* (Zaltbommel/Netherlands, 1991), p. 31; R. Thompson, 'Bothwell', in D. Burns, A. Reid and I. Walker, eds., *Hamilton and District. A History* (Hamilton, 1995), p. 95; W. Jenkins, *Memories of St Ninians* (Stirling, 1999), p. 57.

²⁶ H. Richardson, *English Hospitals 1660-1948* (Swindon, 1998), pp. 182-188.

²⁷ W. G. Macpherson, *History of the Great War. Medical Services General History, Vol. II* (London, 1923), pp. 84-8, 130, 182, 338, 358-9, 427. Although there is some discussion of military convalescent homes established for the duration of the First World War in this study it was not possible to scrutinise them fully because archival sources were not available.

²⁸ Norma Davies Logan, *Drink and Society in Scotland, 1870-1914*, Unpublished PhD Thesis, (University of Glasgow, 1983), pp. 197.

²⁹ W. Maxwell, *History of Co-operation in Scotland. It's Inception and it's Leaders* (Glasgow, 1910), pp. 358-361.

Although many of the Scottish convalescent homes were not attached to a specific hospital, there is a tendency to focus on those organised by the infirmaries, thereby giving a somewhat unbalanced picture of their sponsorship. For example, in her interesting and definitive thesis on *The Development of Occupational Therapy in Scotland*, referring to convalescent homes, Catherine Paterson notes ‘there were about thirty such convalescent hospitals, with about 1,800 beds in Scotland in the 1920s, mainly attached to the large voluntary hospitals.’³⁰ Olive Checkland also opened her chapter on convalescent homes in *Scottish Philanthropy* under the title ‘Post Hospital Care’. Her first sentence states: ‘The move to provide post hospital care for recuperating patients started about 1865.’ This sentence strongly implies that the convalescent homes were mainly for hospital patients.³¹ Although Catherine Heckman also discusses convalescent homes mostly in the context of the hospital she nevertheless recognises the limitation of examining only homes attached to hospitals. This, she explained, was due to insufficiency of documentary evidence to allow the examination of convalescent homes unconnected with the hospitals.³² It contrasts with the archival source material available for the study of non-hospital convalescent homes in Scotland, such as their annual reports and minutes of managing committees. These sources allowed a more extensive study of Scottish convalescent homes to include all types of homes, not just those attached to hospitals. Steven Cherry also focused attention on the hospital convalescent homes. He estimated that by 1911, the voluntary hospitals provided only a third of convalescent beds in Britain, (including Scotland) thereby leaving two-thirds sponsored outside the hospital system.³³ However, he did not discuss the nature of the sponsors that provided the other two-thirds of convalescent home beds. D. Fallows, in *Convalescence, A Neglected Need*, a post Second World War study of

³⁰ C. F. Paterson, ‘The Development of Occupational Therapy in Scotland 1900-1960’, Unpublished PhD thesis, (University of Aberdeen, 2002), p. 124. Statistics given in Chapter 2 of this thesis indicate that the number of convalescent homes in Scotland by the 1920s was far higher.

³¹ Checkland, *Philanthropy*, pp. 214 -218.

³² Heckman, ‘Methodology’, *Convalescence*, p. 10.

³³ Cherry, *Medical Services and the Hospitals*, p. 47.

convalescence, also gives a brief historical perspective of convalescent homes, but only on those attached to hospitals.³⁴

Despite the fragmented nature of the literature relating to convalescent homes, a picture of their history has emerged. However, it is one that often raises more questions than it answers. Checkland, for example, questioned whether small homes with only a few beds, such as Hawthornbrae CH in Edinburgh, encountered greater difficulties in sustaining their existence.³⁵ If survival was more of a challenge to smaller convalescent homes, understanding the reasons for their difficulties may help explain the success of larger homes. This issue is therefore worthy of further exploration.

Another important issue raised within the literature was the motivation of the sponsors. A. Logan-Turner comments that the origins of Corstorphine House, the convalescent home attached to the Royal Infirmary of Edinburgh, (RIE) arose out of an investigation by the managers to establish why their patients remained longer in their infirmary than other hospitals. Their inquiries uncovered a number of reasons including the belief that many patients admitted to the RIE lived further away. Patients could therefore not undertake the longer journey home until fully fit. The managers thought that establishing convalescent houses in Edinburgh was one solution to this problem and consequently sought philanthropists willing to provide temporary convalescent houses in the city. Following the apparent success of the temporary homes, the managers initiated the establishment of Corstorphine House in 1867 as a permanent convalescent home.³⁶ Although this explains the interest of the RIE managers in convalescent homes, it does not necessarily explain the reasons for similar interest by other voluntary hospitals.

³⁴ D. Fallows, *Convalescence, A Neglected Need* (London, 1989), p. 5.

³⁵ Checkland, *Philanthropy*, p. 217.

³⁶ A. Logan Turner, *Story of a Great Hospital, the Royal Infirmary of Edinburgh* (Edinburgh, 1937), pp. 174.

Heckman suggests that in England, the cholera epidemic motivated philanthropists to establish convalescent homes.³⁷ However, there is currently nothing to suggest that a cholera epidemic initiated the foundation of Scottish convalescent homes. Checkland mentions the value of convalescent homes to the redemptive work of evangelical or temperance organisations involved in convalescent home provision such as the Mission Coast Home at Saltcoats.³⁸ W. Maxwell describes how, during the twentieth century, the foundation of convalescent homes began to include homes organised by the Scottish Co-operative Society as a benefit for their members.³⁹ Likewise, John Salmon and John Whitehouse describe how the Railway Convalescent Homes Association established homes as a benefit for railway workers.⁴⁰ Similarly, Norma Logan mentions that the Rechabites, a temperance friendly society, established a convalescent home at Dunoon as an additional benefit to their membership.⁴¹ This shift towards a different clientele raises the question of whether the management and regime in the self-help homes differed significantly from homes specifically established for the sick poor. Richardson suggests that the design of English convalescent homes became less institutional during the twentieth century. This may reflect higher expectations from patients in self-help organisations such as the Co-operative or friendly society convalescent homes.⁴² However, these brief accounts describing initiatives for establishing convalescent homes, only scratch the surface of their history.

In general, there are few references in the literature that describe aspects of regime in the convalescent homes. One exception was in *The Royal*, where the authors, J. Jenkinson, M. Moss and I. Russell, hint at some patient activities at the convalescent home attached to the GRI, the Schaw Home. They describe the recreational rooms in the Home as ‘a smoking room for the men and a large workroom for the

³⁷ Heckman, *Convalescence*, p. 1.

³⁸ Checkland, *Philanthropy*, p. 216.

³⁹ Maxwell, *Co-operation in Scotland*, pp. 358-361. Maxwell’s book was published before the Co-operative Society established their third convalescent home, Airdmhor at Dunoon in 1918.

⁴⁰ J. Salmon, *A Proud Heritage* (London, 1954), pp. 3-50; Whitehouse, *Railway Convalescent Homes*, pp. 1-30.

⁴¹ Logan, *Drink and Society*.

⁴² Richardson, *English Hospitals*, pp. 182-188.

women'.⁴³ They also suggest that the presence of a convalescent home was not necessarily popular in a residential area such as Bearsden (Glasgow). They comment on the complaints received from the middle-class neighbours regarding bad behaviour from some convalescents who strolled around the district. The managers responded by confining patients to the convalescent home and grounds during their stay.⁴⁴ The troubles encountered by the managers of the Schaw Home raises the question of whether other managers experienced similar problems with their patients and if so, how it was managed. Martin Goldman in his book *Lister Ward* also produced background material that illustrates some of the routine at the convalescent home of the Royal Infirmary of Edinburgh, Corstorphine House, through the experience of one patient. The patient, Margaret Mathewson went to Corstorphine House in 1872, following an operation performed by Joseph Lister. Goldman reprinted part of the contents of her diary, written while in the RIE and Corstorphine House.

Staffing is another important aspect of understanding how convalescent homes functioned. Yet there are few references in the literature to the doctors, nurses or domestics that worked in convalescent homes. An exception was Logan Turner who mentioned that when Corstorphine House opened in 1867 they employed a housekeeper, gardener and a gatekeeper. He also noted that at that time the medical officer at Corstorphine House was Thomas Annandale, then a junior assistant at the RIE.⁴⁵ Goldman also commented that John Chiene was the convalescent home doctor for Corstorphine House when Margaret Mathewson was a patient at the infirmary.⁴⁶ Both Annandale and Cheine subsequently achieved illustrious careers within the medical profession. Annandale succeeded Joseph Lister as Regius Professor of Clinical Surgery at the RIE from 1877-1907 and Cheine was Professor of Surgery at Edinburgh from 1882 to 1909.⁴⁷ However, by the twentieth century

⁴³ Jenkinson et al, *Royal*, p. 148.

⁴⁴ *Ibid.*, p. 149.

⁴⁵ Turner, *Story of a Great Hospital*, p. 175.

⁴⁶ Goldman, *Lister Ward*, p. 134.

⁴⁷ Turner, *Story of a Great Hospital*, p. 373.

Bryant argued that there was serious lack of interest and an apathetic attitude towards convalescence from the medical profession.⁴⁸ There is therefore some ambiguity over whether taking up the post of convalescent home medical officer affected the subsequent career of a doctor and there is therefore a need for further clarification on this question.

Heckman's contribution to the staffing issue in convalescent homes is important because she examines the convalescent homes from a nursing perspective. Heckman concludes that nursing care in convalescent homes lacked clear definitions of the term 'nurse' and 'convalescence'. She also believes that nursing in the hospital convalescent homes in the London area was less popular than in acute care hospitals. She commented this was because many nurses thought it required a lower level of skill or was more suitable for those not strong enough for hospital nursing.⁴⁹

However, was this the case in Scottish convalescent homes? Heckman noted an important change in perception towards convalescent homes that developed in England during the inter-war period into two types of convalescent homes. The first were those regarded as 'convalescent hospitals' and a second type perceived as 'recuperative holidays'.⁵⁰ Did a similar perception towards Scottish Convalescent Homes develop during the twentieth century? If so, how and why did this arise? There are few clues in the current literature apart from Gow's comment that that nurses from the Victoria Infirmary in Glasgow made its convalescent home, the Brooksby, the venue for their annual picnic.⁵¹ Checkland also mentions that evangelical missionaries were offered a holiday at the Dunoon Homes provided they undertook a full programme of mission work while resident.⁵²

John Kinnaird suggested that a more tolerant attitude towards the provision of convalescent home facilities for pauper children developed during the twentieth

⁴⁸ Bryant, *Convalescence, Historical and Practical*, p. 1.

⁴⁹ Heckman, *Convalescence*, p. 34.

⁵⁰ *Ibid.*, p. 77.

⁵¹ S. Slater and D. Dow, *The Victoria Infirmary of Glasgow 1890-1990* (Glasgow, 1990), p. 194.

⁵² Checkland, *Philanthropy*, p. 216.

century. He observed that the *1904 Report of the Departmental Committee* approved of larger parish councils subscribing to convalescent homes for their child patients.⁵³ By contrast the Departmental Committee disapproved of the ‘over-generous extension of this benefit to adults, as possibly fostering pauperism and risking objection from ratepayers who could not afford such a facility for members of their own family’.⁵⁴ Although Kinnaird did not offer any reason for the more tolerant attitude towards child patients, the explanation is likely to lie in concern for child welfare that increased during the twentieth century. Lomax also commented on the growth in the number of convalescent homes for children attached to hospitals. She observed that by 1900, most of the larger Children’s hospitals had their own convalescent home. However, Lomax suggests that the reasons were partly medical since the convalescent homes enabled children to lead a more active life than was possible in a hospital ward.⁵⁵ Yet this may have still been part of the same trend toward increased concern for the welfare of children and is a topic worth exploring further.

The shortcomings of the literature suggest a pressing need for greater understanding about the origins, function and development of convalescent homes, their relationship with other hospitals and the wider community of Scotland. The purpose of this thesis is to begin to fill these gaps in our understanding. I chose the timescale of 1860 to 1939 because this was the period of their origin, development and consolidation. It therefore required detailed and careful scrutiny. I have not continued the account beyond 1939 because there were many complex events occurring during and following the Second World War relating to convalescent homes, such as their incorporation into the National Health Service and eventual decline. By concentrating on the period 1860 to 1939, it ensures adequate coverage of the issues surrounding convalescent homes during the most significant period of

⁵³ Kinnaird, J., ‘The Hospitals’ in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987), p. 219. The Departmental Committee was set up by the Local Government Board for Scotland to investigate Poor Law Medical Relief and the Rules and Regulations for the Management of poorhouses.

⁵⁴ *Ibid.*

⁵⁵ Lomax, ‘Small and Special’, p. 85.

their history.

Sources

An extensive survey of information relating to all Scottish convalescent homes established before the Second World War provided the basis for this study.⁵⁶ The collected data was then organised into a database designed to represent essential information about convalescent homes and make it easily accessible.⁵⁷ Much of the data used to compile this survey of convalescent homes originated from *Burdett's Hospitals and Charities Year Book*, commonly known as *Burdett's*.⁵⁸ *Burdett's* appeared annually between 1890 and 1930 and listed hospitals and charitable organisations throughout Britain, including convalescent homes. The compiler and editor, Henry Burdett, was a controversial commentator on the practice of nursing and the administration of hospitals and charities.⁵⁹ Typical information contained in *Burdett's* included: the number of patients and beds; the date of foundation; the number of nurses; admission policy and annual revenue. *Burdett's* is now a valuable and widely used source of statistical information on topics such as hospital income and expenditure.⁶⁰ Nevertheless, *Burdett's* has limitations, posing three major difficulties for this study of convalescent homes. Firstly, the data was often inconsistent because it originated from questionnaires completed by the convalescent home staff who may have been unable or unwilling to answer the questions. For example, *Burdett's* only occasionally published the foundation dates of the convalescent homes. Also, some homes only provided information on their bed numbers, whereas others only gave the annual numbers of patients admitted.

⁵⁶ Further methodological details on this database can be found in Appendix A.

⁵⁷ See Appendix B for names of convalescent homes, location, date of opening and closure.

⁵⁸ *Burdett's Hospitals and Charities* (London, 1890-1930).

⁵⁹ Burdett often upset nurses because many considered he was not qualified to pronounce judgement on the practice of nursing through his numerous articles and books. For discussion on this see p. 58 of this thesis. See also, F. Prochaska, *Philanthropy and the Hospitals of London* (Oxford, 1992), pp. 8-12.

⁶⁰ Examples of authors using Burdett's as a source include: O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), pp. 214-5; S. Cherry, 'Before the National Health Service: Financing the Voluntary Hospitals, 1900-1939', *Economic History Review*, 2 (1997), pp. 305-326; M. Gorsky, J. Mohan and M. Powell, 'British Voluntary Hospitals, 1871-1938. The Geography of Provision and Utilization', *Journal of Historical Geography* 25, (1999), pp. 463-482.

Secondly, *Burdett's* did not include some homes until several years after their foundation and others never appeared at all. For instance, *Burdett's* did not publish details of the many convalescent homes for miners or railway workers established in the mid-1920s. Thirdly, *Burdett's* does not cover the whole period from 1860-1939 as it ceased publication in 1930. So for the remaining period the *Hospital Year Book* has been utilised. Although it was a similar type of publication, as an archival source it presented a further challenge since by 1932 it excluded over three-quarters of the convalescent homes in Scotland. Despite the deficiencies of *Burdett's* and the *Hospital Year Book*, they contain valuable information about the convalescent homes and there was sufficient additional archival source material available to supplement the gaps. These sources include: journal and newspaper reports, annual reports of the convalescent homes together with various committee minute books of convalescent homes.

The additional sources were also used to gain further understanding of issues relating to convalescent homes such as their regime and staffing. These sources, like all source material used for historical analysis, have limitations. For example, the managers of convalescent homes and hospitals wrote and published the annual reports in order to justify their existence to their supporters, particularly the subscribers and other financial benefactors. Although the managers did not necessarily overstate the difficulties encountered by the convalescent poor, they often oversimplified the problem and laid heavy emphasis on the belief that the best remedy was that offered by the convalescent homes. The annual reports also focussed only on problems that could be remedied by financial support or other types of action from their supporters. For instance, the annual reports rarely mentioned difficulties experienced by convalescents when they were discharged from a convalescent home. Despite the limitations of the annual reports they did provide a general view of the development of the convalescent homes. Many provided vital statistics such as annual number of patients admitted, their ages and background, types of illnesses and the regime.

Minute books for the convalescent homes management meetings gave a more thorough account of the day-to-day running of the convalescent homes than annual reports, although fewer of these have survived. They also varied in quality since this was dependent upon the varying degrees of enthusiasm for detail from the minute secretary. Also, like the annual reports, they tended to standardise or generalise the issues raised. Another valuable source used in the research for this thesis was the various lists of 'rules', issued by convalescent homes. Their high survival rate is in itself an indication of the importance attached to the rules by the convalescent homes, though it was sometimes difficult to determine whether the rules were strictly enforced.

Inevitably much of source material used was of an official nature but this was to some extent balanced by articles and comments in newspapers and journals, representing a more popular view. Nevertheless, even here care must be taken when interpreting the attitudes expressed as editors included material that reflected the opinions of their readers. Although only one diary written by a convalescent home patient emerged, this together with correspondence from patients who stayed in convalescent homes during the 1930s, added a glimpse of the patients' perspective to the official documentation. Taken as a whole, despite their inadequacies, the sources were sufficient in quality and depth to appreciate the origins and development of the convalescent homes for the period 1860 to 1939.

The first chapter provides a narrative account of the origins and development of convalescent homes during the nineteenth and twentieth centuries. Much of the discussion focuses upon a survey of Scottish convalescent homes from data extracted from a variety of sources including *Burdett's Hospitals and Charities Year Book* and successor, the *Hospitals Year Book*. Annual reports and minute books of the convalescent homes, supplemented the information contained in *Burdett's*. The categorisation, coding and incorporation of the accumulated data into a computerised database provide a unique insight into various aspects of the homes. It will explain who sponsored the homes, together with when and why? It will also

explain the geographical distribution, the numbers of patients admitted annually, and to what extent these patterns changed over the period.

The remaining chapters explore a range of issues about the development of the homes over the period 1860-1939. Chapter two focuses mainly upon their origins, development and sponsorship during the nineteenth century. The types of sponsors involved were independent promoters, hospitals and religious or temperance organisations. It examines the individuals and organisations whose influence initiated the establishment of the homes. The chapter also explores the financial and administrative procedures that established and maintained the homes. Chapter Three focuses on the development of convalescent homes in the twentieth century, particularly in relation to the new type of sponsorship from mutual assurance organisations. In addition, it considers the effects of the growth of interest in maternal and child welfare, together with advances in medicine, particularly the period following the First World War. It also examines a number of official reports undertaken during the inter-war period. These include: *A Scheme of Medical Services for Scotland*, (MacAlister Report), *the Report of the Hospital Services (Scotland) Committee* (Mackenzie Report), *Report of the Committee on Scottish Health Services*, (Cathcart Report) and the *Scottish Hospital Survey*.⁶¹ Chapter Four examines the illnesses of convalescent patients. This is achieved firstly by exploring the expectations of the convalescent homes towards illness of the patients and secondly, the experience. Also, it investigates differences between the illnesses of patients in the different sponsorship groups. Chapter Five examines the regime of the convalescent homes focusing on the nature of therapeutic aspects of convalescence during the nineteenth and twentieth century, changes that occurred over time and the effects upon the convalescent homes. It also compares the relationship between the regime of a convalescent home and the concept of holidays.

⁶¹ *A Scheme of Medical Service for Scotland*, 1920, Cmd. 1039 (MacAlister Report); *Report of the Hospital Services (Scotland) Committee*, HMSO, 1926 (Mackenzie Report); *Report of the Committee on Scottish Health Services*, 1936, Cmd. 5204, (Cathcart Report); *Scottish Hospital Survey*, HMSO, (1946). See also: J. Jenkinson, 'Social Health Policy 1918-1948 – Paving the Way into a National Health Service?' in C. Nottingham, ed., *The NHS in Scotland* (Hampshire, 2000), pp. 1-17.

The final chapter examines the relationship of the doctors, domestics and nurses within the convalescent home, their function and any changes that occurred over time.

In summary, although some reference to Scottish convalescent homes exists within the literature, overall it is minimal. The reclamation of their history is therefore long overdue.

Chapter One

Vital Statistics

A wealth of material has emerged from both contemporary and modern writers that describe the high levels of poverty and poor social conditions found in urban areas of Scotland during the nineteenth and twentieth centuries.¹ Much of this literature focuses on the detrimental effect this had on the health of the working classes.² As Anne Hardy has recently remarked: 'If the country's cities powered the leading Western industrial economy and the world's greatest imperial power, they exacted a terrible price in terms of ill-health and premature death from their citizens.'³ The overwhelming evidence of gross overcrowding, pollution and insanitary living accommodation, combined with an inadequate diet, leaves little doubt of the need for convalescent facilities for the sick poor, away from the smoky cities.

The emergence of convalescent homes coincided with a rising tide of philanthropic activity that occurred from around the mid-nineteenth century.⁴ Various explanations for the growth of charitable enterprise include, religious obligation; altruism; civic pride; social mobility; social control and self-fulfilment, particularly from middle-class women.⁵ Yet 'need' does not sufficiently explain why philanthropists focused

¹ For current literature on urban poverty in general see introduction to this thesis, note 1. For examples of contemporary literature relating to urban poverty see: G. Macleod, 'Reasons Why Sanatoria should be established on the Clyde for the Sick Poor of Glasgow', *GMJ* (July, 1859), pp. 147-156; J. B. Russell, 'The Children of the City. What can we do for them?' *Health Lectures for the People* (Edinburgh, 1886); 'Health of Glasgow', *GMJ*, February, 1872, p. 285; W. G. Blaikie, *Miss Clugston and her Work* (Glasgow, 1875).

² For example of literature specifically relating to deteriorating standards of health: D. Hamilton, *The Healers* (Edinburgh, 1987), pp. 146-7; R. A. Cage, 'Health in Glasgow' in R. A. Cage, ed., *The Working Class in Glasgow 1750-1914* (London, 1987), pp. 56-76; T. Fergusson, *Scottish Social Welfare, 1864-1914* (Edinburgh & London, 1958), pp. 155-204; J. Harris, *Private Lives, Public Spirit. A Social History of Britain 1870-1914* (Oxford, 1993), pp. 54-57.

³ A. Hardy, *Health and Medicine in Britain since 1860* (Basingstoke, 2001), p. 13.

⁴ M. A. Crowther, 'Poverty, Health and Welfare' in Fraser and Morris, eds., *People and Society*, pp. 274-289.

⁵ E. Gordon, 'Women's Spheres' in Fraser and Morris, eds., *People and Society*, pp. 224-226; F. Prochaska, *The Voluntary Impulse* (London, 1988), pp. 1-40; W. F. Bynum, 'Medical Philanthropy after 1850' in W. F. Bynum and Roy Porter, eds., *Companion Encyclopaedia of the History of Medicine* (London and New York, 1993), pp. 1480-94; A. J. Kidd, 'Philanthropy and the Social History Paradigm', *Social History*, 21 (1996), pp. 180-191; G. Finlayson, *Citizen, State and Social*

on establishing convalescent homes. Neither does it identify individuals or groups that sponsored the convalescent homes, or reveal anything about their demographic and chronological development. Identifying the underlying sponsorship of convalescent homes is essential to our understanding of their origins and development. It is also important because the sponsors often influenced their regime, management and admission policies. For example, the regime of the Kilmun Convalescent Home, a home run by a temperance organisation, focused upon reforming its patients from alcohol consumption. The Directors of Kilmun were therefore drawn from members of the parent organisation, the Glasgow Abstinence Union, and its missionaries recommended many of the patients sent to this convalescent home. Likewise, the managers of convalescent homes attached to hospitals were often on the Board of Management of the parent infirmary. Also, the hospital convalescent homes normally only admitted patients from the infirmary. Similarly, the Co-operative and friendly societies ran their convalescent homes for the benefit of their members, and they extracted their management from their own society. In order to appreciate the range of different individuals and organisations involved in providing convalescent homes for the working classes, the sponsors were therefore categorised according to their type.

Table 1.1 Categorisation of convalescent homes by type of sponsor

Category	Explanation for sponsorship
1 Hospital	Directly sponsored, owned and managed by a hospital
2 Religious/temperance	Sponsored by a temperance society, church or religious organisation
3 Independent	Sponsored either by an individual, committee or trust, not responsible to any other organised body
4 Friendly Society	Sponsored by a friendly society
5 Occupational	Sponsored through an occupational group or scheme
6 Co-operative Society	Sponsored by the Co-operative Society

Source: Data extracted from database described in Appendix A

Table 1.1 explains the categorisation system in detail. The categories cover hospitals, religious/temperance and independent organisations, Co-operative societies, friendly societies and homes organised through occupational schemes. Occasionally, there was an overlap, when a convalescent home fell within two categories. A typical case

was the Alderston Convalescent Home established by the Scottish Rural Workers Friendly Society for the benefit of rural workers. Although it was a friendly society, it also fell within the definition of an occupational group. In such situations, the category used was the type of sponsorship most likely to influence the home. At the Alderston CH, the fact that it was a friendly society catering for a range of rural occupations meant that 'friendly society' was the more appropriate category.⁶

Without a broad understanding of the variety and extent of different types of sponsorship involved in convalescent home provision, it is easy to make false assumptions. For example, as noted in the introduction to this chapter, many authors believe that the infirmaries were more prominent in providing convalescence than they actually were. This misunderstanding has partly arisen because, although the voluntary hospitals established many convalescent homes, they were often quite small. Also, the method used to assess the extent of convalescent home provision was often by the 'number of beds'. For instance, in a survey undertaken in 1929, the *BMJ* estimated that one third of all convalescent home beds were attached to the hospitals.⁷ More recently, Steven Cherry also calculated that the voluntary hospitals provided one third of the beds in convalescent homes in Britain (including Scotland) between 1860 and 1939. Yet considerable margins of errors can occur when using 'number of beds' as a method of assessment to establish the extent of convalescent home provision. Firstly, convalescent homes increased or decreased the number of beds according to demand. Secondly, it was impractical for convalescent homes to report temporary changes to their bed numbers. Thirdly, the provision of beds in a convalescent home did not necessarily mean that patients took them up, or that they were available all the year round.

⁶ There is a comprehensive list of all the convalescent homes, their sponsors, dates of opening and closing and geographical location in Appendix B.

⁷ *BMJ*, 23 February 1929, p. 365. Because the survey was not referenced the data is not reliable.

A more precise method of evaluating the extent of convalescent home provision is to calculate the annual number of patients admitted to the convalescent homes.⁸ This chapter will illustrate that this method of assessment, particularly within sponsorship groups, provides a more accurate perspective on convalescent home provision between 1860 and 1939. The chapter also discusses the results of a survey undertaken to ascertain the extent of facilities both in terms of sponsorship and according to the number of patients admitted annually to convalescent homes. A database compiled from the sources enabled a detailed analysis of the data. Details on the design of the database are in Appendix A. Using the database, the survey explores the growth of convalescent homes, their geographical distribution, together with general and specific reasons why the convalescent homes were established. The chapter also includes some discussion on age and gender of the patients. It concludes by examining reasons why some convalescent homes closed.

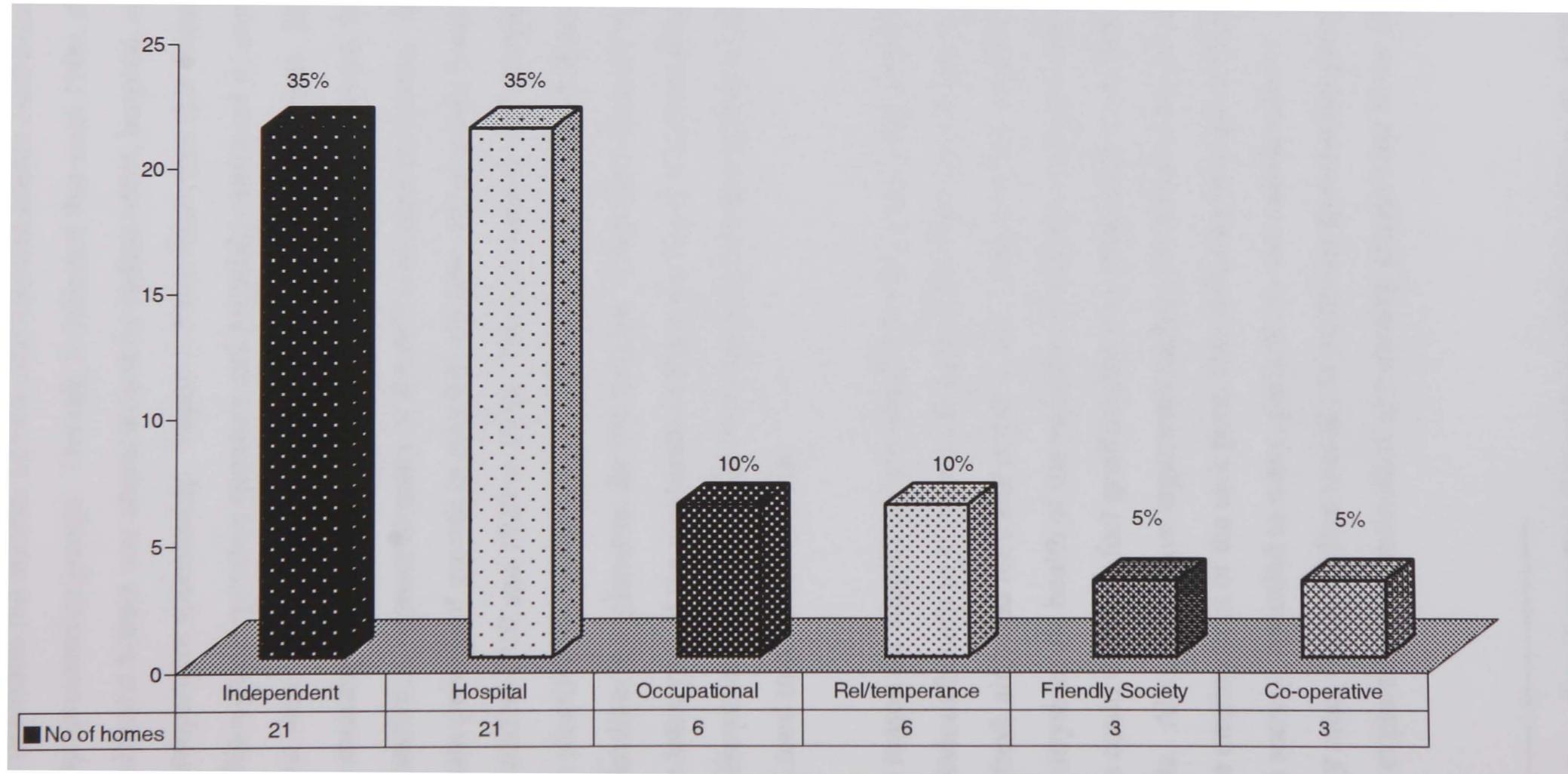
The survey identified over sixty new convalescent homes established throughout Scotland during that over the period 1860 to 1939.⁹ Figure 1.1 illustrates the frequency of the establishment of new convalescent homes within each sponsorship group.¹⁰ This indicates that over the whole period the largest groups were independent providers and the hospitals. Other sponsorship groups established far fewer convalescent homes. Although, as previously discussed, the number of convalescent homes within a sponsorship group is not necessarily indicative of total provision, it nevertheless offers a guide to variations within their development. In order to simplify the process of explanation, this chapter focuses firstly upon their overall growth and development and secondly their distribution.

⁸ The numbers of patients admitted annually to a convalescent home were also more readily available than the number of beds. This information was found in a variety of sources, including *Burdett's*, various annual reports for convalescent homes and hospitals, newspaper and journal articles.

⁹ See Appendix B for list of convalescent homes established between 1860 and 1939. Although it possible that other convalescent homes were established during this period because the major trail of likely archival sources was covered thoroughly, if they exist they are probably few in number.

¹⁰ The equal proportions within this chart are purely coincidental.

Figure 1.1: Establishment of new convalescent homes in sponsorship groups between 1860 and 1939



Source: Data extracted from database described in Appendix A.

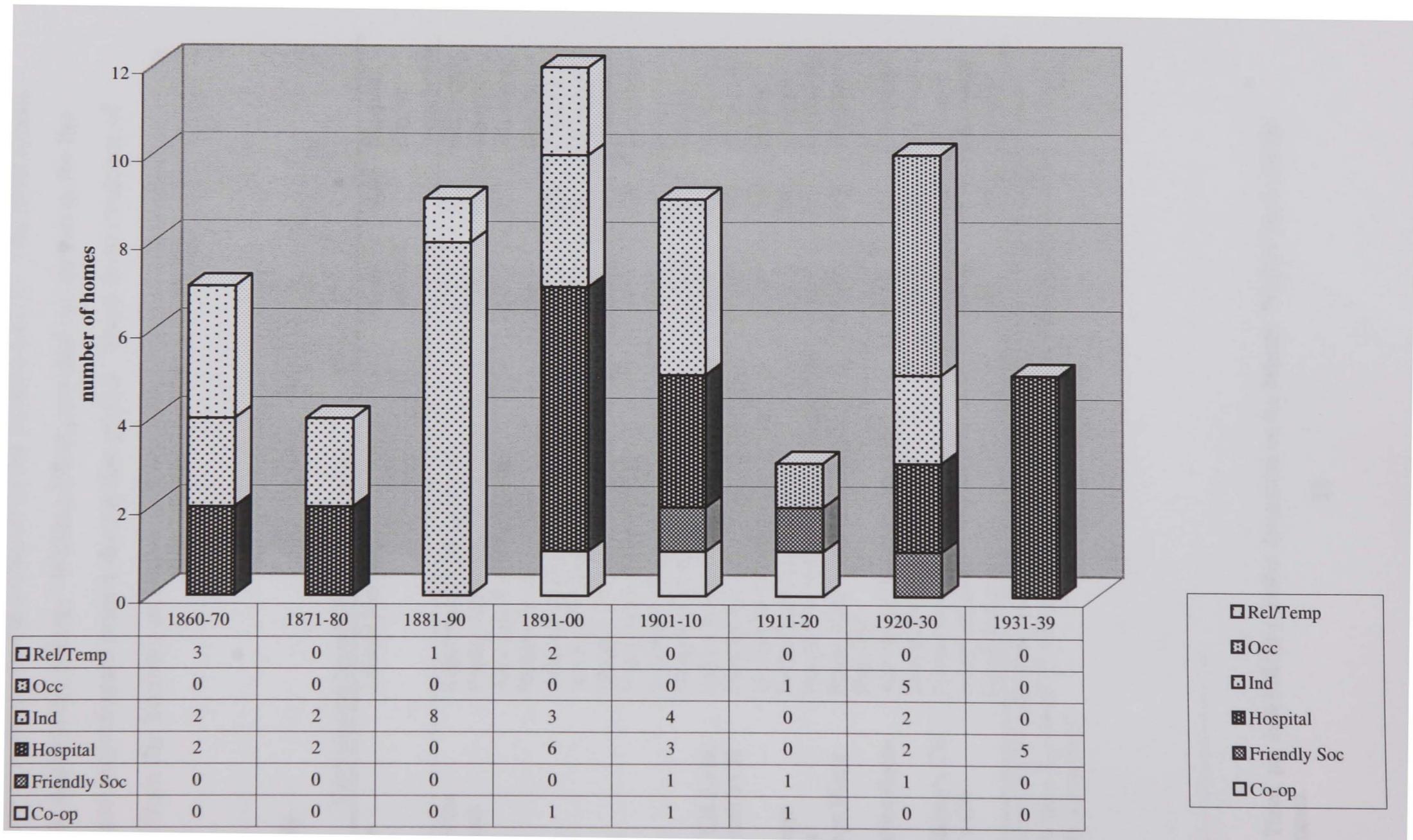
Growth and Development

Figure 1.2 illustrates the number of new convalescent homes established in ten-year intervals by sponsorship groups. Overall, it indicates that until 1900, development of new convalescent homes was characterised by independent, hospital, or religious/temperance sponsorship. Figure 1.2 also illustrates that during the twentieth century, although independent sponsors and hospitals continued to establish new homes none were sponsored by religious/temperance organisations. Instead, self-help or mutual assurance groups, classified as occupational organisations, friendly and co-operative societies, sponsored many of the new convalescent homes. It also indicates that the main periods of growth in establishing new convalescent homes were between 1880 to 1910 and 1920 to 1930. This corresponds with similar cycles of expansion identified by Elizabeth Gardiner in her 1930s study of British convalescent homes. Gardiner's explanation for the increase in new convalescent homes in Britain during the latter part of the nineteenth century was the rise in prosperity during this period.¹¹ However, she does not provide any supporting evidence or identify indicators used to determine wealth.

A general reason for support of convalescent homes during the nineteenth century was the obvious benefit to recipients obtained from this type of charity. Given a few weeks of fresh air, good food and rest at a convalescent home, situated by the sea or in the countryside, the health of the majority of patients improved rapidly. Their supporters could therefore feel gratified that their philanthropic efforts were worthwhile. Also, persuasive arguments such as the faster return to health and productive employment of the sick poor, thus reducing their possibility of becoming a burden on society, appealed to many, particularly the middle-classes. However, there were many more reasons, often specific to particular sponsorship groups. These issues are explored within individual sponsorship groups later in the chapter.

¹¹ E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), p. 40. At the time of writing this book Elizabeth Gardiner was Assistant Professor and Supervisor of Medical Social Work at the University of Minnesota.

Figure 1.2: Sponsors of new convalescent homes between 1860 and 1939 in ten year intervals



Source: Data extracted from survey described in Appendix A

Note: Balmaville CH could not be included in these statistics because the foundation date is unknown

Gardiner's explanation for the second surge of interest in convalescent homes, between 1921 and 1930, was that it arose from the leadership given by the Ministry of Health.¹² However, again Gardiner did not provide any substantiating evidence and her supposition is contrary to the evidence in the current survey. The most recent evidence indicates that the Miners' Welfare Fund provided the incentive for the majority of new convalescent homes during this period. There is no evidence of involvement from the Ministry of Health in the establishment or administration of the Fund.¹³

Hospital CHs

Table 1.2 Convalescent homes linked to hospitals

Name of Home	Linked Hospital	Year opened	Size	Nearest city or large town
Corstorphine Home	Edinburgh Royal Infirmary	1867	L	Edinburgh
Paisley CH (First)	Paisley Infirmary	1869	M	Glasgow
Aberdeen CH	Aberdeen Royal Infirmary	1872	S	Aberdeen
Dundee CH	Dundee Royal Infirmary	1876	L	Dundee
Arbroath CH	Arbroath Infirmary	1891	VS	Dundee
Hozier CH	Western Infirmary	1893	M	Glasgow
Schaw CH	Glasgow Royal Infirmary	1895	L	Glasgow
Bona	Northern Counties Infirmary	1895	VS	Inverness
Brooksby CH	Victoria Infirmary	1897	M	Glasgow
Edzell CH	Montrose Infirmary	1897 ^c	VS	Dundee
Cottage Home CH, Leith	Leith Cottage Hospital	1903	S	Edinburgh
Muirfield Children's CH	Hospital for Sick Children, Edinburgh	1906	VS	Edinburgh
Victoria CH	Stirling Royal Infirmary	1906	VS	Stirling
Calderbank House	Bellshill Maternity Hosp.	1920	VS	Glasgow
Fortevoy Home	Hospital for Sick Children, Edinburgh	1934	S	Edinburgh
Garscube Cottage Home	Royal Maternity and Women's Hospital	1922	VS	Glasgow
Thorngrove Babies Home	Aberdeen Children's Hospital	1935	S	Edinburgh
The Grove	Dumfries Royal Infirmary	1938	S	Dumfries
Sunnybank Children's CH	Broadstone Hospital	1935	S	Glasgow
Leith Children's CH	Leith Infirmary	1935	VS	Edinburgh
Balgavies CH	Forfar Infirmary	NK	NK	Dundee

Source: Data extracted from database described in Appendix A. Key: VS = Very Small (less than 200 patients per year, S = Small (2-500 patients a year), M = Medium (500-1000 patients), L = Large (1-2000 patients per annum)

¹² Ibid.

¹³ See Chapter Three, pp. 106-108 for a further discussion on the Miners' Welfare Fund and the convalescent homes.

Table 1.2 indicates that many of the hospital convalescent homes were small, widely distributed throughout Scotland and mostly established before the outbreak of the First World War. Table 1.2 also indicates that it was mainly voluntary hospitals that sponsored this category of convalescent homes.¹⁴ The two other main groups of hospital types were the Poor Law hospitals and the hospitals for infectious diseases or fever hospitals. The reasons for the exclusiveness of the establishment of convalescent homes by voluntary hospitals arose mainly from their need to treat patients successfully but as quickly as possible. This increased their prestige and credibility amongst the community, thus encouraging subscriptions and donations for financial support.¹⁵ Authorities within the voluntary hospitals were therefore under constant pressure to discharge their patients as soon as possible. Yet, if they discharged patients too early, a possible relapse and return to the infirmary could reduce their success rate. To make matters worse, Poor Law authorities were reluctant to accept patients discharged from the voluntary hospitals.¹⁶ T. Ferguson notes that parochial boards often argued that it was not their responsibility to remove patients 'who had not been admitted to be proper objects of parochial relief previous to their admission to the Infirmary'.¹⁷ It therefore became increasingly important for the voluntary hospitals to discharge their patients to a healthy, safe environment, such as a convalescent home, rather than allow them to languish for too long on the wards.

There are several reasons why the Poor Law hospitals did not establish convalescent homes. Firstly, Poor Law hospitals were not under the same pressure to discharge their patients as the voluntary hospitals. Dr Osborne Mavor, a physician at Stobhill Hospital, (built by Glasgow Parish Council) recalls that the slower turnover of beds

¹⁴ A. Logan Turner, *Story of a Great Hospital, the Royal Infirmary of Edinburgh* (Edinburgh, 1937), Turner defines the underlying principle of the voluntary hospital as a system where subscriptions contributed towards the construction of hospital buildings and their annual upkeep and maintenance. Included in the voluntary hospitals were a number of specialist hospitals catering for specific groups within the population such as women and children or the elderly or diseases of specific areas of the body including the nervous system, eyes or the heart.

¹⁵ During the nineteenth century Scottish voluntary hospitals received no state aid and financial support was therefore essential to the survival of the voluntary hospitals.

¹⁶ T. Fergusson, *Scottish Social Welfare, 1864-1914* (Edinburgh, 1958), pp. 261-262. Also see Introduction to this thesis, page 12.

¹⁷ *Ibid.*, p. 261.

gave him far a far longer period to study his patients than those in the voluntary hospitals:

In the voluntary hospital, if I wished to study rheumatoid arthritis I had to content myself with two or three patients, observed over a period of a few weeks. Beds were scarce and the hospital turnover a matter of importance. In Stobhill at any given time I might have thirty or forty cases and, as Stobhill was their last port of call, I could observe them indefinitely.¹⁸

Secondly, the Poor Law authorities could, if necessary, remove convalescents from a Poor Law hospital to the Poorhouse. Thirdly, as John Kinnaird observed, Poor Law authorities were concerned that if they provided convalescent home facilities for adult patients they risked objection from ratepayers.¹⁹ Similarly, there was less pressure upon authorities in municipal infectious disease hospitals than voluntary hospitals to discharge patients before their convalescence was complete.²⁰ This was because municipal authorities financially supported infectious disease hospitals. Their existence therefore did not depend on voluntary support. By contrast, the supporters of voluntary hospitals expected the privilege of recommending patients for admission. This had the effect of increasing the pressure to free hospital beds by discharging patients as soon as possible. Yet at the same time, credibility was equally important in attracting financial support. Inevitably this was impaired if patients died when they returned home or were readmitted. Convalescent homes gave the voluntary hospitals one solution to this dilemma by providing a speedier and safer recovery environment for their patients.

¹⁸ O. M. Watt, *Stobhill Hospital. The First Seventy Years* (Glasgow, 1971), p. 37. Stobhill was opened in 1903 as a Poor Law Hospital.

¹⁹ J. Kinnaird, 'The Hospitals' in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987), p. 219. Also, see introduction to this thesis, p. 12.

²⁰ There are records of only one Scottish convalescent home, Campie House, specifically for patients recovering from fevers. The lack of any reference to this convalescent home after 1890 suggests that it may have only been a temporary venture. It is therefore not included in Table 2.1.

In addition to the convalescent homes attached to voluntary hospitals, there were two small convalescent homes attached to maternity hospitals. The first was Calderbank House, a convalescent home, established as an annex to Bellshill Maternity Hospital. The second was Garscube CH, a small home attached to the Royal Maternity and Women's Hospital in Glasgow.²¹ They both fell within the criteria of a convalescent home because they provided around two weeks of post-natal convalescence for debilitated mothers. Sir Archibald Campbell provided the funds for Garscube CH. However, according to Derek Dow, it only survived until 1924 because Campbell thought the costs were too high. After this time the funds were used to provide two beds at the Dunoon Homes.²²

The RIE was the first voluntary hospital to attempt a resolution of the bed-blocking problem by introducing convalescent facilities outside the main infirmary. This eventually led to the foundation of Corstorphine House, opened in 1867.²³ Although the Paisley Infirmary also opened a convalescent home two years later, it was short-lived, and closed in 1876.²⁴ In 1873, the Royal Infirmary at Aberdeen opened their convalescent home.²⁵ The Dundee Royal Infirmary followed by opening their convalescent home shortly afterwards in 1876.²⁶ Thus by 1876, the voluntary hospitals in three major urban areas of Scotland, Edinburgh, Aberdeen and Dundee, had all established their own convalescent homes.²⁷

²¹ 'Garscube Cottage Hospital', *GMJ*, July 1922, p. 60; A. MacGregor, *Public Health in Glasgow 1905-1946* (Edinburgh and London, 1967), p. 128.

²² D. Dow, *The Rotton Row. The History of the Royal Maternity Hospital 1834-1984* (Carnforth, 1984), pp. 92-93.

²³ Turner, *Story of a Great Hospital*, p. 175; LHB 1/4/66, 'Manager's Report', *Annual Report of the Royal Infirmary of Edinburgh*, 1866, pp. 4-5.

²⁴ D. A. Dow, *Paisley Hospitals, The Royal Alexandra Infirmary and Allied Institutions 1786-1986* (Glasgow, 1988), p. 25.

²⁵ GRHB 1/7/3, *Annual Report of the Aberdeen Royal Infirmary*, 1873.

²⁶ 'Opening of the late Sir David Baxter's Convalescent Home', *Dundee Advertiser*, 18 December 1876.

²⁷ The methods used by infirmaries at Edinburgh, Aberdeen and Dundee to establish their convalescent homes is explained in Chapter Two, pp. 68-75.

Yet, despite the far greater population of Glasgow, the three infirmaries in the city did not open their own convalescent homes until the 1890s.²⁸ This was surprising because the voluntary hospitals in Glasgow experienced the same external pressures as other hospitals over patient admission and discharge.²⁹ One explanation for their reluctance was the availability of convalescent beds outside the hospital system. Access to these non-hospital convalescent beds by infirmary patients thereby reduced considerably the urgency for the Glasgow infirmary managers to establish their own convalescent homes. For example, in 1888, the Western Infirmary of Glasgow sent three hundred and ninety five patients to various convalescent homes provided by independent or hospital/religious organisations in the West of Scotland.³⁰ This was equivalent to the annual number of patients in a small to medium sized convalescent home, such as the Brooksby (the convalescent home of the Victoria Infirmary of Glasgow). Convalescent homes outside the infirmaries, known to admit infirmary patients from the Glasgow area were the GCH, the Dunoon Homes, Mission Coast Home, Dundonald CH and Kilmun.³¹ The GCH was particularly active in providing beds for infirmary patients, and permanently reserved thirty beds for patients from the GRI and ten for Western Infirmary of Glasgow patients. Part of the explanation for the late establishment of the Brooksby in 1897 was that their parent hospital, the Victoria Infirmary, did not open until 1890. However, the legacy that provided the finance for the Victoria Infirmary also allocated funds for a convalescent home. Yet it was not until 1893 that the Victoria Infirmary appointed a 'special committee' to find a building suitable for a convalescent home.³² It is therefore probable that the availability of independent convalescent homes near Glasgow again diminished the urgency for the Victoria Infirmary managers to establish a convalescent home. According to Derek Dow, the presence of the Dunoon Homes also made it unnecessary for the Royal Samaritan Hospital for Women to establish their own

²⁸ The Western Infirmary of Glasgow opened the Lady Hozier Home in 1890, GRI opened their convalescent home, the Schaw Home in 1895 and the Victoria Infirmary opened the Brooksby in 1897.

²⁹ Kinnaird, 'Hospitals', p. 219.

³⁰ GGHB HB 6/3/3, *Annual Report of the Western Infirmary of Glasgow*, 1888-89, p. 7.

³¹ See Appendix B for further information on these convalescent homes.

³² ML G.362.94143, 'The Victoria Infirmary of Glasgow,' *Historical Statement, 1878 to 1895*, p. 7.

convalescent home. They decided instead that it was better to use their resources to subscribe to the Dunoon Homes.³³

By contrast, when the Infirmaries of Edinburgh and Aberdeen established their own convalescent homes, there were no others in their areas. Dundee had one small convalescent home with approximately ten beds that only accepted female patients over the age of ten years. This was the Dundee Convalescent House, established in 1860.³⁴ In order to provide convalescent facilities for their patients, the infirmaries at Edinburgh, Dundee and Aberdeen therefore had to establish their own convalescent homes.

The provision of convalescent homes for children by non-hospital sponsors also explains why the Children's Hospital in Glasgow, opened in 1882,³⁵ never established its own convalescent home.³⁶ Table 1.3 lists seventeen convalescent homes for children in Scotland established before 1939. It highlights five children's convalescent homes in the Glasgow area established before the First World War, organised either independently or by a religious group. These were: Convalescent Cottage Homes at Helensburgh (Helensburgh); Dundonald Convalescent Home (Dundonald CH); Ravenscraig Children's Convalescent Home (Ravenscraig CH); Scottish Convalescent Home for Children (Scottish Children's CH) and Ashgrove Convalescent Home (Ashgrove CH). They all admitted children from various hospitals. This diluted the need for the Glasgow Children's Hospital to provide its own convalescent home. At least one of these convalescent homes, Ravenscraig CH, was specifically established for patients from the Children's Hospital in Glasgow. In 1890, the Annual Report of their Ladies Auxiliary Association stated that, 'in addition to the existing convalescent homes for children, one of special value to the Hospital

³³ D. Dow, *The Royal Samaritan Hospital for Women, Glasgow* (Glasgow, 1986), p. 29.

³⁴ THB 13/1, *First Annual Report of the Dundee Convalescent Hospital*, 1861, p. 7. This convalescent Home was renamed during the following year as Dundee Convalescent House. See Appendix C for further explanation of inconsistency in names.

³⁵ E. Robertson, *The Yorkhill Story* (Glasgow, 1972), p. 26.

³⁶ *Ibid.*, p. 67. Although there was a country branch of the children's hospital at Drumchapel Edna Robertson notes that it was not intended as a convalescent home but rather for children with prolonged illnesses.

has been started by the Rev. John Hunter's Congregation of Trinity Congregational Church, at Eaglesham and the use of it given to the Hospital for twelve months.'³⁷ Despite their original intention, Ravenscraig CH continued to admit large numbers of patients from the Children's Hospital until the beginning of the Second World War. The Almoner's Report for the Glasgow Children's Hospital of 1938 remarked that: 'Ravenscraig CH has, as usual, been our great stand-by and has this year steered a hundred and forty-five of our patients through the difficult period of convalescence.'³⁸

Table 1.3 Children's convalescent homes established between 1880 and 1939

Name of Convalescent Home (First Titles)	Yr. Opened	Size	Category	Location
Eidda CH	1880	VS	Ind	Aberdeen
Gilmerton Children's CH	1881	VS	Ind	Edinburgh
Cottage Homes for Children, Helensburgh	1884	VS	Ind	Glasgow
Dundonald CH	1885	S	Ind	Glasgow
Ravenscraig Children's CH	1890	VS	Rel	Glasgow
Newport Children's CH	1893	S	Ind	St Andrews
Ashgrove CH	1897	M	Rel	Glasgow
Linn Moor Country Home	1905	VS	Ind	Aberdeen
Scottish CH for Children	1905	M	Ind	Glasgow
Muirfield Children's CH	1906	VS	Hospital	Edinburgh
St Leonard's CH	1907	VS	Ind	St Andrews
Bandrum Children's Country Home	1928	VS	Ind	Dunfermline
Armitstead CH	1930	S	Ind	Dundee
Forteviot CH	1934	S	Hospital	Edinburgh
Sunnybank Children's CH	1935c	S	Hospital	Glasgow
Leith Children's CH	1935	S	Hospital	Edinburgh
Thorngrove Babies Home	1935	S	Hospital	Aberdeen

Source: Data extracted from database described in Appendix A.

Abbreviations: Ind = Independent, Rel = religious/temperance: VS = very small, S = small, M = medium, (VS = <200 patients annually, small = 2-500, medium = 500 -1000, large = 1-2000, very large = >2000)

By 1900, most voluntary hospitals recognised the social and economic benefits gained from owning a convalescent home. Although there were some exceptions such as the Children's Hospital in Glasgow, infirmaries without such an auxiliary institution were usually anxious to acquire one. For instance, the principal benefactor of the Victoria Convalescent Home (the convalescent home of the Stirling Royal

³⁷ ML G.362.78094141425, 'Annual Report of the Ladies Auxiliary Association' in: *The Annual Report of the Glasgow Hospital for Sick Children*, 1890, p. 13.

³⁸ ML G.362.78094141425, 'Almoner's Report' in: *AR, Glasgow Hospital for Sick Children*, 1938, p. 37.

Infirmary). in a letter explaining the terms of his donation, noted that, ‘all the large hospitals own such useful annexes’.³⁹ At the opening ceremony in August 1906, the Duchess of Montrose also indicated that convalescent homes were no longer perceived as radical and innovative but rather a ‘must have’ type of auxiliary institution:

No institution is capable of doing more good than a convalescent home such as this, working in connection with an infirmary. We must hope that in days to come it may be considered a necessity for every hospital or infirmary in our cities to have, as a valuable adjunct, a convalescent home in the country, for a change to the country during convalescence after operations or serious illness is very essential to complete recovery.⁴⁰

However, following the First World War, the interest shown by managers of voluntary hospitals in traditional convalescent homes declined. This was partly because of the increased costs of running the convalescent homes, and also because the focus of interest of many doctors shifted to institutions offering earlier convalescence and rehabilitation, such as the Astley Ainslie Institution (AAI). There will be a discussion on these issues in later chapters.⁴¹

³⁹ *The Stirling Observer*, 1 August 1906, p. 5.

⁴⁰ *Ibid.*

⁴¹ See discussion on AAI especially Chapter Four and pp. 92, 119-120.

Independent CHs

Table 1.4 Convalescent homes sponsored by independent individuals or organisations between 1860 and 1939

Name of Home	Name of Sponsor	Year	Size	Location
GCH	Beatrice Clugston	1865	L	Glasgow
Dunoon Homes	Beatrice Clugston	1869	VL	Glasgow
Newhills CH	Catherine Cruikshank	1874	S	Aberdeen
Ravenscroft CH	Not known	1879	S	Edinburgh
Eidda CH	Catherine Lumsden	1880	VS	Aberdeen
Gilmerton Children's CH	Not known	1881	S	Edinburgh
Ochiltree CH	Not known	1881	VS	Glasgow
Nairn CH	Annie Chambers	1882	S	Inverness
Helensburgh	Jean Colville	1884	S	Glasgow
Dundonald CH	Lady Dundonald	1885	S	Glasgow
Paisley CH (second)	Family of James Arthur	1886	L	Glasgow
Ailsa CH	Marchioness of Ailsa	1888	VS	Glasgow
Bannatyne Home	Alexander Hay Moncur	1892	S	Dundee
Newport Children's Home	Not known	1893	S	St Andrews
Glencapel Convalescent Home	Trustees of unknown benefactor	1894	S	Dumfries
St Leonard's Convalescent Home, Linn Moor	St Leonard's School for Girls	1903c	S	St Andrews
Scottish CH for Children	Alexander Webster and others	1905	S	Aberdeen
Manderston CH	Not known	1905	M	Glasgow
Bandrum Children's Country Home	Lady Miller	1908	VS	Edinburgh
Armitstead CH	Dunfermline Carnegie Trust	1928	S	Edinburgh
	Trustees of Lord Armitstead	1930	S	Dundee

Source: Data extracted from database described in Appendix A

Abbreviations: VS = very small, S = small, M = medium, L = Large, VL = very large

(VS = <200 patients annually, small = 2-500, medium = 500 -1000, large = 1-2000, very large = >2000).

Independent charitable organisations or individuals continued to establish new convalescent throughout the nineteenth and twentieth century. However, as Table 1.4 indicates, most of these were small. There were three exceptions, the Dunoon Homes, the largest convalescent home in Scotland (3,000 to 5,000 patients annually), the GCH (1,500 to 1,700 patients annually), and the second Paisley Convalescent Home, (700 to 1,100 patients annually). Table 1.4 also reveals that a characteristic of sponsorship during the nineteenth century was the domination by independent female sponsorship. Their lack of power within the voluntary hospital management partly explains this anomaly. Although women were important as fundraisers, and organised the aftercare of patients through Samaritan or Dorcas societies, they were rarely, if

ever, allowed on the management committees of voluntary hospitals until the later nineteenth century. For example, the first lady manager of the RIE was not elected until 1896.⁴² It would therefore have been more difficult, or impossible, for a woman to establish a convalescent home directly through the management of a voluntary hospital. Nevertheless, they would have been acutely aware, through their involvement with Dorcas and Samaritan societies, of the need for convalescent homes. In cases where there was insufficient initiative from hospital managers in founding a convalescent home, women solved the problem by establishing one independently. Nevertheless, the women who established independent convalescent homes often did so initially for the benefit of the voluntary hospitals. The most prominent example was Beatrice Clugston, principle founder of the GCH. Although the GCH later accepted patients recovering from illness at home it was initially intended solely for patients from the GRI. Similarly, the sponsors of Eidda CH, the Cottage Homes at Helensburgh, Dundonald CH, the Scottish Convalescent Home for Children, were all women and all these convalescent homes accepted a high proportion of their patients from the hospitals.⁴³

Religious/Temperance CHs

Although there were only six homes in the religious/temperance group, two of these convalescent homes, the Mission Coast Home and Kilmun, eventually developed into two of the largest homes in Scotland (Table 1.5). The sponsorship of new convalescent homes by religious organisations occurred exclusively during the nineteenth century. The reasons for this reflect a changing attitude towards religion within Scottish society during the twentieth century particularly in relation to charity.⁴⁴ During the nineteenth century, good works and charity were bound up with religion to a much greater extent than in the twentieth.⁴⁵

⁴² Turner, *Story of a Great Hospital*, p. 223.

⁴³ This is discussed further in Chapter Three, in the context of the influence of the concern for maternal and child welfare that developed during the twentieth century.

⁴⁴ C. Brown, 'Religion, Class and Church Growth' in Fraser and Morris, *People and Society in Scotland*, p. 330.

⁴⁵ *Ibid.*

Table 1.5 illustrates that various religious organisations sponsored five of these convalescent homes but only one was sponsored by a temperance organisation. This temperance convalescent home was Kilmun, sponsored by the Glasgow Abstainers' Union.

Table 1.5 Convalescent homes founded by religious organisations between 1860-1895

Convalescent Home	Foundation year	Promoter	Size	Location
Mission Coast Home	1866	James Smith, Missionary from Glasgow City Mission and William Bryden	L	Glasgow
Kilmun	1867	Glasgow Abstainers Union	L	Glasgow
Ashgrove CH	1897	Glasgow United Evangelistic Association	M	Glasgow
Dundee Convalescent House	1860	Lady Jane Ogilvy and Bishop Alexander Forbes, Scottish Episcopal Church	VS	Dundee
Hawthornbrae CH	1895	Edinburgh Medical Missionary Society	S	Edinburgh
Ravenscraig CH	1890	Trinity Congregational Church, Glasgow	S	Glasgow

Source: *Burdett's, Hospitals and Charities 1899, Annual Reports of Mission Coast Home, Kilmun, Glasgow Poor Children's Fresh-Air Fortnight and Cripple Children's League, Dundee Convalescent House and Ravenscraig CH.*

In searching for reasons to explain why the religious/temperance organisations sponsored convalescent homes, it is easy to be cynical and argue that their main purpose was to encourage religious converts or moral reform from the perceived evil of alcohol consumption. Although moral reform or redemption cannot be ignored as reasons for the interest of religious groups in establishing convalescent homes, neither can humanitarian concern for the plight of sick poor. Temperance organisations such as the Glasgow Abstainers Union, sponsors of Kilmun, developed in response to the belief that alcohol was a dominant social evil.⁴⁶ Yet, the managers at Kilmun argued

⁴⁶ For example: Checkland, *Philanthropy* (Edinburgh, 1980), pp. 95-101; C. G. Brown, 'Popular Culture', in T. M. Devine and R. J. Finlay, eds., *Scotland in the 20th Century* (Edinburgh, 1996), p. 210; T. Fergusson, *Scottish Social Welfare, 1864-1914* (Edinburgh & London, 1958), pp. 70-71; I. Levitt, *Poverty and Welfare*, pp. 81-82; C. Brown, 'Religion, Class and Church', p. 240-243; O. and S. Checkland, *Industry and Ethos* (Edinburgh, 1989), p. 104; J. H. Treble, *Urban Poverty in Britain* (London, 1979), pp. 116-117.

that the promotion of their ideals was incidental and the real purpose was the care of the sick:

Regarded simply as an agency in promoting the special object of the Mission it is invaluable, but this of course is only incidental, the direct object in restoring the weak and infirm to health and strength, and fitting them to return to the active duties of life, continues to be realised to a degree that would scarcely be credited.⁴⁷

This was also the case at the Dundee Convalescent House, established by Lady Jane Ogilvy, a local aristocrat⁴⁸ and Alexander Penrose Forbes, a bishop of the Scottish Episcopal Church.⁴⁹ When the Dundee Convalescent House was established, the Scottish Episcopal Church was recovering from a period of illegality. During the seventeenth and eighteenth centuries the government outlawed the church because so many members supported the Jacobite cause.⁵⁰ Consequently, during the nineteenth century, the Episcopal Church was still making strenuous attempts to increase the size of its congregation. However, the biographers of Alexander Forbes describe him as a humane man who took his pastoral duties seriously.⁵¹ A. Drummond and J. Bulloch comment that 'he lived in simplicity and poverty and worked unsparingly amongst

⁴⁷ GCA TD.432/13, *Annual Report of the Glasgow Abstainers Union*, 1871, p. 6.

⁴⁸ Jane Ogilvy (1809-1861) was the third daughter of the Sixteenth Earl of Suffolk and Berkshire. In addition to co-founding the Dundee Convalescent House, her philanthropic interests included founding a Home for prostitutes and the 'Baldovan Orphanage and Asylum for Idiot Children'. She died in 1861, only eight months after the opening of the Dundee Convalescent Hospital.

⁴⁹ R. Strong, *Alexander Forbes of Brechin* (Oxford, 1995), p. 234; W. Perry, *Alexander Penrose Forbes* (London, 1939), pp. 74-75; A. Drummond and J. Bulloch, *The Victorian Church in Scotland* (Edinburgh, 1975), pp. 210-211. Alexander Penrose Forbes (1817-1875) was the son of a prominent lawyer John Hay Forbes, who later became Lord Medwyn. He went first into the East India Company but returned to Britain in 1840 due to ill health and while still on paid sick leave, entered Brasenose College, Oxford. Following his studies at Oxford, he entered the ministry of the Episcopal Church and eventually became Bishop of Brechin in 1847. Despite this elevated position in society Bishop Forbes lived amongst the poor. He initiated various social projects including a model lodging-house for mill girls, an agricultural school for boys, an institution for training schoolmistresses. Although his religious views sometimes caused controversy biographers stress the significant contribution made by Bishop Forbes to the revival of the Scottish Episcopal Church in Dundee.

⁵⁰ F. Goldie, *A Short History of the Episcopal Church in Scotland* (London, 1951), p. 60.

⁵¹ D. Mackay, *Bishop Forbes, a Memoir* (London, 1888), pp. 89-94; J. D. Mowat, *Bishop A. P. Forbes* (Edinburgh, 1925), p. 65-66; W. Perry, *Alexander Penrose Forbes* (London, 1939), pp. 74-76; R. Strong, *Alexander Forbes of Brechin* (Oxford, 1995), pp. 64-80; F. Goldie, *A Short History of the Episcopal Church in Scotland* (2nd Edition, Edinburgh 1871), pp. 109-111.

the poor.’⁵² His residence amongst the urban poor rather than the middle-classes point towards humanitarianism. It is therefore unlikely that initiating social projects to attract membership into the congregation was the sole reason why Bishop Forbes established the Dundee Convalescent House. However, Drummond and Bulloch also observed ‘his Episcopal duties were slight’.⁵³ This allowed Bishop Forbes the time to become involved in numerous social projects. The lack of interest demonstrated by subsequent bishops of the Episcopal Church when they inherited the Dundee Convalescent House in 1878 also suggests that the convalescent home was a low priority in their search for the reclamation of souls.

Evangelism was also only part of the reason for sponsorship of the Mission Coast Home at Saltcoats. A letter written by James Smith, one of the founders in 1871, indicates that the convalescent home expanded because of demand for admission and not simply to increase efforts to evangelise. In this letter Smith stated: ‘we never expected or sought such a work that has now forced itself upon us. Yet, without seeking it, the work grows in every direction in an ever-increasing demand for admission.’⁵⁴ Further comments from Smith re-iterates his belief in the dual role of the Mission Coast Home with a statement that ‘men, women and children are receiving benefit for their bodies and not a few are obtaining blessings to their souls.’⁵⁵

None of the religious/temperance homes made membership of their organisations a condition of entry to their convalescent homes although attendance at church services or mission meetings probably helped. The Dundee Convalescent House was particularly concerned to publicise their non-sectarian admission policy. Their first annual report stated: ‘It must be recollected that the assistance rendered to convalescents is restricted to no single class of person, but extended to all, without

⁵² A. Drummond and J. Bulloch, *The Church in Victorian Scotland, 1843-1874* (Edinburgh, 1975), p. 211.

⁵³ *Ibid*, p. 210.

⁵⁴ *Ardrossan and Saltcoats Herald*, 14 October 1871, p. 4.

⁵⁵ *Ibid*.

restriction of creed.’⁵⁶ However, the annual report of 1865 suggests a challenge to their liberal admission policy with the comment that ‘there has sometimes been a misapprehension as to the catholicity of the institution.’⁵⁷ Following this, until 1870, the Dundee Convalescent House published tables proving the variety of religious denominations amongst their patients. These revealed that, between 1865 and 1870, there were one hundred and thirty eight Presbyterians, one hundred and eighteen Episcopalians, seventy-two Roman Catholics, and fifteen who were either dissenters or not recorded, admitted to the Dundee Convalescent House. Nevertheless, in 1867, there were further suggestions of challenge to the catholicity of the admission policies. In the annual report, Alexander Forbes reprinted a letter originally published in the *Dundee Advertiser*. This letter stated that,

I have never allowed religious preferences to enter into the question of the selection of patients. We take those who are sent to us from the infirmary, or who are put in by private individuals on payment without reference to creed. Patients, when inmates, are free to receive visits from their own ministers; and when well enough, have permission to go to their own places of worship.⁵⁸

The fortunes of the religious/temperance homes were mixed. Although Kilmun and the Mission Coast Home, Ashgrove CH, and Ravensraig CH developed into substantial convalescent homes, Hawthornbrae CH remained relatively small. As previously mentioned, following the death of Bishop Forbes, there was less interest from subsequent Episcopal bishops in the Dundee Convalescent House, and it eventually closed in 1911.

Mutual Assurance CHs

From around the turn of the century, self-help or mutual assurance groups took over as the main providers of new convalescent homes. The shift towards sponsorship

⁵⁶ THB 13/1/1, *First AR, Dundee Convalescent Hospital*, 1861, p. 7. In the following year this Home was renamed as the ‘Dundee Convalescent House’.

⁵⁷ THB 13/1/1, *Fifth AR, Dundee Convalescent House*, 1865, p. 8.

⁵⁸ THB 13/1/1, *Seventh AR, Dundee Convalescent House*, 1867, pp. 5-6.

from mutual assurance societies reflects the increasing demands placed upon employees, either by government legislation or attitudes within society, to provide for insurance against sickness or unemployment.⁵⁹ There were three types of sponsor in the mutual assurance or self-help groups: the Co-operative Society; the friendly societies and occupational schemes. The reason why these three groups established convalescent homes represented an important development because they did not regard the homes as a charity, but as a benefit to encourage and sustain membership. However, there may also have been demands for the provision of convalescent homes by members as they had gained in popularity by the twentieth century, particularly amongst the Co-operative and friendly societies. In total, there were twelve convalescent homes identified amongst the self-assurance convalescent homes. Six were established through occupational schemes, three by the Co-operative Society and three by friendly societies. Understanding the methods used to establish the convalescent homes in this group has complexities that are best understood in relation to events that affected the homes in the twentieth century. Chapter Three therefore deals with further issues relating to homes sponsored through self-assurance schemes.

Extent of Distribution

Whereas the foregoing text explored why the various sponsorship groups established convalescent homes, this section examines the extent of convalescent home provision. It uses the annual number of patients admitted to the convalescent homes rather than beds to provide a more realistic indicator.⁶⁰

⁵⁹ J. Harris, 'Victorian Values and the Founders of the Welfare State', in T. C. Smout, ed., *Victorian Values* (Oxford, 1992), pp. 178-182.

⁶⁰ See pp. 15-16 of this thesis for discussion on using beds as an indicator of provision.

Table 1.6 Annual admission rates of patients to convalescent homes between 1871-1934 (eight to twelve year intervals)

	Rel/ Temp	Hospital	Ind	Co-op	FS	Occ	Total patients
(f) 1871	689	1099	2212	0	0	0	4000
%	17	27	56	0	0	0	100
(f) 1881	1008	2051	5458	0	0	0	8817
%	11	23	63	0	0	0	100
(f) 1892	1416	2204	8475	0	0	0	12095
%	12	18	70	0	0	0	100
(f) 1900	2313	5054	9959	2406	0	0	19732
%	12	26	50	12	0	0	100
(f) 1912	2330	5872	11820	4359	225	0	24606
%	13	18	45	22	1	1	100
(f) 1924	2713	6188	11547	5982	1200	3550	28980
%	9	20	37	19	4	11	100
(f) 1934	3340	7102	12203	5400	1200	4107	34452
%	10	23	35	16	3	12	100

Source: Data extracted from database described in Appendix A. The AAI has not been included in these figures because it offered a high level of active treatment and patients remained for long periods. It therefore fell outside the criteria for a traditional convalescent home

Table 1.6 highlights both the total number and percentage of patients admitted annually, at eight to twelve year intervals, within each sponsorship group. This table indicates that the number of patients admitted annually to the convalescent homes rose from 4,000 patients in 1871 to 34,452 patients in 1934. Table 1.6 also highlights the greater percentage of patients in independent convalescent homes during the nineteenth century, when it was over 50%. During the 1930s when there was a rise in sponsorship by mutual assurance societies, this figure fell to 35%. This table also illustrates that although the hospitals were important in terms of overall provision of convalescent homes, they were far less significant than the independent sponsors. Between 1871 and 1934, the percentage of patients in hospital convalescent homes averaged less than 23%, far less than the 33% represented by surveys when using bed numbers as the indicator. It also demonstrates that, from around 1912, the Co-operative Society convalescent homes admitted annually almost as many patients as the total number admitted to the hospitals convalescent homes. This was despite the fact that the Co-operative Society only had three convalescent homes. Table 1.6 also reveals a significant growth in the number of patients in the occupational group. By 1934 this had risen to four thousand, one hundred and seven.

Figure 1.3 provides a further illustration of the annual growth of patients admitted to convalescent homes between 1860 and 1939. It indicates the growth rate within their sponsorship groups in six to ten year intervals. This indicates that, during the twentieth century, despite having only three convalescent homes before 1939, the Co-operative Society was significant in terms of convalescent homes provision. This was also the case amongst the religious/temperance convalescent homes. Although there were only six homes in this group, by 1934 they still provided 10% of all the admissions to convalescent homes (Table 1.6). Figure 1.3 also illustrates the lesser significance of the hospital convalescent homes compared to the other groups. In addition it indicates the greater significance of the independent homes and the close relationship between hospital and co-operative convalescent homes in terms of overall provision after 1912.

Even more significant were the results of a comparison between the largest independent convalescent home, the Dunoon Homes, and the total annual number of patients in the voluntary hospitals.

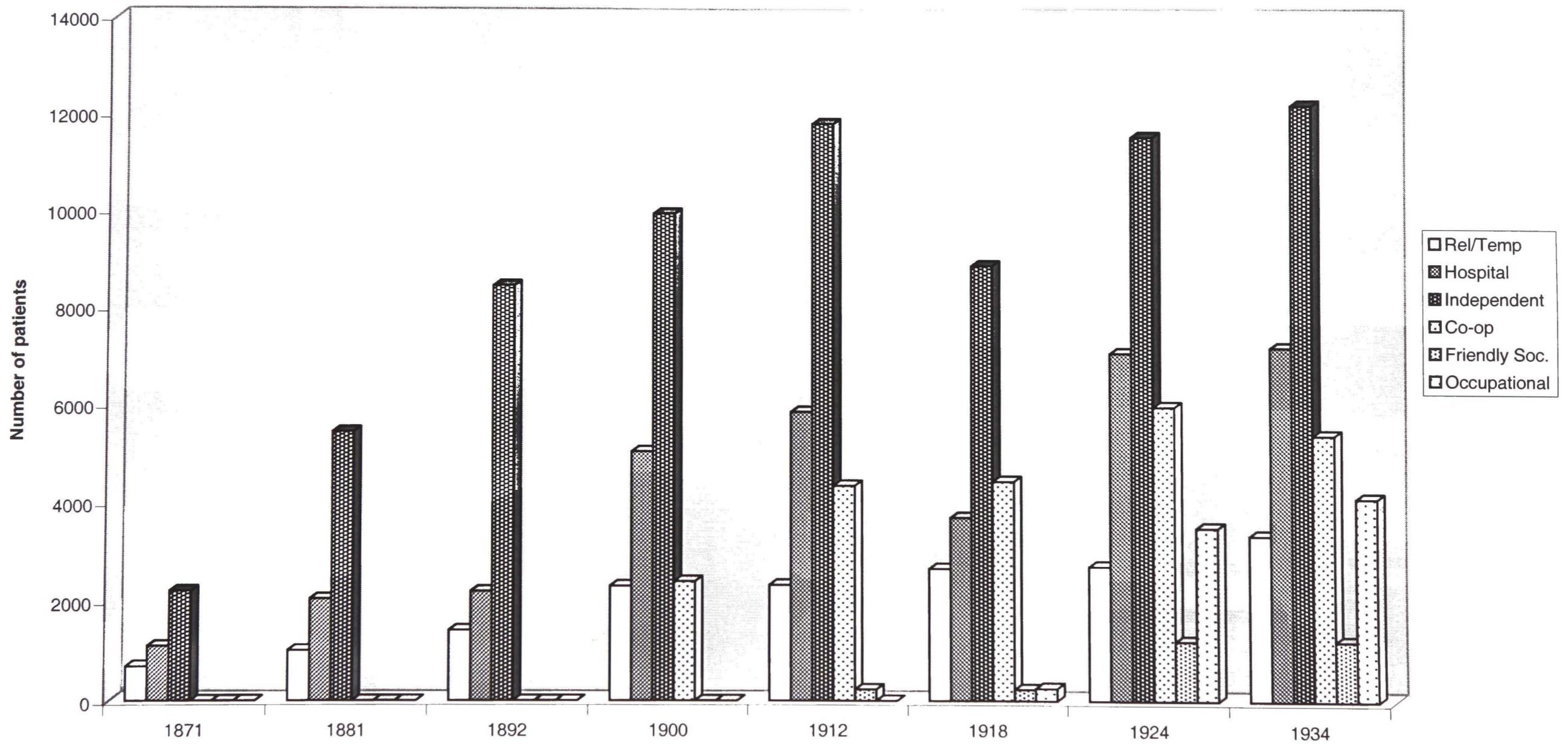
Table 1.7 Comparison of annual numbers of patients in hospital convalescent homes with Dunoon Homes

Year	Total Dunoon Homes patients	Total hospital patients
1871	964	1,099
1881	2,367	2,051
1892	3,327	2,204
1900	4,110	5,054
1912	4,981	5,872
1918	3,372	3,707
1924	5,410	6,188
1934	5,200	7,102

Source: Database compiled from sources described in Appendix A.

Table 1.7 illustrates that the annual patient intake at the Dunoon Homes often equalled or exceeded the annual number of hospital convalescent home patients, particularly in the years 1881 to 1892. This highlights the importance of the Dunoon Homes in the overall provision of convalescent facilities. It is an important point for later discussion on the *Scottish Hospital Survey* in Chapter Three because this survey

Figure 1.3: Growth in the annual number of patients during intervals of 8 to 12 years between 1871 and 1934



Source: From database described in Appendix A.

excluded many important convalescent homes such as the Dunoon Homes and another large non-hospital convalescent home, Kilmun.

Geographical Distribution

Although the Glasgow infirmaries provided the least number of convalescent homes, when non-hospital convalescent homes were included, provision was proportionally far higher in the Glasgow area than any other area in Scotland.

Table 1.8 Population of Glasgow, Edinburgh, Dundee and Aberdeen 1861-1931

	1861	1891	1911	1931
Glasgow	394,864	564,981	599,614	1,027,419
Edinburgh	168,121	261,225	293,491	322,465
Dundee	90,417	143,051	160,146	175,585
Aberdeen*	73,905	122,002	152,463	154,835

Source: Census returns for 1861, 1891, 1911 and 1931: Glasgow, Edinburgh and Dundee are the parliamentary Burgh figures. The Aberdeen figures were obtained by subtracting the total Aberdeen Burgh population from the Aberdeen City population figures.

Table 1.8 indicates the extent of the demographic variance between Glasgow and the other major urban areas in Scotland: Edinburgh, Dundee and Aberdeen. It illustrates that Glasgow consistently had a population at least three times that of other urban areas in Scotland. However, when the annual number of convalescent home patients was compared with the overall population in the four urban areas, in 1871 and 1934, the proportion of convalescent home patients to the general population was still far higher. The higher population of Glasgow was therefore a less convincing explanation for the higher number of convalescent home patients.

Table 1.9 Comparison between the general population and annual number of patients from four major Scottish cities admitted to convalescent homes in 1871 and 1934

	1871		1934	
	General Population %	CH population %	General. Population %	CH population %
Glasgow	53	85	62	74
Edinburgh	23	12	19	17
Dundee	14	03	10	06
Aberdeen	10	N/A	09	03
	100%	100%	100%	100%

Source: *General Population %*: The information in columns under this heading is the total population in the parliamentary burghs of Glasgow, Edinburgh and Dundee and taken from the census returns, 1871 and 1931 being the nearest accurate population figures to the sample dates of annual convalescent home patients. In the absence of parliamentary burgh figures for Aberdeen comparative figures were obtained by subtracting the total annual Aberdeen burgh population numbers from Aberdeen City population figures. *CH %*: These figures are taken from my database collected from a variety of sources including *Burdett's* and annual reports of convalescent homes.

Table 1.9 indicates that in 1871, Glasgow had 53% of the total general population of the four cities (Edinburgh had 23%, Dundee 14% and Aberdeen 10%). By contrast, Glasgow had 85% of the total number of convalescent home patients, Edinburgh had 12% and Dundee had 3%. There were no convalescent homes in Aberdeen in 1871. However, by 1934, the picture had changed, and Glasgow's proportion of the general population had risen to 62%, while Edinburgh's proportion had fallen to 19%, Dundee's to 10% and Aberdeen's to 9%. The proportion of the convalescent home patients had fallen in Glasgow to 74%, whereas in Edinburgh, Dundee and Aberdeen it had risen. Therefore, by the 1930s although there was a more even distribution of convalescent home provision throughout Scotland, the highest proportion was still in the area around Glasgow. The higher level of population of Glasgow is therefore not a sufficient explanation for the higher proportion of convalescent home patients in the area. Neither can the extent of poverty in Glasgow explain the disproportionate number of convalescent patients, because conditions amongst the working class in Dundee were equally poor.⁶¹ Yet the proportion of convalescent home patients in Dundee was similar to that found in Edinburgh and Aberdeen.

⁶¹ C. Whatley, *Life and Times of Dundee* (Edinburgh, 1993), pp. 103-107; C. Whatley, *The Industrial Revolution in Scotland* (Cambridge, 1997), p. 85.

Maps 1, 2 and 3 indicate more clearly changes in the distribution of convalescent homes between 1870 and 1935. Map 1 illustrates the small number of convalescent homes in 1870 (seven), all clustered in the West of Scotland. Dundee and Edinburgh were the only other areas with a convalescent home. Map 2 shows the growth of convalescent homes by 1890 in the West of Scotland and elsewhere, particularly Aberdeen. Map 3 reveals that by 1935, despite far greater dispersal of convalescent home in Eastern and Southern Scotland, there was also an increase in size and number of convalescent homes in the West of Scotland.

In order to exclude the possibility of the admission by convalescent homes of patients from outside the West of Scotland as the reason for the higher annual convalescent home population, I examined the origin of patients in the Dunoon Homes as a representative home. In two sample years of 1885 and 1939, nearly all the patients admitted to the Dunoon Homes originated from the West of Scotland. In 1885, out of a total of 2,779 patients admitted during the year, only twenty-nine were from places other than the West of Scotland. There were seventeen patients from Edinburgh, two from Perth, three from Dunfermline, two from Tillicoultry and five from Falkirk.⁶² In 1939, when the total admission figures for that year was 5,572 patients, there were seven patients from Edinburgh, three from Dundee and fifty-five from other unspecified districts.⁶³ It is therefore extremely unlikely that the admission of patients from outside the area accounts for the higher proportion of patients in convalescent homes in the West of Scotland.

However, the higher level of philanthropy involved in providing convalescent homes does support Olive Checkland's observation that the charitable response from the middle classes towards the poor was demonstrably higher in Glasgow than other

⁶² ML G.362.160941435, *Sixteenth Annual Report of the West of Scotland Convalescent Seaside Homes*, Dunoon, [hereafter *WSCSH*], 1885, p. 12. This convalescent home was commonly known amongst contemporaries as 'the Dunoon Homes'. It changed its name in the 1930s to include Glasgow. See Appendix C for details.

⁶³ ML G.362.160941435, *Seventieth Annual Report of the Glasgow and West of Scotland Convalescent Seaside Homes*, [formerly *WSCSH*] 1939, p. 12.

Map 1.

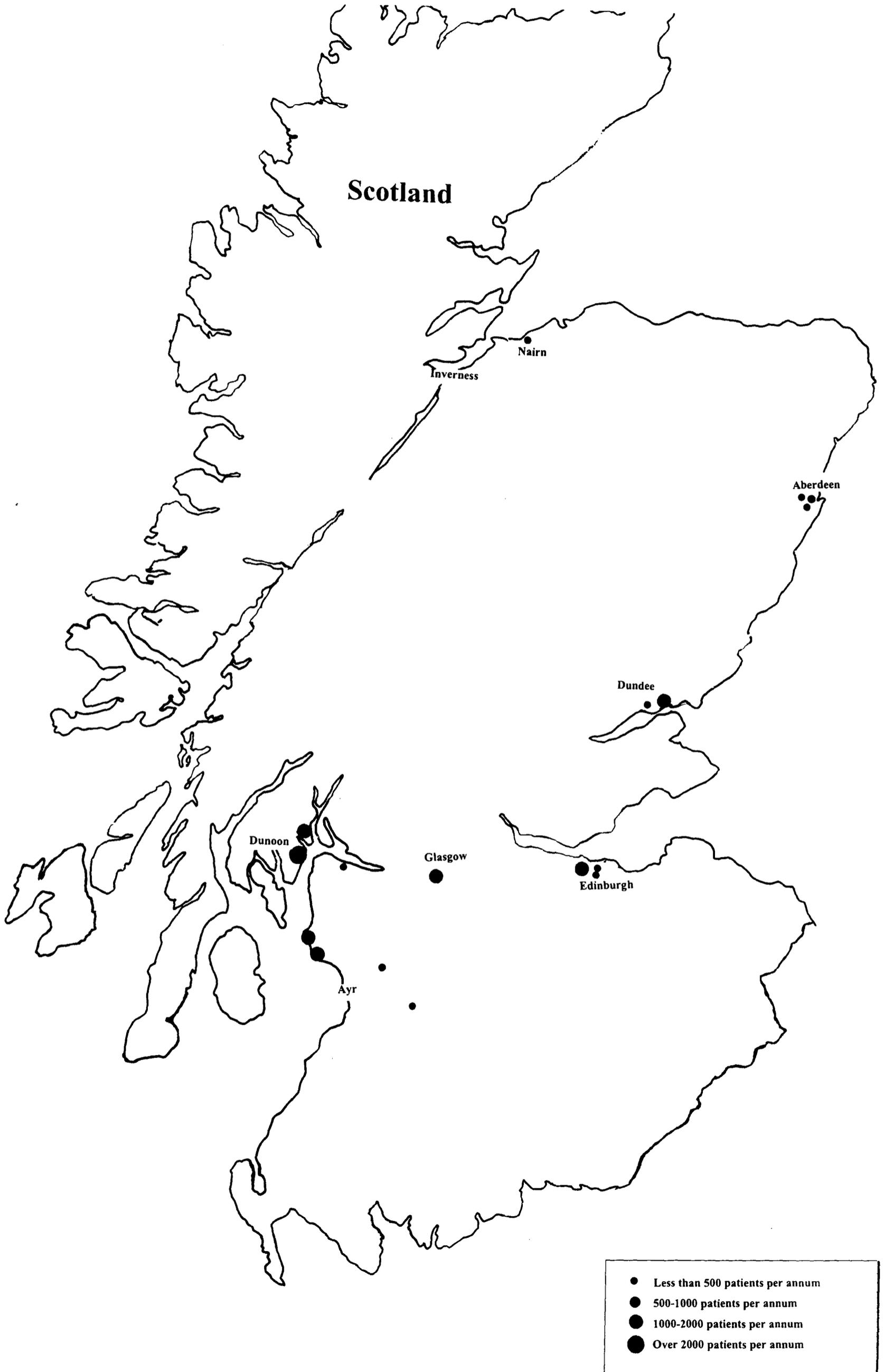
Distribution of convalescent homes in Scotland in 1870



Source: Database from extracted sources described in Appendix A

Map 2.

Distribution of convalescent homes in Scotland in 1890



Source: Database from extracted sources described in Appendix A



Source: Database from extracted sources described in Appendix A

towns and cities in Scotland.⁶⁴ Checkland explains this anomaly as due to Glasgow's predominance in commercial activities. She observes that ameliorative social action rested upon the commercial, merchant and industrial classes, and comments that religious evangelism motivated the philanthropy of Glasgow. Checkland remarks that 'generous Glasgow' was a well-known phrase, and appeals made in the city rarely fell on deaf ears.'⁶⁵ This question clearly needs further research but is outwith the scope of this thesis. Nevertheless, the presence of very large convalescent homes such as the Dunoon Homes and Kilmun, partly explains the higher proportion of convalescent home patients in the Glasgow area.

Age and Gender of Patients

This section examines the gender and age structure of the patient. The GCH and the Dunoon Homes were the only two convalescent homes with records that provided consistent and comparable figures on the age structure of their patients.

Table 1.10 Age ranges of patients at GCH and Dunoon Homes between 1881-1939

	1881 GCH %	1884 Dunoon Homes %	1893 GCH %	1901 Dunoon Homes %	1936 GCH %	1939 Dunoon Homes %
Under 5	1	4	1	2	0	16
5-15	13	10	10	6	15	17
15-30	45	41	36	38	26	18
30-50	29	29	31	32	26	22
Over 50	14	16	20	22	33	27

Source: *Annual Reports for GCH, 1881, 1893, 1936, Annual Reports for Dunoon Homes, 1884, 1891 and 1939*

Table 1.10 illustrates changes in the age structure at the GCH and the Dunoon Homes between 1881 and 1939. This indicates a rise in the numbers of patients in the five to fifteen age group in both homes. The percentage increase in the under-five age group was consistent with the response to the increased national concern over maternal and child health during the twentieth century. It is less easy to understand why the fifteen

⁶⁴ Checkland, *Philanthropy*, p. 312.

⁶⁵ *Ibid*, pp. 312-3. The influence of Thomas Chalmers is another possible explanation for the higher level of charitable giving amongst Glasgow citizens. He encouraged and systemised charitable giving amongst the better off earlier in the nineteenth century.

to thirty age groups had dropped from 41% in 1884 to 26.5% in 1936. Overall, there were only a few changes in the thirty to fifty age group. There was a slight rise in 1893/1902 but this fell again during the 1930s. The rise in the over-fifty age group is mostly explained by the greater longevity within the population during the twentieth century. Overall, the rise and fall in ages of patients between 1882 and 1939 were consistent at both the Dunoon Homes and the GCH.

Kilmun was the only other convalescent home to publish information on age structure. Although their method of assessment was slightly different, it was possible to observe a similar trend in the age structure of patients at the Dunoon Homes and GCH. A comparison between 1880 and 1913 at Kilmun revealed that they admitted 8% of under fourteen or fifteen year-olds. The percentage of fourteen or fifteen to twenty-five year olds dropped from 38% to 17% between 1880 and 1913. However, the greatest change occurred in the twenty-five to sixty age group. This was 36% in 1880 and 59% in 1913. This age group included twenty-five to sixty year-olds whereas in 1880 it was twenty-five to fifty-five year-olds. This may account for a fall in the older age group from 19% in 1880 to 16% in 1913. Clearly further research is necessary into this aspect of convalescent home provision but if the Dunoon Homes, GCH and Kilmun are indicative of the age structure then overall the largest group were young adults. During the twentieth century, although there was an increase in the age of patients, the over-sixties were still in a minority.

Although some of the convalescent homes, such as the Dundee Convalescent House (female only) and Kirkmichael CH (for male miners) were single sex, most accepted both sexes. However, the gender division was not necessarily equal. At the GCH, men always outnumbered women. This was mainly due to the high proportion of employee subscriptions (mostly male employees) that allowed men easier access to the convalescent homes. However, this was not the case at Kilmun where admission did not necessarily depend upon a subscriber's letter and there was therefore no bias towards the admission of male patients. This explains why there were usually slightly more women than men at Kilmun throughout the period 1870-1939. By contrast, at

Corstorphine House during the nineteenth century there were more male than female patients. Figure 1.4 indicates constantly higher numbers of male patients until the 1930s. After this time female patients dominated. This reflects the findings illustrated in Table 4.1 found later in this thesis. This table shows that the number of female patients admitted to Corstorphine House with gynaecological conditions between 1881 and 1939 doubled.⁶⁶ At Seamill, there were only slightly more men admitted than women in 1900 and 1902. In both years, male patients exceeded female patients by only 6%. There was no significance therefore drawn from the small variation, particularly as comparative figures were not available for later years.⁶⁷ In summary, the explanation for variations in gender division at other convalescent homes, was influenced by the policies regarding subscribers or the gender intake of parent infirmary, as at Corstorphine House.

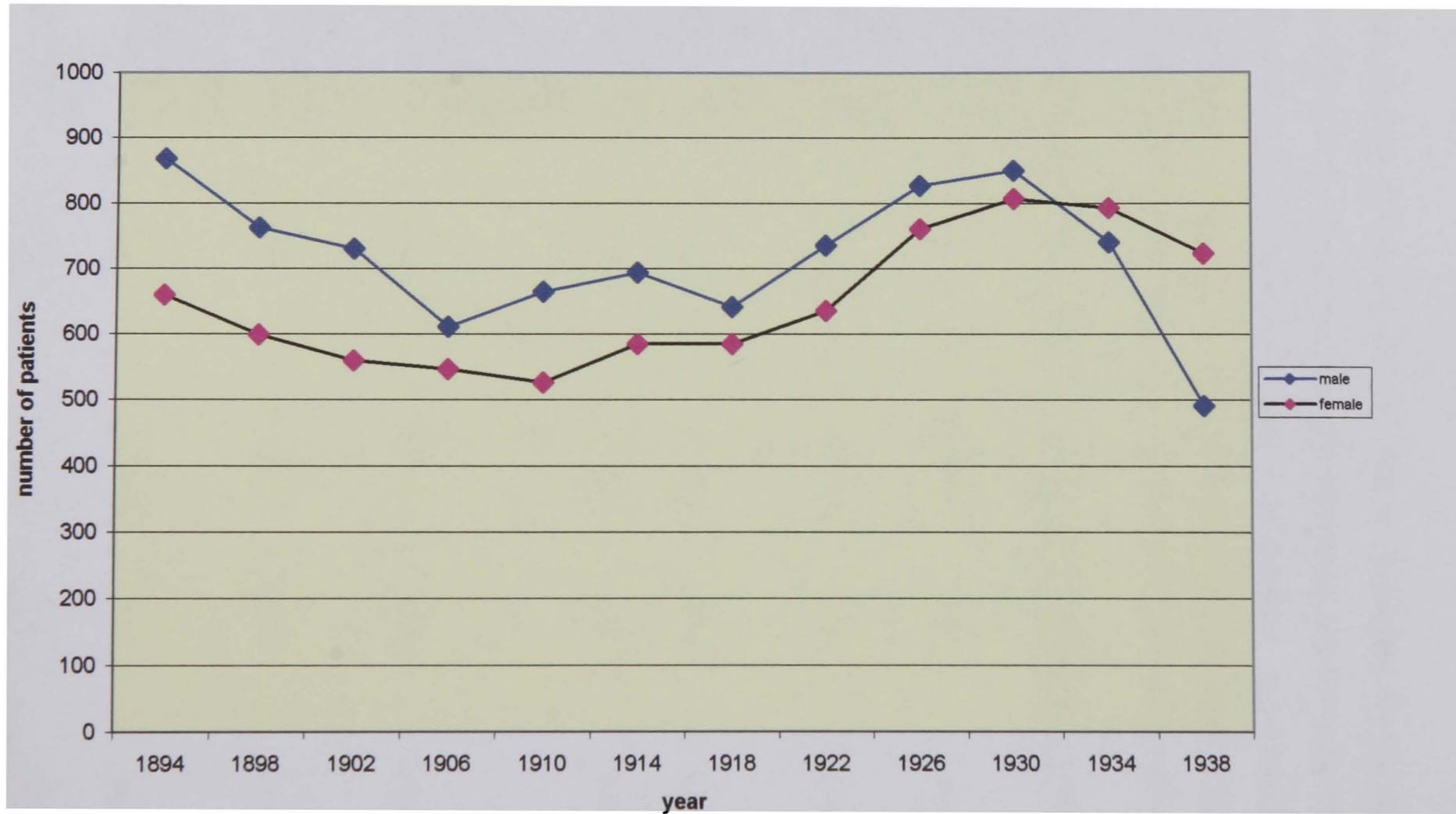
Closure of Convalescent Homes

Once opened, most of the convalescent homes established between 1860 and 1939 were still functioning after the Second World War. Table 1.10 records the names of the non-survivors, describing their name, year of foundation, closure, category, size and the reasons why they closed.

⁶⁶ Table 4.1 is in Chapter Four, p. 161.

⁶⁷ GGHB HB6/4/55, *Eighth Annual Report of the Scottish Co-operative Convalescent Seaside Homes Association Limited, Seamill*, 1900, p. 5 and *Tenth AR, Co-operative Seaside Homes*, 1902, p. 7.

Figure 1.4: Variation in gender at Corstorphine House between 1869 and 1939



Sources: Annual reports of the Royal Infirmary of Edinburgh 1869-1939

Table 1.11 Convalescent homes that closed before the Second World War

Name of Home	Year of Foundation	Year of Closure	Category	Size	Nearest City	Reason for Closure
Manderston CH	1908	NK	Independent	VS	Edinburgh	Disappeared from records
Paisley CH (First)	1869	1876	Hospital	S	Glasgow	Disagreement with the benefactor over temporary use as a smallpox hospital
Campie CH	1889	1890	Municipal	S	Edinburgh	Disappeared from records, but may have been a temporary fever convalescent home
Ailsa CH	1888c	1894	Independent	VS	Glasgow	When the benefactor and Manager, the Marchioness of Ailsa died, the CH disappeared from records.
Dundee CH	1860	1911	Religious	VS	Dundee	Converted to a convalescent fund
Lochend	1895	1918	Hospital	VS	Inverness	Inconvenient location and staff difficulties during the First World War
Garscube CH	1922	1924	Hospital	VS	Glasgow	Home sold and funds used to support of two beds at Dunoon Homes
Eidda CH	1880	1925	Independent	VS	Aberdeen	Aberdeen Children's Hospital stated that it was no longer required.

Abbreviations: S (Small, 2-500 patients annually) VS (Very Small, less than 200 patients annually)

The table reveals that there was a spread of non-surviving convalescent homes within different sponsorship group and geographical location. The first convalescent home to close was the Paisley CH. Established in 1869, it closed only seven years later following a dispute between the benefactor, James Arthur⁶⁸ and the managers of the parent hospital, the Paisley Infirmary. Arthur objected when the Infirmary Managers

⁶⁸ GGHB HH/70/2/7, *Eighty-eighth Annual Report of the Paisley Infirmary*, 1873, p. 4; HH/70/7, *Minute Books on the Paisley Infirmary*, 1 December 1873.

decided to take over the convalescent home as a temporary smallpox hospital.⁶⁹ The Infirmary managers insisted and settled the dispute by returning Arthur's original donation of £742.⁷⁰ The second home, Campie House, was a convalescent home for fever patients. The origins and development of this Home are not entirely clear but it may have been a temporary convalescent home established during an epidemic.⁷¹ These two homes, although small in comparison to the Dunoon Homes and Kilmun, still had an annual admission rate of around four to five hundred patients. However, the others that closed were very small and admitted less than two hundred patients annually. The smaller homes simply disappeared from the records or were replaced by a convalescent fund.⁷² This suggests that size may have been a contributing factor, particularly as they often depended on a single individual for management, leaving no successor when the manager died or retired. This was the case with the Ailsa CH and the Dundee Convalescent House, where both were under sole management. Ailsa CH was managed by the Marchioness of Ailsa and the Dundee CH by Bishop Alexander Forbes.

Also, when a small convalescent home closed, it was less likely to encounter opposition from within the community because the impact was low. For example, Bona, the convalescent home of the Northern Infirmary, a small home at Lochend, admitting less than two hundred patients annually, closed in 1914. The reasons given for the closure were staff problems due to the First World War, combined with difficulties associated with the remote location of Lochend.⁷³ The impact of the closure of this relatively small home created few difficulties for the infirmary, and a neighbouring convalescent home at Nairn CH absorbed the patients. By contrast, larger homes such as the Dunoon Homes and Kilmun, that had powerful management teams, attracted higher levels of funding and support, thus contributing to their

⁶⁹ James Arthur was a wealthy Paisley wholesaler. See: O. and S. Checkland, *Industry and Ethos* (Edinburgh, 1989), p. 15.

⁷⁰ Dow, *Paisley Hospitals*, p. 25.

⁷¹ *BMJ*, July 1889, p. 1248. Because it seems that Campie House was a temporary convalescent home with few records available, it was not included in the statistics for the survey.

⁷² The Dundee Convalescent House was sold in 1911 and replaced by a convalescent fund. I am grateful to the current Bishop of Brechin for this information.

⁷³ HHB 1/5/4, *Annual Report of the Royal Northern Infirmary*, 1918, p. 7.

success. Had these homes closed, the impact would have been far greater. The larger homes therefore found success and survival easier than the smaller homes.

Conclusion

In summary, the survey revealed that between 1860 and 1939, a variety of individuals and organisations sponsored over sixty new convalescent homes. In order to expand our understanding of the variations in sponsorship, the convalescent homes were categorised according to their type. The six types identified were: independent; hospitals; religious/temperance; Co-operative Society; friendly societies and occupational schemes. Further examination of the sponsorship groups revealed that independent and hospital providers sponsored the majority of convalescent homes. However, because the homes varied considerably in size it was important to examine the overall number of patients in each sponsorship group. The results revealed that the annual number of patients admitted to independent homes over the whole period averaged 50% but in the hospital convalescent homes, it was less than 23%. It also emerged that Co-operative Society homes admitted nearly as many patients annually as the hospital convalescent homes. Another unexpected result was that the annual number of patients admitted to the Dunoon Homes on several occasions equalled or exceeded the annual intake of patients in hospital convalescent homes. This emphasised the importance of examining the annual admission rates of patients alongside the actual number of convalescent homes.

The survey also identified two major periods of activity in establishing new homes. The first occurred at the end of nineteenth century when their success in returning the sick poor to health made them a popular focus for philanthropists. The second period occurred during the 1920s when there was an increase in the number of convalescent homes established through occupational schemes. The results of the survey also concluded that the distribution of convalescent homes and patients was geographically unbalanced and skewed towards Glasgow. The larger population of Glasgow did not explain this anomaly. However, the convalescent homes in the West of Scotland were much larger than in other parts of Scotland.

There were some differences in admission of male and female patients between homes. This tended to be associated with either influence from subscribers or variations in the patient intake at hospital convalescent homes. During the nineteenth century patients in convalescent homes were younger than in the twentieth, and only a minority were over sixty years of age. Once established, most homes continued to flourish until after the Second World War. The convalescent homes that closed were mostly quite small, and their size might therefore have contributed to their closure. The aim of this chapter was to provide a basis for understanding aspects of the development and growth of convalescent homes. The next chapter will take this exploration a stage further, and examines the methods used to establish the convalescent homes.

Chapter Two

Origin, Influence and Development in the Nineteenth Century

If you have in a community a class of people who are accustomed to pass through the depths of physical depression and suffering without help, or even sympathy, you have people who are brutalised in all their relationships, who have no respect for human life, and are at war with society.¹

This potent warning from Glasgow's Medical Officer for Health, James Burn Russell in 1890, about the dangers of ignoring the problems encountered by the sick poor targeted both the sympathetic and the fearful.² His message was typical of radical opinions expressed by influential reformers and commentators during the nineteenth century. Russell was just one of many influential personalities involved in the development of convalescent homes. Yet there is little comment within the literature on the influence of public figures, the collaboration between individuals and the plethora of promotional activity that often accompanied their foundation. Instead, authors often attribute the founding of a convalescent home to just one or two people. For example, A. Logan Turner commented that 'in July, 1864, a welcome offer was made by an anonymous benefactor to build and present to the Infirmary a Convalescent House.'³ Similarly, Olive Checkland notes that, 'in July 1864, William Seton Brown offered the Edinburgh Royal Infirmary a convalescent home on condition that the managers would take it over and maintain it.'⁴ However, the offer from Seton Brown was not a spontaneous gesture. In reality, the managers of the RIE

¹ J. B. Russell, 'Overlapping of Charitable Funds'. A paper given at conference organised by the COS in 1882.

² Public lectures given by Russell, such as 'Life in One Room' and 'The Children of the City', although not directly aimed at convalescent homes, nevertheless highlighted the plight of the appalling living conditions experienced by the poor and also supported the idea of removing city children for short periods into the country.

³ A. Logan Turner, *Story of a Great Hospital, the Royal Infirmary of Edinburgh* (Edinburgh, 1937), p. 175.

⁴ O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p. 216.

were actively seeking a benefactor to provide a convalescent home for many years beforehand.⁵ In another example, Loudon MacQueen in his *History of the Western Infirmary of Glasgow*, referred to William Hozier as the founder of their convalescent home, the Hozier Home. Neither does he mention previous concern expressed by the managers in the annual reports over the lack of convalescent facilities for the patients.⁶ Furthermore, MacQueen did not comment on the anonymous approach made to Sir William before he offered to establish a convalescent home for the Western Infirmary.⁷ In the non-hospital convalescent homes, promoters such as Beatrice Clugston, (founder of the GCH and Dunoon Homes) and Bishop Alexander Forbes (founder of the Dundee Convalescent House) received the credit for establishing convalescent homes. But in order to accomplish their task they needed considerable help in funding and setting-up the Home. The attention given to the main promoters or benefactors of a convalescent home therefore often hid the voluminous activity surrounding their establishment.

This chapter examines more closely the activity that usually surrounded the foundation of convalescent homes during the nineteenth century. It also unravels the mechanisms used by the promoters to establish a convalescent home. However, the main focus is on the development of hospital, independent and religious/temperance convalescent homes during the nineteenth century. This reason for this approach is because the issues that influenced their sponsors were different from those of the twentieth century.⁸ This chapter also discusses the individuals and organisations that, although not directly involved in establishing convalescent homes, were nevertheless, a major influence upon their development. In addition, this chapter examines the financial and administrative aspects of the convalescent homes. Although the focus of the chapter is upon the development of convalescent homes in the nineteenth century, some aspects of their finance inevitably extend into the twentieth century. In

⁵ LHB 1/4/55-63, *Annual Reports for the Royal Infirmary of Edinburgh*, 1858-1863.

⁶ L. MacQueen and A. Kerr, *The Western Infirmary, 1874-1974* (Glasgow, 1974), p. 16.

⁷ Opening of the Lady Hozier Convalescent Home, Lanark', *Glasgow Herald*, 11 July 1893, p. 3.

⁸ The other sponsorship groups, Co-operative Society, friendly society and occupational, were established either very late in the nineteenth or during the twentieth century.

order to provide a background to the establishment of convalescent homes of the nineteenth and twentieth centuries, I will introduce the chapter by examining some of the institutions providing convalescence services before 1860.

Institutions providing convalescence before 1860.

Dr John Bryant, a recognised authority on convalescence during the 1920s, described two convalescent hospitals established in the seventeenth century at the Hotel-Dieu in Paris in 1640 and the Charite in 1659.⁹ During the eighteenth century, these French convalescent institutions gradually fell into disuse. Nevertheless, they illustrate that the first convalescent homes of the mid-nineteenth century were not entirely innovative. Although there are no records of similar convalescent institutions to those in France existing in Britain before the mid-nineteenth century, during the Reformation, the early hospitals cared for a range of vulnerable individuals.¹⁰ These included the chronic sick, aged, travellers and disabled and might also have catered for convalescents, since both institutions emphasised care rather than cure. Barbara Harvey, in her work on *Living and Dying in England, 1110-1540*, mentions that following illness monks sometimes went to monastic houses in the countryside to convalesce.¹¹ This indicates that convalescence was a recognised concept during the Middle Ages in which monastic houses were actively engaged in caring for convalescents.

Elizabeth Gardiner suggests that in England the first move towards institutions specifically for convalescence originated with the foundation of Bellott's Mineral

⁹ J. Bryant, *Convalescence, Historical and Practical* (New York, 1927), pp. 10-11.

¹⁰ For accounts of early hospitals see: R. A. Clay, *The Medieval Hospitals of England* (London, 1909), pp. 104-142; M. Risley, *The House of Healing* (London, 1962), pp. 111-116; N. Orme and M. Webster, *The English Hospital 1070-1570* (London and New Haven, 1995); R. Miri, 'Development and Change in English Hospitals, 1100-1500' in Lindsay Granshaw and Roy Porter, eds., *The Hospital in History* (London and New York, 1989); M. Carlin, 'Medieval English Hospitals' in Granshaw and Porter, *Hospital in History*, pp. 21-40; W. S. C. Copeman, 'The Royal Hospitals before 1700', in F. N. L. Poynter, ed., *The Evolution of Hospitals in Britain* (London, 1964), pp. 27-40; J. Woodward, *To the Sick Do No Harm* (London, 1974), pp. 1-16. Literature relating to early Scottish hospitals includes: Turner, *Story of a Great Hospital*, pp. 11-18; J. A. Gray, *The Edinburgh City Hospital* (East Lothian, 1999), p. 7; D. Hamilton, *The Healers* (Edinburgh, 1981), pp. 19-21; J. Comrie, *History of Scottish Medicine* (London, 1932), pp. 1-2; D. Rorie, ed., *The Book of Aberdeen* (Aberdeen, 1939), pp. 10-11.

¹¹ B. Harvey, *Living and Dying in England, 1100-1540* (Oxford, 1993), p. 99.

Water Hospital, at Bath in 1610, the Royal Mineral Water Hospital, in 1737 and Royal Sea Bathing Hospital in Margate in 1791.¹² However, these hospitals were mainly for the chronic sick rather than specifically convalescents.¹³ Nevertheless, in common with the convalescent homes, their location illustrates the interest in establishing hospitals in areas perceived as healthy, such as seaside resorts or the countryside.

The first English convalescent home not connected with sea bathing, and specifically for the sick poor, was the Metropolitan Convalescent Institution, opened in 1840 at Walton on Thames.¹⁴ This institution, sponsored by Theodore Munro, a medical student at St Bartholomew's Hospital, was a major milestone in the development of convalescent homes in England.¹⁵ It was large, visible and heralded the introduction of the foundation of many similar institutions. Following the establishment of the Metropolitan Institution, a convalescent home for 'Women and Children' appeared in 1847 at Hastings. In 1854, the 'Convalescent Home for Gentlewomen' at St Leonards-on-Sea (and another Home with a similar title) opened in Torquay. However, the title of these homes, 'Homes for Gentlewomen', imply that their admission policy excluded the working classes. Finally, the Prudow Memorial Convalescent Home, a substantial home with 165 beds, opened at Newcastle-on-Tyne in 1859.¹⁶ Only a few convalescent homes in England therefore preceded the opening of the first known permanent convalescent home in Scotland for the sick poor. This was the Dundee Convalescent Hospital established in 1860.¹⁷ Unlike England, perhaps because of the cooler climate, there were no sea-bathing hospitals recorded in Scotland during the nineteenth century. Nevertheless, articles such as 'Observations on the Climate of Largs with Notices of other Principal Watering-Places on the Clyde

¹² E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), pp. 24-26.

¹³ J. Robinson, 'The Royal Sea Bathing Hospital at Margate', MSc, dissertation 1996. This recent study of Royal Sea Bathing Hospital in Margate indicates that it was mainly used for the treatment of Scrofula rather than convalescence.

¹⁴ Gardiner, *Convalescent Care*, p. 30.

¹⁵ H. Richardson, *English Hospitals* (Swindon, 1998), p. 9.

¹⁶ *Burdett's Hospitals and Charities* (London, 1899), p. 651.

¹⁷ THB 13/1, *First Annual Report of the Dundee Convalescent Hospital*, 1861. In the following year the Home was renamed the Dundee Convalescent House.

and their General Characteristics' by William Davidson in 1848, illustrate the growing interest from Scottish doctors in the therapeutic aspects of a healthy environment.¹⁸

Major Influences

George MacLeod, an influential surgeon at the Glasgow Royal Infirmary, was one of the first doctors to encourage the foundation of convalescent homes for the sick poor in Scotland. In 1859, he wrote an article for the *Glasgow Medical Journal* on 'Reasons Why Sanatoria should be established on the Clyde for the Sick Poor of Glasgow'. In this article, MacLeod suggested establishing convalescent institutions and other sanatoria for the sick poor away from the cities, particularly after injury or operation when patients were more susceptible to hospital diseases.¹⁹ MacLeod was subsequently one of the founder members of the Board of Management at the GCH.²⁰ Although the extent of his involvement in setting-up the Home is not entirely clear, he may have collaborated with Beatrice Clugston, the primary promoter, given his interest in convalescent homes for the sick poor. Beatrice Clugston was active within the GRI as the first secretary of the Dorcas Society²¹, for several years before her involvement with the GCH.²² Chapter Six discusses in detail the support and influence amongst the medical profession for convalescent homes.

¹⁸ W. Davidson, 'Observations on the Climate of Largs, with Notices of the Other Principal Watering Places on the Clyde and their General Characteristics', *Edinburgh Medical and Surgical Journal*, 69 (1948) pp. 32-50.

¹⁹ G. MacLeod, 'Reasons Why Sanatoria should be Established on the Clyde for the Sick Poor of Glasgow', *GMJ* (July, 1859) pp. 147-156.

²⁰ ML G.362.160941435, *Second Annual Report of the Managers of the Glasgow Convalescent Home* [hereafter, *GCH*] *to the Subscribers*, 1866, p. 11. MacLeod was recorded as having attended this meeting. He also took an active part by responding to questions about communication between the Infirmary and convalescent home.

²¹ The main function of the GRI Dorcas Societies was to provide clothes and some aftercare for patients. Also see: J. Jenkinson et al, *The Royal* (Glasgow, 1994), pp. 118-119.

²² Beatrice Clugston (1827-1888), daughter of a prosperous merchant, was born in Glasgow but spent much of her early life in Larkhall, Lanarkshire. Following the death of her father she went to live at Lansdown Crescent in the West End of Glasgow. She later went to live just outside Glasgow in the new suburb of Kirkintilloch. Although never a rich woman, she was comfortably off and had private means, allowing her to devote her considerable energies to various philanthropic activities. Before becoming involved in establishing convalescent homes, she was a prison visitor and founder member of the Dorcas Society at the GRI. Following the establishment of a new building for the GCH at Lenzie, she initiated the foundation of the Broomhill Homes for Incurables at Kirkintilloch. She died at Ardrossan on 6 June 1888. The role of Beatrice Clugston in the convalescent home movement is

Another high profile supporter of convalescent homes throughout Britain was Florence Nightingale. She disseminated her views on the importance of convalescent homes through a variety of books and other publications that influenced various authorities, organisations and individuals. For instance, in 1864, the *BMJ* reported on hospital authorities at Winchester who followed her advice that ‘convalescent patients should not be cared for in hospital convalescent wards but in convalescent homes away from cities.’²³ Her comments on convalescent homes and convalescence were also much quoted in medical journals. For example, in 1866, in a short article on nursing convalescent patients, *the Lancet* noted her observation on the connection between relapse during illness and lack of convalescent facilities. This said:

Long convalescence, ending in relapse or death, says Miss Nightingale, is by no means infrequent amongst the poor, many of whom leave hospital to make way for more necessitous cases, long before they are able to return to their customary employment.²⁴

Several months later, a leading article in the *BMJ* promoting the concept of convalescent homes for the poor used this same quotation.²⁵

Sponsors of convalescent homes also used the influence of Florence Nightingale to enlist support from the community. For example, the Dundee Convalescent House published the following extract from *Practical Notes on Nursing* in their annual report in 1861.

It is my own conviction that, next to removing hospitals entirely out of towns, there is nothing that would add so much to the efficiency of these institutions,

discussed in greater detail further in the chapter, pp. 65-66, 75-79. See also: E. L. Stewart, ‘The Incurable Miss Clugston’, *Glasgow Herald*, 15 December 1964, p. 10; W. G. Blackie, *Miss Clugston and her Work* (Glasgow, 1875).

²³ *BMJ*, 14 May 1864, p. 550.

²⁴ *Lancet*, 3 November 1866, p. 448.

²⁵ *BMJ*, 30 March 1861, p. 358.

or at the same time be such a blessing to the sick poor, as henceforth to look on convalescence as a state as much requiring its special conditions and management as sickness and to provide for it accordingly.²⁶

Beatrice Clugston also exploited the high profile of Florence Nightingale and the influence she exerted upon the public. In 1871, she wrote to Florence Nightingale requesting that she might become a patron of a fundraising bazaar for the Dunoon Homes. She also asked her if she would host one of the tables at this bazaar. Although the reply was negative for both requests, Beatrice Clugston nevertheless named one of the tables at the Bazaar 'the Florence Nightingale Table', despite the fact that she had nothing to do with it.²⁷ She also reproduced the entire responding letter in a widely circulated pamphlet aimed at promoting and raising funds for the Dunoon Homes. Beatrice Clugston perhaps judged that remarks in Florence Nightingale's letter were likely to appeal equally to the pockets of the rate-paying middle-classes and to their concern for the health of the working classes. The comments included:

If every hospital, every workhouse, every town, had its Convalescent Home by the sea-side or in the hills, there is probably no one thing which would conduce more to health of the population or to the diminution of pauperism, by restoring the hard-working to their homes and by preventing whole families from becoming a burden on the rates.²⁸

It is also difficult to ignore the influence of Sir Henry Burdett, the controversial author, commentator and administrator of hospitals and charities. He distributed information about convalescent homes through his publication of *Hospitals and Charities Yearbooks*, published annually between 1890-1931. These yearbooks

²⁶ Quoted in: THB 13/1, *First AR, Dundee Convalescent Hospital*, 1861, p. 3.

²⁷ *Ardrossan and Saltcoats Herald*, 14 October 1871, p. 4.

²⁸ Letter from Florence Nightingale in: B. Clugston, *West of Scotland Convalescent Seaside Homes, Dunoon. A short account of their present position and capabilities of extension and use* (Glasgow, 1871), pp. 22-23.

dispersed useful data about hospitals and medical institutions, including convalescent homes, to the general public and health professionals. The information they contained included: the number of beds, patients, staff, the type of patients accepted, and how to obtain admission to the convalescent homes. In addition to the circulation of his yearbooks, Burdett pronounced judgement on various aspects of the convalescent homes in numerous other publications about medical institutions. For example, in 1880, in *Cottage Hospitals, General and Fever*, he echoed Florence Nightingale by saying, 'convalescent homes are much needed by the general hospitals and it would be a great boon if every hospital, especially in large towns, could have its own convalescent institution.'²⁹ Later, in *Hospitals and Asylums of the World*, he gave a brief history of the convalescent homes together with his perception of their purpose and benefit to the patients by improving their recovery time.

Formerly an attempt was made to keep the patients in the hospital under treatment until their health and strength were sufficiently established to enable the breadwinners to resume work on leaving the institution. As the population increased, it became more and more difficult to follow out this system, especially in large towns, and hospital managers realised that the recoveries would be much more hastened if the patients could be removed into the country directly the convalescent stage had been reached. This led to an organisation of a new class of medical institutions called 'convalescent homes' and to them must be attributed in no small degree the improvement that has taken place in the results of medical treatment of late years.³⁰

Burdett also collaborated with the Prince of Wales and set up the 'Prince's Fund' (later the King's Fund).³¹ The royal patronage of this charity attracted vast sums of money and it became an extremely wealthy charity. It also distributed funds for convalescent homes, but mainly in the London area. The acquaintance of Burdett

²⁹ H. C. Burdett, *Cottage Hospitals, General Fever and Convalescent* (London, 1880), pp. 308-309.

³⁰ H. C. Burdett, *Hospitals and Asylums of the World* (London, 1893), p. 849.

³¹ F. Prochaska, *Philanthropy and the Hospitals of London* (Oxford, 1992), p. 13.

with the Prince of Wales and his involvement in the administration of the Prince's Fund further increased the authority of his views on hospital and charities.

Nevertheless, the influence of Burdett was not entirely universal. His books and articles on nursing generated hostility amongst nurses, because many considered him ignorant on the topic. Florence Nightingale was reported to have had a 'horror' of Burdett.³² In 1898, an editorial in the *Nursing Record* pronounced 'for ten years past, this gentleman has incessantly interfered in nursing affairs, and we have stood alone in disputing his right to do so.'³³ Publications contributing to this irritation included, *How to Become a Nurse* and *Nursing Profession: How and Where to Train etc.*³⁴ Despite the annoyance he aroused amongst the nurses, numerous repeat editions of these books provides evidence that they were widely read. Also, the fact that his remarks generated so much aggravation amongst his opponents is a further indication that his views were influential.

Authoritative support was also important to offset any neighbourhood opposition over plans to establish a convalescent home. One such example was the practical support given by James Burn Russell towards convalescent homes. Firstly, he sat on the management committee of the Hozier Home at Lanark.³⁵ Secondly, he defended Jean Colville when local residents opposed her plans to open a small convalescent home for children in Helensburgh. The residents based their objections mainly upon fears that poor city children might bring infectious diseases to the area. They believed that this might adversely affect their summer lettings by discouraging the lucrative summer visitors. One of the residents wrote thus:

A number of the householders in the immediate neighbourhood of your proposed site are dependent in a measure upon letting their houses during the summer season, and the circumstances of a hospital in their neighbourhood

³² Quoted in Prochaska, *Hospitals of London*, p. 34.

³³ *Nursing Record/Hospital World*, 19 February 1898, p. 145.

³⁴ H. C. Burdett, *Nursing Profession: How and Where to Train* (London, 1899); *How to Become a Nurse* (London, 1905).

³⁵ GGHB HB 7/1/1, *Annual Report of the Lady Hozier Convalescent Home*, 1895, p. 1.

would be equal to a deprivation of a portion of their livelihood, for no one would willingly take lodgings in the vicinity of such an institution; and the same objection applies to the whole neighbourhood for a general depreciation of the value of property would be the natural result of its establishment.³⁶

The battle between the residents and Jean Colville raged for some weeks through letters in *Helensburgh and Gareloch Times*. In a reassuring letter distributed to the protestors, Russell promised that there was no danger from infection. His letter contained the following remarks:

They will be selected from the Sick Children's Hospital which does not admit infectious diseases, and they will be visited and personally watched over by you and other ladies, who have young children of their own, and have, therefore the best reason for avoiding any source of injury by disease. There is not a single item of risk to the neighbours attending the use to which you propose to put this house.³⁷

Russell's authority as the Medical Officer of Health for Glasgow overcame most of the neighbourhood objections, and the convalescent home at Helensburgh opened shortly afterwards. Nevertheless, one dissenting neighbour still complained that:

I cannot accept Dr Russell as competent to judge of what would or what would not injure Helensburgh; he is the paid official of another town and as such his time ought to be fully taken up as each town has its own peculiarities he can know little of matters here.³⁸

³⁶ *Helensburgh and Gareloch Times*, April 1884, p. 3.

³⁷ Correspondence relating to the siting of the children's convalescent home, *Helensburgh and Gareloch Times*, 30 April 1884, p. 3.

³⁸ 'Letter from a recipient of Dr Russell's letter to the Promoter', *Helensburgh and Gareloch Times*, 30 April 1884, p. 3.

Jean Colville was not alone in encountering neighbourhood resistance to her convalescent home. The Convalescent Home Committee of the Dundee Convalescent Home (Broughty Ferry CH) also ran into hostility when they sought necessary building land for the Project. In 1872, the *Dundee Advertiser* reported 'the money is ready but a site for the Hospital cannot be found. The proprietors in the neighbourhood of the town have absolutely refused to allow the Hospital to be placed on their properties.'³⁹ A landowner, Lord Dalhousie, eventually relinquished land at Barnhill near Broughty Ferry for the construction of the Dundee Convalescent Home. It is perhaps of significance that the main benefactor of this convalescent home, David Baxter, was also one of the most prominent businessmen in Dundee and this may have influenced the Lord Dalhousie to sell his land.⁴⁰

The *Glasgow Herald* also remarked on opposition from the neighbourhood when Beatrice Clugston first proposed the idea of a convalescent home in Dunoon:

When her project to establish a home at Dunoon was first made known it encountered a good deal of opposition in the place and neighbourhood but, as everyone knows, a great deal of bad feeling exists in this world through misapprehension and that when it became generally known that no one likely to communicate infectious disease would be admitted to the institution, bad feeling on the subject almost, if not entirely disappeared.⁴¹

Although the reporter on the *Glasgow Herald* seemed to believe that the opposition was suppressed by assurances of the exclusion of patients with infectious diseases, it is equally probable that it was influenced by the powerful support from patrons of the Dunoon Homes. In 1872, Patrons of the Dunoon Homes included, Princess Louise,

³⁹ 'Refusal of a Site for the Convalescent Hospital', *Dundee Advertiser*, 2 March 1872.

⁴⁰ Sir David Baxter, (1793-1872) was initially manager of a sugar refining company but later became a jute mill owner. He was also a well-known benefactor in Dundee. His other benefactions included the donation Baxter Park for Dundee citizens.

⁴¹ *Glasgow Herald*, 16 August 1869, p. 5.

the daughter of Queen Victoria, the Duke of Argyle, the Duke and Duchess of Roxburgh, the Earl and Countess of Glasgow and the Earl of Blantyre.⁴²

An exploration of attempts by the Charity Organisation Society [COS] to control aspects of Scottish convalescent homes indicates that not all efforts to influence aspects of their development were successful. The COS was a major co-ordinating society that originated in England around 1869.⁴³ The strategies of the COS and similar co-ordinating societies involved retaining a central record of recipients, thereby preventing duplication of charity. They also sent official visitors to assess applicants in their own homes to check on whether they were 'deserving'. The 'undeserving' included anyone considered thriftless, work shy, or involved with alcohol. Around the same period, societies similar to the COS appeared in Edinburgh, Glasgow and Aberdeen.⁴⁴ The predecessor of the COS in Edinburgh was 'the Edinburgh Association for Improving the Condition of the Poor'. The forerunner in Glasgow was 'Glasgow Association for Organising Charitable Relief and Repressing Medicity'. The COS were involved in a range of social topics, in particular the distribution of charitable funds. They also commented on issues such as the relief of unemployment, compulsory old age pensions, free dispensaries, and free dinners for schoolchildren.⁴⁵ It is therefore not surprising that the COS also attempted to influence the admission procedure for patients to convalescent homes.

⁴² B. Clugston, *West of Scotland Convalescent Seaside Homes, Dunoon. A short account of their present position and capabilities of extension and use* (Glasgow, 1871), p. 4.

⁴³ F. K. Prochaska, *Women and Philanthropy in 19th Century England* (Oxford, 1980), p. 106.

⁴⁴ Checkland, *Industry and Ethos*, p. 101; I. Levitt, *Poverty and Welfare in Scotland, 1890-1948* (Edinburgh, 1988), p. 14.

⁴⁵ For various descriptions of the ideology and function of the COS see: G. Finlayson, *Citizen, State and Social Welfare in Britain 1830-1990* (Oxford, 1994), pp. 71, 79, 92, 103-6, 135-6, 140-142, 145, 147-51, 156, 158-9, 170, 172-9, 180, 192-5, 199, 215, 227; E. M. L. Thompson, *The Rise of Respectable Society* (London, 1988), pp. 356; L. Granshaw, *St Mark's Hospital, London* (London, 1985), p. 89; M. Baly, *Nursing and Social Change* (London, 1977), pp. 51, 81; Checkland, *Industry and Ethos*, p. 101, 115, 101, 115; F. B. Smith, *The People's Heath*, (London, 1979), pp. 115, 179-180, 185-6, 224, 278, 297-8, 401; J. R. Hay, *The Origins of the Liberal Welfare Reforms, 1906-1914* (London and Basingstoke, 1975), p. 38; P. H. Gosden, *Self-Help. Voluntary Associations in the 19th Century* (London, 1973), p. 271; B. Able-Smith, *The Hospitals* (London, 1960); pp. 86, 92, 101, 106-10, 163, 166, 174-175, 200, 276; T. M. Devine, *The Scottish Nation 1700-2000* (London, 1999), p. 343; Prochaska, *Hospitals of London*, pp. 4, 6-7, 8, 12, 20, 36, 74, 78, 165; N. Whiteside, *Bad Times* (1991), p. 44.

A paper written by Bernard Bosanquet, Secretary of the COS, argued that it was necessary for their organisations to act as a clearing house for convalescent homes. He based this argument on his belief that there was an unequal allocation of beds in convalescent homes. As an example, he cited difficulties that he believed occurred when a clergyman or other such person wished to send a poor person to a convalescent home:

He first has to find out what home will suit the case; then, probably to go about asking for a subscribers letter, and then he may find that the home he has chosen has no vacancy for weeks, while another equally suitable, could have admitted the patient at once.⁴⁶

Bosanquet was not entirely accurate in this concern over admission procedures because patients admitted directly to Scottish convalescent homes from the infirmaries did not require a subscriber's letter.⁴⁷ Also, at some homes such as Kilmun and the Mission Coast Home, patients were admitted on the recommendation of a suitably qualified person. Acceptable referees included clergymen, missionaries or ministers. Although in 1883, the COS claimed that they referred 1,300 patients to convalescent homes and a similar number in 1886, this mainly occurred in the London area.⁴⁸ Current evidence suggests that they were less successful in influencing the organisation of convalescent homes in Scotland during the nineteenth century. In 1881, their annual report recorded that they organised convalescence in convalescent homes on less than thirteen occasions.⁴⁹

⁴⁶ B. Bosanquet, 'The Principles and Chief Dangers of the Administration of Charity', *International Journal of Ethics*, 3 (April 1893), pp. 323-336.

⁴⁷ The Dunoon Homes and GCH were examples of non-hospital convalescent homes that accepted patients without a subscriber's letter, although only when they were admitted directly through the infirmaries.

⁴⁸ *BMJ*, 25 October 1884, p. 827; *BMJ*, 20 July 1887, p. 249.

⁴⁹ ML G.362.506241435, *Annual Report of the Council of the Glasgow Association for Organising Charitable Relief and Repressing Medicity*, 1881, p. 24.

Despite his usual sympathy towards the poor, Russell also agreed with the COS that misuse of convalescent homes by patients sometimes occurred. In a paper he gave to their conference on 'Overlapping of Charitable Funds' he was reported as saying that:

The convalescent homes, in so far as they admit persons direct from one or other of the hospitals, can hardly be imposed upon but I fear that not infrequently, among those commended by the general public, may be found loafers who manage to spend a deal of their time in one home or another, persons who really subsist upon chronic ailments and are in a perpetual state of convalescence.⁵⁰

Similarly, Burdett also remarked that:

There is reason to believe that a certain class of the population find the convalescent home to offer them an inexpensive means of taking a holiday. It has come to pass that very many persons who are not ill in any true meaning of that word at present obtain admission to the convalescent home when they want a holiday or a rest from labour.⁵¹

It is likely therefore that authorities in some convalescent homes were aware of possible misuse as managers of convalescent homes such as Peter Coats, Chairman of the Management Committee at the Dunoon Homes and William Hozier, a patron of the Dunoon Homes and later the benefactor of the Lady Hozier Convalescent Home were also members of the COS.⁵² Yet there is little evidence of this type of alleged misuse in annual reports from the convalescent homes. It is possible that managers of convalescent homes preferred to retain control of admission procedures to avoid any harmful publicity as allegations of this sort could be damaging to the credibility of the homes. In turn, this could also have affected financial support from subscribers. It is

⁵⁰ J. B. Russell, 'Overlapping of Charitable Funds'. A paper given at conference organised by the COS in 1882.

⁵¹ H. C. Burdett, *Hospitals and Asylums of the World* (London, 1893), p. 850.

⁵² ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, p. 2. [Dunoon Homes].

also probable that misuse of the homes by non-convalescent patients was negligible since many annual reports suggest that an even greater problem was that many patients admitted to convalescent homes during the nineteenth century were too ill.⁵³

The COS may have been more successful in influencing the introduction of a higher level of medical and nursing care to convalescent homes than in organising their admission procedures. In 1880, the *Lancet* reported on suggestions made by the COS to improve the amount of medical advice available in convalescent homes:

We are glad to notice and to corroborate two or three conclusions of the Committee. One is in favour of more accommodation for medical and surgical advice in Convalescent Homes than at present exists, for many of them it is taken for granted that the convalescent requires no more medical or surgical attendance.⁵⁴

In 1881, the *BMJ* also reported on comments from the COS and concluded that ‘the supply of convalescent accommodation for hospital cases, i.e., for cases requiring continued medical or surgical treatment and nursing is insufficient.’⁵⁵ Coincidentally, during the 1880s and 1890s some of the convalescent homes, such as the GCH and Corstorphine House, did begin to employ trained nurses specifically to deal with the dressing of wounds.⁵⁶ However, since none of the convalescent homes specifically acknowledged the COS in their decision-making, it is difficult to establish the extent of their influence, particularly as there was an increase in the number of trained nurses available.

Although the foregoing has demonstrated that prominent personalities were important in promoting the concept of convalescent homes, the sponsors themselves generated most of the practical and financial support. Establishing a convalescent home was

⁵³ This topic is discussed further in Chapter Four on Illness, especially pp. 144-145.

⁵⁴ ‘Convalescent Homes’, *Lancet*, 7 August 1880, p. 224.

⁵⁵ *BMJ*, 2 July 1881, p. 16.

⁵⁶ See Chapter Six, pp. 254-9.

rarely, if ever, a solitary activity, and sponsors usually enlisted support from friends or the community. Beatrice Clugston fostered help from all sections of the population, including the aristocracy, women, wealthy businessmen, religious organisations, employees, and even children.⁵⁷ This promotional activity not only advertised her convalescent homes, but also played an important role in publicising convalescent homes in general. It is therefore worthwhile scrutinising her methods closely. Her methods involved a succession of promotional meetings throughout the West of Scotland that often drew large audiences. She also wrote and distributed a variety of pamphlets to publicise her cause. For example, the front cover of one of these publications issued the forthright declaration that the pamphlet was: ‘for the purpose of stirring up the community of Glasgow and the West of Scotland to greater efforts for the working classes in times of sickness and distress.’⁵⁸ Beatrice Clugston also wrote letters to newspapers and influential individuals asking for help with either finance or support for the bazaars. For example, according to Robert Hillhouse, a ‘touching letter’ from Beatrice Clugston persuaded Sir Archibald Or Ewing, (then member of parliament for Dumbartonshire) to make a donation to the Dunoon Homes. Or Ewing had once lived in an old mansion in the grounds of the Dunoon Homes. Beatrice Clugston wrote describing his old home and explaining that it was now part of a convalescent home. She also asked that ‘might she be favoured, since God had blessed him with wealth, with a subscription as a token of thankfulness for past mercies, and vivid recollections of “memories dear”.’⁵⁹ Apparently a cheque for £100 from Or Ewing arrived shortly afterwards.

⁵⁷ Pamphlets written by Beatrice Clugston included, *West of Scotland Convalescent Seaside Homes; Missing Links in Scotland's Charities* (Glasgow, 1880); *Six Sabbaths in the Hospitals* (Glasgow, 1876); *Speak to the Clock* (Glasgow, 1881).

⁵⁸ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 1

⁵⁹ R. Hillhouse, *Bygone Years of the West of Scotland Convalescent Seaside Homes, Dunoon*, (Glasgow 1909), pp. 14-15.

Another example occurred in 1871 when she wrote to the *Ardrossan and Saltcoats Herald* about the forthcoming bazaar in support of the Dunoon Homes.⁶⁰ In this letter she wrote that:

Many ladies of rank and influence are to preside at the stalls, and although only one name is put at each of most of the tables, each of these includes an immense circle of friends who are at present canvassing their relatives and others for donations to a cause which cannot fail to enlist the sympathies of a city where the mortality is so terrible and the working classes so very numerous.⁶¹

This extract also illustrates the courtship of Beatrice Clugston towards the aristocracy. One of the reasons for her enthusiasm to involve their support was that the aristocracy encouraged involvement from those lower down the scale wishing to climb the social ladder. It is not surprising therefore that the Dunoon Homes had the highest aristocratic patronage count for any convalescent home in Scotland. For example, in 1871 they had thirty-one aristocratic or wealthy patrons.⁶² By 1885, this had increased to sixty-four.⁶³

Although there were many other individuals actively involved in establishing convalescent homes, in common with Beatrice Clugston, they did not act alone. Alexander Penrose Forbes, Bishop of Brechin,⁶⁴ and philanthropist, Lady Jane Ogilvy were co-founders of the Dundee Convalescent House in 1860.⁶⁵ They also used their connections to persuade aristocratic associates to become patrons of the convalescent home. In the first year of the Dundee Convalescent House, the patrons, staff and

⁶⁰ Raising funds for the convalescent homes by Beatrice Clugston are dealt with further in this chapter. See pp. 75-79

⁶¹ Letter from Beatrice Clugston, *Ardrossan and Saltcoats Herald*, 30 September 1871.

⁶² Clugston, *West of Scotland Convalescent Seaside Homes*, pp. 22-23.

⁶³ ML G.362 160941435, *Sixteenth AR, WSCSH*, 1885, pp. 4-5. [Dunoon Homes].

⁶⁴ See: R. Strong, *Alexander Forbes of Brechin* (Oxford, 1995), p. 234; W. Perry, *Alexander Penrose Forbes* (London, 1939), pp. 74-75; A. Drummond and J. Bulloch, *The Victorian Church in Scotland* (Edinburgh, 1975), pp. 210-211. See Chapter One, p. 37 for bibliographic details.

⁶⁵ 'Dundee Convalescent House', *Dundee Advertiser*, June 1870. See Chapter One, p. 37 for bibliographic details of Jane Ogilvy.

other supporters outnumbered the average number of patients in the Home.⁶⁶ Another early promoter of a convalescent home was James Smith, a city missionary with the Glasgow City Missionary. He collaborated with merchant, William Bryden, to establish the Mission Coast Home at Saltcoats in 1886.⁶⁷ E. Oliphant referred to a number of people associated with the establishment of Newhills by Catherine Cruikshank writing that she 'started upon a most modest scale, with perfect economy and with the advice and help of many in Aberdeen City and County, the Home grew in usefulness.'⁶⁸ In addition to support from James Burn Russell, Jean Colville also gathered a number of female associates from Helensburgh to establish the Cottage Homes for Children. In 1892, there were nine women on the Committee.⁶⁹ Establishing a convalescent home therefore involved a network of organisations or individuals who were either actively involved or indirectly influenced their foundation.

Raising Funds

Although the foregoing has explained much of the influence involved in establishing the convalescent homes, there is far more to understand about the mechanism used to establish the convalescent homes. It was also difficult to differentiate between methods and funding. For clarity, I have dealt with the funding and methods used to establish the convalescent homes within their sponsorship groups of the nineteenth century; hospitals, independent and religious/temperance. There were three principal methods used by sponsors to raise funds to establish a convalescent home. In the first method, one major benefactor or legatee agreed to finance the majority of the project. In the second method, a fund was established from an assortment of smaller donations and subscriptions, using a variety of charitable sources. In the third method, a convalescent home began as a small operation and raised additional financial support

⁶⁶ THB 13/1, *First AR, Dundee Convalescent Hospital*, 1861, p. 1.

⁶⁷ 'Report on Centenary Meeting' *Glasgow Herald*, 30 May 1966, p. 3; J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888) p. 44.

⁶⁸ E. Oliphant, 'Newhills Convalescent Home and Sanatorium' in: David Rorie, ed., *The Book of Aberdeen* (Aberdeen, 1939), p. 94.

⁶⁹ ML Glasgow Pamphlets, Vol. 30. 312453-70. *Glasgow Charitable and Philanthropic Institution* (Glasgow, 1892), p. 21; J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888), p. 166.

after proving its value. Sometimes, sponsors used a combination of these processes but one usually dominated.

Hospital CHs

Most hospital managers preferred to obtain one main benefactor to finance their convalescent homes. However, this method usually involved a high level of promotional initiative for many years beforehand to find an individual sufficiently benevolent and willing to fund such an expensive project. In 1858, the managers at the RIE delivered the following message:

We need in Edinburgh a Convalescent House, where those who have been treated in the Infirmary and now no longer need active remedies, may yet be tended until their strength is fully restored. We are aware that some of our benevolent institutions are very helpful in these circumstances. But assistance is needed on a larger scale, and in a more systematic manner, for that interval of inevitable inaction which exists between the day of dismissal from the Infirmary and a full restoration to health.⁷⁰

The appeal was partly successful, and one or two benefactors provided temporary convalescent homes, but the infirmary managers insisted that the amount of accommodation was inadequate. Consequently, in 1861, they made a further petition, stating:

The Managers have on former occasions expressed their gratification at the aid afforded them by the convalescent houses which now receive a limited number of both male and female patients. Were this institution greatly extended it would give a very considerable relief to the funds of the Royal Infirmary and would confer much benefit upon patients, who though not any longer requiring medical treatment, can yet have their health completely re-

⁷⁰ LHB 1/4/57, AR, RIE, 1857-8, p. 8.

established, only by being comfortably lodged and supplied with wholesome, nourishing food.⁷¹

William Seton Brown eventually offered to finance and to build a permanent convalescent home for the RIE in 1863.⁷² This convalescent home, Corstorphine House, was completed in 1867. It therefore took five years between the second round of appeals from the managers until Corstorphine House finally opened.

A similar situation occurred in Glasgow at the Western Infirmary, where appeals for a benefactor to establish a convalescent home began around 1888.⁷³ Although William Hozier eventually offered to build a home in 1890, it still took another three years before this home, the Hozier Home, opened in 1893.⁷⁴ Douglas Guthrie also commented on the 'long period of anticipation' by managers at the Children's Hospital in Edinburgh before the Dewar family offered to finance a second convalescent home, Forteviot Home.⁷⁵ Guthrie noted that 'the directors had long hoped that it might be possible to institute a subsidiary home for very young children.'⁷⁶ It is hardly surprising that using this method to establish a convalescent home took so long, since there were relatively few people willing or able to part with such large sums of money.

Another disadvantage of financing the convalescent home from a single source were the conditions often imposed by the benefactor that affected the development of the convalescent home. A common condition upon a gift was the dedication of the convalescent home to a deceased relative. Examples of this were: Seton Brown, who

⁷¹ LHB 1/4/61, AR, RIE, 1861-2, p. 4.

⁷² 'Death of John Brown's Grandson', *Illustrated Edinburgh News*, 8 May 1897, p. 3. William Seton Brown was the son of Dr William Brown, well-known at the time as Secretary of the Scottish Missionary Society and grandson of bible commentator, John Brown of Haddington. Seton Brown was born at Prestopans near Edinburgh but spent much of his life in India where he had business connections in Bombay. He died in 1897.

⁷³ GGHB HB 6/3/3, *Annual Report of the Western Infirmary of Glasgow*, 1888-9, p. 7.

⁷⁴ 'Opening of the Lady Hozier Convalescent Home, Lanark', *Glasgow Herald*, 11 July 1893.

⁷⁵ Fortivoit Home differed from the first children's convalescent home, Muirfield, established for the Edinburgh Children's Hospital because it was specifically for children under the age of two.

⁷⁶ D. Guthrie, *The Royal Edinburgh Hospital for Sick Children, 1860 - 1960* (Edinburgh, 1960), p. 30.

gave Corstorphine House to the RIE in memory of his deceased brothers; Marjorie Schaw, who presented the Schaw Home to the GRI as a memorial to her brother and William Hozier who dedicated his benefaction of the Lady Hozier Home to his wife. Although these benefactors consulted with the infirmary managers over the building, they nevertheless had considerable influence over the design. The buildings were usually more elaborate and expensive than many non-hospital convalescent homes. For instance, Logan Turner estimated that the total cost for Corstorphine House, with fifty beds, was £12,000.⁷⁷ At Dundee, the estimated costs of building the Dundee Convalescent Home (Broughty Ferry CH) were £8,000.⁷⁸ The costs involved in the Lady Hozier Home established twenty years later were more modest at £8,000.⁷⁹ The most expensive convalescent home attached to a hospital was the Schaw Home. Margorie Schaw gave £47,000 to finance this venture although £15,000 of this was set aside as an endowment.⁸⁰

Illustrations 1, 2, and 3 reveal the ornate design of three hospital convalescent homes established by sole benefactors, Corstorphine House, Broughty Ferry and the Schaw Home. The expensive style contrast with the plainer buildings of purpose-built convalescent homes established through a general fund. Illustrations 4, 5 and 6 show the less ostentatious purpose-built buildings used for the GCH, Kilmun and Newhills. The new building that housed the GCH at Lenzie in 1871 cost only £6,000, although it was a substantial building with sixty beds. This included the purchase of a farm, laying out the grounds and furnishing.⁸¹ An even more economical building, built of whinstone rubble, faced with freestone and brick, was erected for Kilmun and cost only £3,000, yet it contained 100 beds.⁸² The building costs of Newhills are unknown but in 1895 the *BMJ* remarked that ‘the Newhills Convalescent Home near Aberdeen

⁷⁷ Turner, *Story of a Great Hospital*, p. 175.

⁷⁸ ‘Opening of the late Sir David Baxter’s Convalescent Home’, *Dundee Advertiser*, 18 December 1876.

⁷⁹ ‘Lady Hozier Convalescent Home’, *GMJ*, August 1914, p. 108.

⁸⁰ *Nursing Record and Hospital World*, 28 March 1896, p. 251.

⁸¹ ML G.362.160941435, *Seventh AR, GCH*, 1871, p. 4.

⁸² J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888), p. 163; ‘Kilmun Seaside Home’, *BMJ*, 14 June 1873, p. 684. For further discussion on costs involved see also p. 81 of this chapter.

Illustration 1: Corstorphine House, Edinburgh, 1912
(Image courtesy of Lothian Health Services Archive/SCRAN)

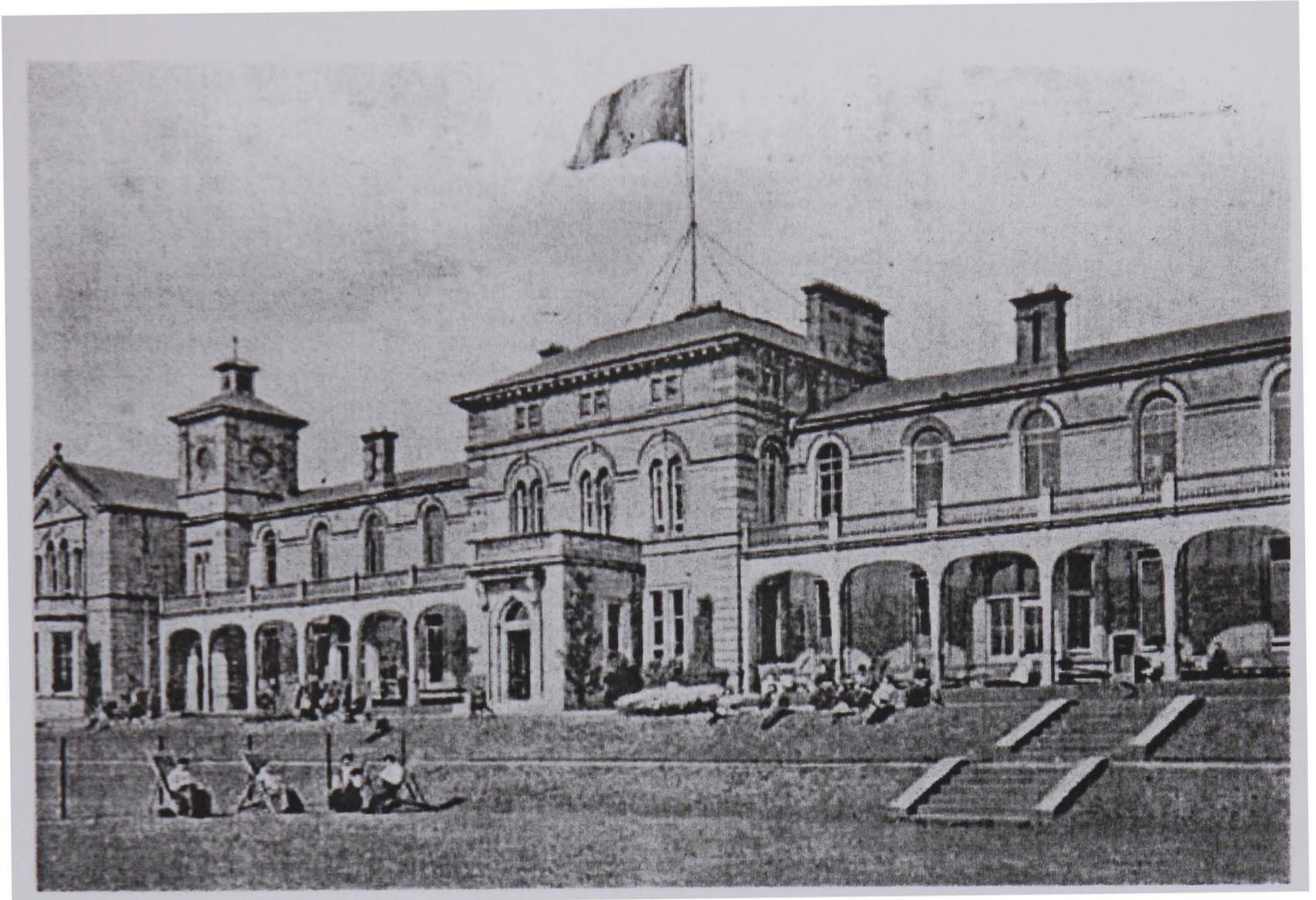


Illustration 2: Dundee Convalescent Home (Broughty Ferry), 1895
(Image courtesy of Dundee City Council, Central Library, Photographic Collection/SCRAN)



Illustration 3: Schaw Convalescent Home
(Image courtesy of Scottish Media Group/SCRAN)



Illustration 4: Glasgow Convalescent Home, Lenzie, c.1905
(Reproduced by kind permission of William Patrick Library, Kirkintilloch)



Illustration 5: Kilmun Convalescent Home, 2000 (now residential flats)
Although this a recent photograph, it has been included because the exterior of the building has changed little since the nineteenth century



Illustration 6: Newhills Convalescent Home, Aberdeen, c. 1900
(Image courtesy of Aberdeen City Council, Arts and Recreation Department, Library & Information Services/SCRAN)



is evidently conducted on thrifty Scotch principles.’⁸³ It is therefore likely that their building costs were equally economical.

Sole benefactors also laid down conditions over the policies and administration of convalescent homes. For instance, David Baxter, benefactor of Broughty Ferry CH, insisted on the admission of convalescent patients recovering from fevers. He also selected the Committee who administered the setting-up and running of the Home. Another condition made by Seton Brown was that the RIE should be responsible for the financial maintenance of Corstorphine House.⁸⁴ David Ainslie, benefactor of the AAI stipulated the name and the function of the home, ‘for the purpose of erecting and endowing a hospital or institution to be called the AAI, for the relief and behoof of the convalescents in the Royal Infirmary of Edinburgh.’⁸⁵ This prevented the managers from using the funds to improve their existing home, Corstorphine House. The establishment of a convalescent home was sometimes delayed because the benefactor insisted on a specific period of time between the allocation of funds and their use. David Ainslie stipulated that the funds from his bequest were to accumulate interest for fifteen years. In this case this ultimately benefited the AAI, since the First World War delayed the establishment of the new convalescent home and by that time the accumulated funds had risen to £600,000.⁸⁶ This made the AAI by far the wealthiest of all the convalescent homes and enabled the managers to take the new convalescent home in a completely different direction.⁸⁷ There was also a delay in establishing the Victoria Convalescent Home at Stirling, because a condition of their benefactor was that interest should accumulate for a number of years beforehand.⁸⁸ Problems also occurred sometimes when a single benefactor bequeathed a legacy to establish a convalescent home. Although this might spark off

⁸³ *BMJ*, 29 June 1895, p. 264.

⁸⁴ It will be shown later in the chapter that the RIE subsequently forgot this condition laid down by Seton Brown. See pp. 81-83 of this thesis.

⁸⁵ Astley Ainslie Institute Confirmation Act, 1929, quoted in C. F. Paterson, ‘The Development of Occupational Therapy in Scotland 1900-1960’, Unpublished PhD thesis, (University of Aberdeen, 2002), p. 120; Also in: LHB 1/4/121, AR, *RIE*, 1921, p. 38.

⁸⁶ *Ibid*; ‘The Care of the Convalescent, a New Departure’, *Lancet*, 10 November 1923, p. 1053.

⁸⁷ New methods of treatment at the AAI are discussed in Chapter Four, pp. 129-30, 200-201.

⁸⁸ *The Stirling Observer*, 1 August 1906, p. 5.

the initial interest in establishing convalescent home, the funds were often insufficient. This was the case at the Edinburgh Children's Hospital, when in 1906, Jane Meikleham left her house and grounds at Gullane as a convalescent home for children.⁸⁹ The managers decided the house was too small and unsuitable and consequently had to raise a further £20,000 through appeals and subscriptions.⁹⁰ Illustration 7 indicates that the design of the building for the new convalescent home, Muirfield at Gullane, in common with the non-convalescent homes established through a general fund, was homely and unadorned.

Only two further infirmaries were identified as financing the establishment of their convalescent homes by the second method, through a general fund. These were the Northern Infirmary and Aberdeen Royal Infirmary. Their funds came from various sources, and therefore no single person could dictate the terms of establishment. Although in both cases their managers had more control over the type of building used, the time taken between the initial appeal and opening of a home was equally as long as when a sole benefactor or legatee provided the funds. Fundraising for the Aberdeen Convalescent Hospital began in 1868, but sufficient funds were not raised until 1874. A residential property was used as first building for the convalescent home. In 1881, the neighbouring lunatic asylum purchased Lochhead House and enabled the managers of Aberdeen Royal Infirmary to construct a new purpose built convalescent home just outside Aberdeen at Pitfodels. This home opened in 1882. Illustration 8 indicates a simple design, unlike the hospital convalescent homes such as Corstorphine House and the Schaw Home, established by one benefactor and as a memorial.

Fundraising for convalescent facilities for the patients of Royal Northern Infirmary began in 1888, but the Home was not established until 1894. Initially, instead of establishing their own convalescent home the managers decided to raise a

⁸⁹ 'Convalescent Home for the Royal Hospital for Sick Children, Edinburgh', *BMJ*, 24 March 1906, p. 704.

⁹⁰ 'A Convalescent Home for the Royal Edinburgh Hospital for Sick Children', *Lancet*, 14 July 1906, p. 127; D. Guthrie, *Edinburgh Hospital for Sick Children*, p. 30.

Illustration 7: Muirfield Children's Convalescent Home, Gullane
(Image courtesy of East Lothian Council, Library Services/SCRAN)

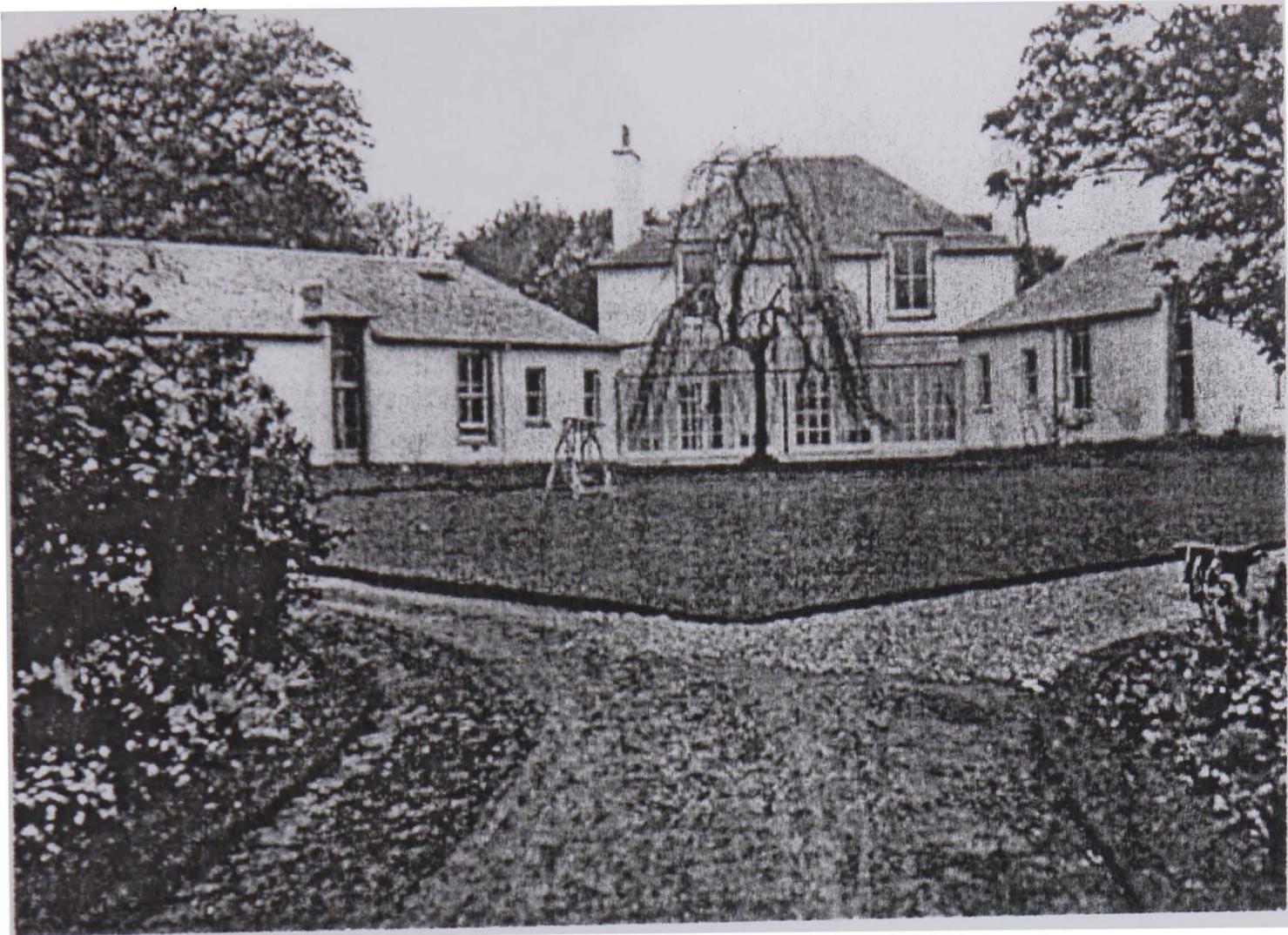


Illustration 8: Aberdeen Convalescent Hospital, 1897
(Image courtesy of Aberdeen City Council, Arts & Recreation Department, Library & Information Services /SCRAN)



convalescent fund to send patients to a neighbouring independent convalescent home at Nairn. The managers at the Royal Northern delegated the fund-raising to the Ladies' Committee. By the following year, they had raised only £38.00, mostly from church collections, sufficient to send ten patients to Nairn CH.⁹¹ In 1892, the managers decided to raise funds for their own convalescent home but in one year this still only amounted to £152.⁹² Although Bona was a small convalescent home with estimated costs of only £1,500 for the purchase and setting up the home, it took another two years before they raised sufficient funds.⁹³ Most of these costs were obtained from loans rather than fundraising.

When planning a convalescent home, sponsors often investigated the methods used by other established convalescent homes. The Convalescent Home Committee for the Aberdeen Royal Infirmary sent a representative to visit the GCH, the Dunoon Homes in Glasgow and Corstorphine House in Edinburgh. His report on the visit provided the rest of the Committee with an account of issues such as regime, staffing and setting-up of the homes. The reports also discussed in detail the costs of setting up and running a convalescent home. Following his report, the Committee set about raising further funds before they finally established their convalescent home.⁹⁴

The Convalescent Home Committee at the Dundee Royal Infirmary also visited Corstorphine House and other unspecified convalescent homes in Glasgow. Although reports on these visits have not survived, the minutes of the meeting beforehand provide some indication of one issue that troubled the Committee. This was the admission of patients recovering from fevers as most convalescent homes refused admission to this class of patient.⁹⁵ The minutes of Dundee Convalescent Home Committee in February of 1872 recorded thus:

⁹¹ HHB 1/5/2, 'Convalescent Fund Account', *Annual Report of the Northern Infirmary*, 1889, p. 12.

⁹² Ibid, 1892, p. 12.

⁹³ HHB 2/1/1, Minute book of Managing Committee of Convalescent Home of the Royal Northern Infirmary, 2 October 1894.

⁹⁴ GRHB 10/1/1, Aberdeen Convalescent Hospital Minutes, January, 1871.

⁹⁵ David Baxter, the major benefactor had stipulated that fever patients were admitted.

It was agreed that Mr Dalglish (committee member) should go to Edinburgh and inquire into the practical working of the Edinburgh Convalescent Home and as to the patients admitted into that institution - the classification of patients and whether convalescent patients recovering from fever are admitted into the same buildings and airing ground and generally that he might obtain all other information needful for the due consideration of the matters in question and with the same effect it was agreed that Mr Smith and Mr Watson [committee members] should go to Glasgow.⁹⁶

Subsequent annual reports indicate that some fever patients were admitted to the Dundee Convalescent Home, (Broughty Ferry CH).⁹⁷ The Children's Hospital in Edinburgh demonstrated a rather more systematic method of investigating other convalescent homes. Before rebuilding Muirfield, their convalescent home, the organisers sent questionnaires to several others in Scotland and England. Inquiries in this questionnaire illustrate the areas the managers considered important. They included topics such as the size of building, number of wards and the amount of ground. They also asked about the number and type of staff, staff accommodation, the number of patients, the cost of establishing the home, and the annual running costs. The final question was: 'Has the home been found of value as an adjunct of the hospital?'⁹⁸ This question suggests that they were seeking reassurance that the convalescent home was a worthwhile project. Overall the investigations made by the infirmaries into the running of other convalescent homes indicate that they were in unfamiliar territory and possibly seeking a model to emulate. However, they did not necessarily use the convalescent homes attached to infirmaries as models. This indicates that during the nineteenth century the non-convalescent homes were as well-respected as the hospital convalescent homes.

⁹⁶ THB 1/7, Minutes of the Dundee Convalescent Home Committee, 8 February 1872. The minutes did not make it clear which convalescent homes in Glasgow they visited.

⁹⁷ THB 1/2/5, AR, *Dundee Royal Infirmary*, 1881.

⁹⁸ LHB 5/33/5, Questionnaire sent by the managers of the children's hospital in Edinburgh to several convalescent homes, including Princess Mary, Paddington, Victoria Hospital, Chelsea and Glasgow Children's Convalescent Home (it is not clear which one they meant).

Independent CHs

Amongst the independent providers, all three methods of establishing a convalescent home were identified. The convalescent homes established by sole benefactors during the nineteenth century were usually quite small, admitting less than 200 patients annually. They included: the Ailsa CH,⁹⁹ established by the Marchioness of Ailsa; Lady Miller of Manderston, who founded Manderston Convalescent Home¹⁰⁰ and Glencapel CH, funded by an anonymous donor.¹⁰¹ During the twentieth century, several wealthy trusts, also a type of sole benefactor, provided funds for establishing convalescent homes. These homes were: Bandrum Children's Country Home, established by the Carnegie Dunfermline Trust and the Armitstead CH established by the Trustees of Lord Armitstead's estate.

The most prominent of the sponsors using the 'raising a fund' as a method to establish a home was Beatrice Clugston. In sharp contrast to most of the infirmary convalescent homes it took only ten months between the first meeting to discuss the setting-up of a home in October 1864 and the opening of GCH in July 1865. During this time, Beatrice Clugston raised £10,000, sufficient to rent and equip two villas, and provide an endowment for part of the financial maintenance. Although Beatrice Clugston was the driving force behind the foundation of the GCH, she did so under the auspices of the Dorcas Society of the GRI.¹⁰² Despite her prominent role in establishing the GCH, Beatrice Clugston retained the type of gender division common to administration in the voluntary hospitals with a 'ladies committee' and a 'committee of gentlemen'. The ladies committee took on the fundraising whilst the committee of gentlemen managed and distributed the Fund.¹⁰³

⁹⁹ Records of this Home disappeared when she died in 1888.

¹⁰⁰ Founded by Lady Miller of Manderston for nine patients in 1908, at Coldringham. There are no records after 1908, so may have existed for only a short time.

¹⁰¹ Glencapel was opened in 1894 and was financed by an anonymous donor. It was still open after the Second World War.

¹⁰² 'Convalescent Home Bazaar in the City Hall', *Glasgow Herald*, 15 December 1864.

¹⁰³ J. Lewis, 'The Boundary between Voluntary and Statutory Social Service in the Late Nineteenth and Early Twentieth Centuries', *Historical Journal*, 39 (March, 1996), p. 165.

The bulk of the funds for the GCH were raised through a Bazaar, held in the City Halls in Glasgow in December 1865, over a period of four days. Bazaars were a popular fundraising method, particularly amongst women, because they not only raised funds rapidly but also allowed their middle-class female organisers to engage in business, an activity normally denied to them.¹⁰⁴ This was probably one of the reasons why Beatrice Clugston seemed to encounter few problems in persuading the wealthy, aristocratic or other influential ladies to become patrons or stallholders. The wealthy patrons ensured a plentiful supply of goods for sale. The entrance fee of 2/6 during the day and one shilling in the evening raised further funds.¹⁰⁵

Further techniques used by Beatrice Clugston to persuade customers to part with their money were banners adorning the walls of the City Halls inscribed with various biblical quotations exhorting almsgiving. Some examples were: 'blessed is he that considereth the poor' and 'I was sick and ye visited me, naked and ye clothed me.'¹⁰⁶ The Town Council provided the City Halls free of charge and even donated money for decorations. The *Glasgow Herald* applauded the success of the bazaar by observing that 'the crowds were so great that locomotion around the Halls was difficult.'¹⁰⁷ But even more importantly, it took in £6,520 in four days. Frank Prochaska estimated that although nineteenth century bazaars took between £100 and £10,000, most were nearer to the lower figure.¹⁰⁸ Two bazaars held by the Co-operative Women's Guild to raise funds for Seamill in 1894 and 1899 realised far less, with £2,000 and £4,000 respectively.¹⁰⁹ The results of Beatrice Clugston's bazaar, by the standards of the day, were therefore relatively high. By December further donations brought the total to over £10,000.

¹⁰⁴ Prochaska, *Women and Philanthropy*, pp. 47-42. Frank Prochaska gives a good description of the Victorian Bazaar.

¹⁰⁵ 'Convalescent Home Bazaar in the City Hall', *Glasgow Herald*, 15 December 1864.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid.

¹⁰⁸ Prochaska, *Women and Philanthropy*, p. 54.

¹⁰⁹ W. Maxwell, *History of Co-operation in Scotland. Its Inception and its Leaders* (Glasgow, 1910), p. 360; GCA CWS 1/24/64, M. Cullen, *The History of the Scottish Co-operative Women's Guild* (n.d), p. 6; A. Buchan, *The History of the Scottish Co-operative Women's Guild* (Glasgow, 1913), p. 52; 'Grand Bazaar', *Scottish Co-operator*, January 1899, p. 7.

Beatrice Clugston and the managers decided to rent premises for the GCH rather than build a purpose-built home. It subsequently opened in July 1865 with space for thirty patients. Table 2.1 illustrates the strong financial position at the end of the second year. Although the rent and maintenance of the GCH was £800, the capital sum £10,000 remained, realising £422 interest per annum. This was an important form of security because they did not have a sponsoring organisation to underwrite any losses incurred, or to raise funds on their behalf. Also, there were no payments received from patients or any contribution from the infirmary, but instead they relied mostly on subscriptions for the majority of their income.

Table 2.1 'Abstract of Accounts' for 1866 at the GCH

Charge		Discharge	£
Funds at close of last account	£10,453 13s 05d	Expenses connected with alterations	£302 12s 10d
Contributions and Subscriptions to the Home	£958 14s 05d	Rent and maintenance of Home	£837 13s 02d
Interest on Funds	£422 05s 11d	Expenses of Management	£102 18s 04d
		Collectors Commission	£37 17s 07d
		Advertising and Printing	£22 03s 06d
		Miscellaneous expenses	£13 01s 07d
		Funds at close of this Account	<u>£10,517 06s 09d</u>
	£11,834 13s 09d		£11,834 13s 09d

Source: *Annual Report for the Glasgow Convalescent Home, 1867*

The Structure of the Board of Management at the GCH also provided the Home with both influence and stability. (See Appendix D). The Board included eminent representatives from civic elites on the Town Council, Merchants House, Trades House, Glasgow University, and representatives from the GRI and Royal College of Surgeons. Beatrice Clugston also managed to recruit Professor Lister to the Board of Management between 1865-1869. His name on the Board of Management during the early years of the GCH ensured the credibility of the Home within the medical

profession.¹¹⁰ Beatrice Clugston had therefore established both a very strong financial and management base upon which the GCH could function.

Only two years after opening the GCH, Beatrice Clugston established another much larger convalescent home, the Dunoon Homes. The fundraising and promotional methods used were similar to that at the GCH, with the engagement of large numbers of aristocratic patrons. Again, the time taken between the first public meeting in March 1868 and admission of the first patients in June 1869 was relatively short, at just over a year.¹¹¹ Beatrice Clugston again used another bazaar as the main source of funding for the Home. She also used an existing building, originally built as a hydropathic, by Robert Wylie of Wylie and Lochhead. However, it was never used as such, mainly because Wylie died shortly after its completion. The building lay empty for two years despite attempts by the trustees to sell it. This probably explains why it was sold for £6,000, although the construction of the hydropathic cost £11,000.¹¹² This sum included the fixtures and fittings.

Several other independent homes used the third method of establishing a convalescent home, by starting small, and then moving to a larger purpose-built property.

Newhills, a convalescent home sponsored by Catherine Cruikshank, wife of Rev. Dr Smith of Newhills, began with a few beds, in 1874. Once established, the Home moved to larger premises in 1881. As Edward Oliphant points out, 'with the advice and help of many in Aberdeen City and County, Newhills grew'.¹¹³ Likewise, Nairn CH opened in 1882 through a small group of friends, who rented a cottage with sufficient bed space for four patients. They later raised funds, enabling them to move

¹¹⁰ James Arthur, the founder of the first Paisley Convalescent Home, established in 1869, was also on the Board of Management at the GCH between 1869 and 1972. His association with the GCH may have prompted him to initiate the Paisley Convalescent Home.

¹¹¹ R. Hillhouse, *Bygone Years of the West of Scotland Convalescent Seaside Homes, Dunoon*, (Glasgow 1909), pp. 4-6.

¹¹² Clugston, *West of Scotland Convalescent Seaside Homes*, p. 7.

¹¹³ E. Oliphant, 'Newhills Convalescent Home and Sanatorium' in D. Rorie, ed., *The Book of Aberdeen*, (Aberdeen, 1939), p. 95.

to larger and permanent premises.¹¹⁴ Similarly, Linn Moor began by sending children to stay in the homes of rural families in 1892 but only later established a permanent home at Culter, Fife in 1907.¹¹⁵

Religious and Temperance CHs

Amongst the religious and temperance homes, Kilmun, the Mission Coast Home and the Dundee Convalescent House used the low-start method of establishing their convalescent homes. Using this conservative method involved less risk. These three homes rented relatively cheap and modest accommodation and only moved to larger, more permanent premises after they had gained the confidence of their supporters. Although the Mission Coast Home moved into a purpose-built convalescent home early in its history, according to J. Christie, when they opened in May 1866, the convalescent facilities consisted of a rented room and kitchen.¹¹⁶ The new building was purpose-built but unlike many hospital convalescent homes the design was functional and relatively plain.

Similarly, Kilmun also began by renting 'the Old Mansion' at Kilmun, a house with sufficient space to accommodate 500 patients annually. The move to larger, purpose-built premises was therefore not urgent, and did not occur until seven years later, in 1874.¹¹⁷ Confidence amongst supporters increased once Kilmun was established and the directors found it easier to obtain donations or subscriptions. The annual report stated that, 'the more the object and benefits of this Home become known, the less difficulty is experienced in getting the funds necessary for its support.'¹¹⁸ The new building accommodated 70 patients, a similar number to Corstorphine House and Broughty Ferry CH.¹¹⁹ Nonetheless, the estimated cost of the building was only £2,500, although this eventually crept up to £3,000. One of the reasons why Kilmun

¹¹⁴ David Stewart and Monica Edwards, *100 years of the Convalescent Home, Nairn* (Nairn, 1993), p. 5.

¹¹⁵ ACL 362/78/L64, 'Brief Summary of the History of Linn Moor Home from 1888 to 1948', *Sixtieth Annual Report of the Home for Ailing Children and Fresh-Air Fortnight*, 1949, p. 9. [Linn Moor].

¹¹⁶ J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888), p. 163.

¹¹⁷ See Illustration 5, for photograph of this building.

¹¹⁸ GCA TD.432/13, *Annual Report of Glasgow Abstainers Union*, 1874, p. 8.

¹¹⁹ See illustrations 1 and 2.

was so much cheaper than the hospital convalescent homes was that they did not waste money on facilities they considered over indulgent such as indoor water closets. At Kilmun, Henry Burdett described the sanitary arrangements as, ‘the closets are of the earth system and are outside the building.’¹²⁰ Most other larger convalescent homes, particularly the hospital convalescent homes such as Corstorphine House were built with indoor water closets.¹²¹ At the Schaw Home, *the Hospital* described the sanitary arrangements as ‘Bathrooms, w.c.’s and lavatory accommodation, carefully and properly isolated, are provided on each floor in separate blocks over the cloakrooms and on the principal floor.’¹²²

The following extract from an annual reports at Kilmun indicates that the plain design and economical construction of the building was part of a policy of keeping costs as low as possible:

Twenty-five years ago the present Home was erected, plain and substantial in its three separate buildings, without any attempt at display or architectural adornment and in its accommodation, provided with everything that was needful but nothing superfluous or extravagant, recognising that as it was intended for a Home it should be made as homely as possible for the class of patients who were to occupy it.

Further comments directed criticism at other convalescent homes they considered extravagant in style:

During recent years, other Homes have been erected, some of them grand mansions, with somewhat sumptuous accommodation and equipment,

¹²⁰ H. Burdett, *Hospitals and Asylums of the World. Vol IV* (London, 1893), p. 300.

¹²¹ GHHB 10/1/1, Minute Book of the Aberdeen Convalescent Hospital. Memorandum of Visit to the Edinburgh Convalescent Home, the Convalescent Home at Dunoon and the Glasgow Convalescent

¹²² ‘Hospital Construction’, *The Hospital*, 19 June 1897, p. 202. See also illustration 3.

providing not only for the necessities and comforts of life, but also for some of its luxuries, to which the Kilmun Home makes no pretensions.¹²³

These remarks probably referred to the Schaw and Hozier Homes, which displayed various ornate features in the design. The criticisms might also have been directed at the Dunoon Homes that was originally intended as a hydropathic for the middle-classes and had retained some of the luxurious features.

In common with Kilmun and the Mission Coast Home, the Dundee Convalescent House also began in small premises in a house in Union Street, Dundee in 1860. Later, in 1867, supporters of the Dundee Convalescent House raised £2121 through a bazaar. This was sufficient to purchase a larger house in William Street, then a pleasant suburb of Dundee.¹²⁴

One exception to the 'starting small' method was Hawthornebrae CH, run by the Edinburgh Medical Missionary Society (EMMS). A sole benefactor, Margaret Sanson, bequeathed a villa and grounds at Duddingston, for use as a convalescent home in 1892.¹²⁵ However, according to Olive Checkland, William Burns Thomson, superintendent of the EMMS between 1859 and 1871, sent patients to convalesce in three rented houses at Elie, Fife, and Polton.¹²⁶ During the 1880s the EMMS also sent many patients to convalesce at Ravenscroft CH.¹²⁷ Although it is not clear whether the EMMS promoted the idea of a new convalescent home amongst supporters, the established practice of sending patients to convalescent homes might have encouraged the bequest.

¹²³ GCA TD.432/13, *Thirty-Third Annual Report of the Kilmun Seaside Home for Convalescent Poor*, [hereafter *KSHCP*], 1900-1901, p. 5. [Kilmun].

¹²⁴ 'Dundee Convalescent House', *Dundee Advertiser*, June 1970.

¹²⁵ J. Wilkinson, *The Coogate Doctors. The History of the Edinburgh Medical Missionary Society 1841-1991* (Edinburgh, 1991), p. 41.

¹²⁶ O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p. 217.

¹²⁷ *Quarterly Papers of the Edinburgh Medical Missionary Society*, Vol. 2, p. 167. I am grateful to David Sutton, at the Centre for the History of Medicine, Glasgow for this information.

Financial Maintenance

Once the convalescent homes were up and running, managers of convalescent homes expected that endowments, donations, legacies or subscriptions would provide sufficient income for their financial support. Although the total income from these sources enabled the independent homes and the religious and temperance homes to achieve a relatively high level of financial stability, this was rarely the case for the hospital convalescent homes.

Table 2.2 Annual income and expenditure of convalescent homes in 1897 and 1928

Convalescent Home	Income 1897 £	Expenditure 1897 £	Deficit or Surplus 1897 £	Income 1928 £	Expenditure 1928 £	Deficit or Surplus 1928 £
Aberdeen Convalescent Hospital (H)	423	472	-49	1,193	1,243	-50
Arbroath (H)	145	198	-53	426	413	-13
Brooksby (H)	23	723	-700	920	2,541	-1,621
Broughty Ferry CH (H)	1,436	1,559	-123	2,352	4,512	-2,160
Corstorphine House (H)	2,003	2,229	-226	1,294	4,111	-2,817
Edzell (H)	188	188	0	372	482	-110
Hozier Home (H)	753	1,383	-630	1,730	2,282	-552
Dunoon Homes (I)	6,390	5,186	+1,204	12,935	12,740	+195
GCH (I)	2,418	2,540	-122	4,412	3,949	+463
Nairn CH (I)	125	129	-3	248	220	+28
Newport (I)	186	179	+7	608	608	0
Paisley (I)	1,256	1,383	-127	3,924	3,755	+169
Kilmun (R)	1,136	1,151	-15	4,715	4,610	+105
Mission Coast Home (R)	1,172	1,194	-22	3258	3,416	-158

Source: Burdett's Hospitals and Charities (1899 and 1930) [information in Burdett's took two years to filter through the system]

Key: H = Hospital Convalescent Home, I = Independent Convalescent Home, R = Religious Temperance Convalescent Home

Table 2.2 lists the income and expenditure of seven hospital and seven independent or religious and temperance homes during two periods, 1897 and 1928. In both years, the expenditure at the hospital convalescent homes exceeded their annual income. Although most of the non-hospital convalescent homes also experienced some deficit in 1897, it was small compared with the infirmaries. By 1928, the only non-convalescent home whose expenditure exceeded income was the Mission Coast Home. Given their total income of £3258, the £158 deficit was a relatively small. By contrast, the deficit between income and expenditure was high in hospital

convalescent homes. Survival of most hospital convalescent homes depended on the parent infirmaries making up the deficit. For example, the Western Infirmary at Glasgow made up deficits of £408 in 1894¹²⁸ and £516 in 1912 at the Hozier Home.¹²⁹ However, the financial strain on the infirmary resources dampened the initial enthusiasm of the managers towards convalescent homes.

Table 2.3 provides a closer perspective on the income and expenditure for each patient. These figures were obtained by dividing the total income and expenditure of the convalescent homes between their total number of patients admitted during 1897 and 1930.

Table 2.3 Income and expenditure per patient in 1897 and 1930

Name of Home	Income Expenditure		Surplus or Deficit	Income Expenditure		Surplus or Deficit
	1895	1895		1928	1928	
	£	£	£	£	£	£
Aberdeen Convalescent Hospital (H)	2.41	2.69	-0.28	2.65	2.76	-0.11
Arbroath CH (H)	1.96	2.71	-0.75	5.13	4.97	+0.16
Brooksby (H)	0.06	2.01	-1.95	1.55	4.29	-2.74
Broughty Ferry CH (H)	1.35	1.46	-0.11	2.09	4.11	-2.02
Corstorphine House (H)	1.53	1.71	-0.18	0.81	2.59	-1.78
Edzell (H)	0.26	1.73	-1.47	0.81	5.02	-4.21
Hozier Home (H)	1.09	1.76	-0.67	1.73	3.71	-1.98
Dunoon Homes (I)	1.57	1.27	+0.03	2.01	1.98	+0.03
GCH (I)	1.38	1.45	-0.07	2.71	2.04	+0.67
Nairn CH (I)	2.01	2.08	-0.07	3.39	3.11	+0.28
Newport (I)	0.91	0.88	+0.03	1.31	1.31	0
Paisley (I)	1.07	0.98	+0.09	2.09	2.46	-0.37
Kilmun (R)	0.75	0.79	-0.04	3.27	2.37	+0.09
Mission Coast Home (R)	1.23	1.46	-0.23	2.11	2.44	-0.33

Key: H = Hospital convalescent home, I = Independent convalescent home and R = Religious and temperance convalescent home

Source: *Burdett's Hospitals and Charities*, 1897 and 1930 [figures given in *Burdett's* were two years preceding publication date]

¹²⁸ GGHB HB 6/3/3, AR, WI, Glasgow, 1893-95, p. 7.

¹²⁹ GGHB HB 6/3/8, AR, WI, Glasgow, 1912-13, p. 86.

Table 2.3 illustrates that the difference between income and expenditure ‘per patient’ was far greater in 1928 than in 1897 in the hospital convalescent homes. Only the Arbroath Convalescent Home managed a higher income per patient than expenditure, although at the Aberdeen Convalescent Hospital the deficit was negligible. Expenditure in the other hospital homes was far higher than non-hospital convalescent homes, and by 1928 it exceeded their income. Henry Burdett believed that the voluntary component in the non-hospital convalescent homes enabled them to function more economically than the hospital convalescent homes.¹³⁰ However, a comparison between the expenses at the GCH and Corstorphine House in the late 1930s in Table 2.4 indicates that there were additional factors besides the ‘voluntary component’ involved. These two homes admitted a similar number of patients each year. For example, in 1934 Corstorphine House admitted 1523 patients and the GCH admitted 1500 patients. Comparable figures on expenditure for the nineteenth century were not available.

Table 2.4 Expenditure in 1936 at GCH and 1938 Corstorphine House

Expenses	GCH 1936 (nearest £)	Corstorphine House 1938 (nearest £)
Provisions	959	1,350
Transport (patients)	23	107
Heating	398	415
Taxes	193	48
Water	56	0
Cartage of Coal	24	0
Doctors Salaries	136	15
Other salaries	651	1,255
Cost of Gardening	217	118
Administration or Management expenses	314	75
Advertising, Printing, Stationery	58	33
Furnishings	116	311
Repairs	384	1,053
Miscellaneous	203	91
Surplus	91	0
Laundry, Cleaning and Chandlery	0	80
Medicines	0	208
Total Expenditure	3,823	5,159

Sources: *Annual Report of the GCH, 1936* and *Annual Report for the Royal Infirmary of Edinburgh, 1938*.

¹³⁰ *Burdett's Hospitals and Charities* (London, 1917), pp. 140-142.

Corstorphine House spent far more on food, transport, medicines and laundry, and additional salaries; by comparison the GCH spent more on administration, cost of gardening and taxes. Surprisingly, the doctors' expenses were higher at the GCH, but overall their salaries bill was far lower than at Corstorphine House. However, the major contribution to the higher expenditure at Corstorphine House was the £1,144 spent on repairs and furnishings. In order to exclude the possibility that this was not an isolated incident, expenditure in 1922 and 1923, was also examined. In both these years expenditure on furnishing and repairs was almost identical, at £1,014 and £1,180 respectively. Although expenditure on provisions, medicines and laundry contributed to the higher expenses, it seems therefore that the main cause was the running costs of the building.

Examining the various income sources, such as subscriptions and investments, to some extent explains the stronger financial position of non-hospital convalescent homes. The subscriber system operated by either individuals or an organisation, such as a church or group of employees, pledging an annual sum of money to the charity.¹³¹ Because these annual subscriptions were such a valuable source of income, charities often offered incentives to become a subscriber. One such incentive was the publication of the names of subscribers in annual reports and sum subscribed, thus advertising the generosity of the donor. Another incentive was the opportunity to act as representative of the subscribers on the Board of Management. At the larger charities and institutions this was often regarded as a prestigious appointment. An even greater source of encouragement, particularly at hospitals and some convalescent homes, was the entitlement of some subscribers to recommend the admission of patients.¹³² However, subscribers to convalescent homes attached to the infirmaries could not recommend patients for admission. This was because the

¹³¹ H. W. Hart, 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24 (1980), pp. 447-460; M. Gorsky, J. Mohan and M. Powell, 'British Voluntary Hospitals 1871-1938: The Geography of Provision and Utilization', *Journal of Historical Geography*, 25 (1999), p. 467.

¹³² The number of patients a subscriber could recommend depended upon the annual amount subscribed but it was usually around one patient per annum for each pounds subscribed annually.

hospital doctors usually took the decision to send a patient to an infirmary convalescent home. There was therefore less incentive to subscribe to the hospital convalescent home than the parent infirmary. By contrast, the incentive to subscribe to an independent convalescent home was far greater, since many of these homes gave their subscribers the privilege of recommending patients for admission. Some convalescent homes, such as the Dunoon Homes and the GCH, admitted patients only on recommendation from a subscriber or hospital doctor.

The lack of subscriber lines at hospital convalescent homes was probably one reason why subscriptions to most hospital convalescent homes only increased by a small amount between the nineteenth and twentieth centuries. For example, subscriptions at the Hozier Home between 1893 and 1914 rarely rose above £300 per annum.¹³³ By contrast, at the GCH, their total annual subscriptions, between 1873 and 1938 were usually between £1,000 and £1,500 per annum. At the Dunoon Homes, annual subscriptions were higher, because it was a much larger home with four times as many patients. Subscriptions were therefore proportionally similar. In 1885, subscriptions at the Dunoon Homes totalled £4,240, rising to £5,334 in 1895 and £6,503 in 1901.

Despite their financial advantages, the admission of patients through subscriber's lines caused concern amongst some convalescent home managers, particularly the religious/temperance homes, because they believed it excluded many needy people. There was some truth in this view, since obtaining admission to a convalescent home through a subscribers line depended on having a connection to a subscribing individual or organisation. The poorest people, often in the greatest need, were the least likely to have such connections. Kilmun compromised by allowing subscribers to recommend patients for admission provided they did not displace those in greatest need. In 1871, their Managers stated, 'it is also first for the poor of the mission districts and after that, for the poor by whomsoever recommended.'¹³⁴ The Mission

¹³³ GGHB HB 7/1/1, ARs, *Lady Hozier Convalescent Home*, 1893-1914.

¹³⁴ GCA TD.432/13, *Annual Report of the Glasgow Abstiners Union*, 1871, p. 6.

Coast Home also displayed a certain amount of moral caution over subscriptions. But they reconciled the dilemma by allowing recommendation from subscribers or another suitably qualified person.

Many of the hospital convalescent homes relied more on the interest from an endowment or from the accumulation of capital sums as income for their convalescent homes than subscriptions. However, it was necessary to have very large capital sums to raise sufficient income to sustain a convalescent home. Even a vast capital sum such as the £39,000 at the Dunoon Homes recorded in 1933 produced only £1,949 out of their total income of £12,681. It was therefore not surprising that in 1876, the *BMJ* expressed some doubts over whether an apparently substantial endowment of £20,000 presented to the Dundee Royal Infirmary was sufficient to maintain their new convalescent home at Broughty Ferry CH.¹³⁵ This also explains why, despite the provision of an endowment of £12,600 intended to support the Hozier Home, it continued to have financial problems. In 1914, William Hozier's son, the second Lord Newland, alleviated the financial problems of this convalescent home by providing a £25,000 top-up to the endowment.¹³⁶ Similarly, only a year after the opening of the Schaw Home, managers of the GRI were commenting on the insufficiency of funds from their endowment. The report stated:

The net expenditure of £1,062.16s.1d, last is at the rate of £1.11s. 7d per patient and keeping in view that the Home will probably be more advantageous in the future it is evident that, after imputing the interest on the endowment fund a considerable amount of charge will remain to be defrayed from the general revenue.¹³⁷

Other forms of income included legacies, donations, either as money or as food, magazines, books and clothes. The non-hospital convalescent homes seemed to fare

¹³⁵ *BMJ*, 24 June 1876, p. 793.

¹³⁶ 'The Lady Hozier Convalescent Home', *GMJ*, August 1914, p. 108; L. MacQueen and A. Kerr, *The Western Infirmary, 1874-1974* (Glasgow, 1974), p. 16; *GMJ*, February 1915, pp. 140-141.

¹³⁷ GGHB HB 14/2/10, *Annual Report of the Glasgow Royal Infirmary*, 1896, p. 9.

better with these additional resources than the hospital convalescent homes. Again, this is probably explained by the competition from the more prestigious parent infirmaries. Some homes also received payments from patients, but generally they were small amounts. The Dunoon Homes, for instance, only took a few paying patients during the quiet winter months, and in 1933 the total amount from this source was only £25.00, while Glencaple only charged the patients 2/6 per week.

Many convalescent homes used collectors to solicit regular donations from the community. Although the hospital convalescent home also used collectors, it was often the same as the collector from the main infirmary. A letter from James Smith published in the *Ardrossan and Saltcoats Herald* addressed to his 'friends and associates' indicates that most homes used collectors, either paid or unpaid. This stated that, 'many of our kind friends think and urge that we should canvass and push for funds as other institutions do, and they assure us that like them we would obtain large sums.'¹³⁸ The final part of the letter expressed Smith's distaste for canvassing and his belief that the Mission Coast Home had sufficient friends or influence:

Funds sufficient to meet all demands will still be sent in to us, a further plea to, allow me again to say that the work is already so great that I am utterly unable to do more, and that I shall take it kind of friends not to press the very objectionable work of canvassing upon me.¹³⁹

Despite the conservative attitude towards fundraising at Kilmun and the Mission Coast Home, neither seemed to suffer financially, perhaps because they were always able to promote the homes through their underlying sponsorship. The religious and temperance homes also did not experience equivalent competition for funding from a grander and more prominent institution such as the main infirmary. The Glasgow Abstainers Union, sponsors of Kilmun, raised money and support for the Home through the mission meetings, regular Saturday concerts and through members of the

¹³⁸ 'West Coast Mission Home', *Ardrossan and Saltcoats Herald*, 18 November 1871.

¹³⁹ *Ibid.*

Glasgow Abstainers Union. On one occasion in 1921, when funds were low, the directors at Kilmun sent a letter to all their supporters requesting donations to the Home.¹⁴⁰ Other non-hospital homes also made continual efforts to raise funds. For example, after the initial bazaar to raise funds to establish the Dunoon Homes, Beatrice Clugston organised several more to raise further funds, in 1871, 1875 and 1882. The final bazaar in 1882 organised by Beatrice Clugston raised £15,000.¹⁴¹ Given that Prochaska's estimate of £10,000 was at the top end of the scale in terms of the usual proceeds from a bazaar, £15,000 was remarkable.¹⁴²

The foregoing discussion has therefore established that (apart from the exceptionally wealthy AAI) few hospital convalescent homes received sufficient annual income from donations, subscriptions or an endowment to maintain the expenditure of their convalescent homes. The difficulties experienced by Corstorphine House were typical of those experienced by other hospital convalescent homes. It therefore makes an interesting case study, upon which to understand the problems experienced by other hospital convalescent homes.

Case study of Corstorphine House Finances

Following its establishment in 1867, Corstorphine House received some revenue from donations, legacies and subscriptions, but in common with other hospital convalescent homes, the annual income received from these sources was insufficient to fully maintain the Home. For example, subscriptions at Corstorphine House between 1870 and 1939 seldom rose above £200 per year. This was despite recognition that the convalescent home had to compete for subscriptions from the parent infirmary. In 1870, they reported that:

The managers have again to express their regret that the subscribers to the convalescent house are so few. An opportunity was given in the collecting

¹⁴⁰ GCA TD.432/20, Letter from Directors of Kilmun in 1921 to all supporters requesting further donations to the convalescent home.

¹⁴¹ A. D. Morrison, *The Story of Free St David's* (Kirkintilloch, 1926), p. 84.

¹⁴² Prochaska, *Women and Philanthropy*, p. 54.

books of subscribing separately for the convalescent home but there was not any material difference from the receipts of the preceding year. The managers hope that the public will see the necessity of increasing support to this excellent institution either by subscribing specially to its funds or by increased subscriptions to the funds of the Infirmary.¹⁴³

The managers continued to express concern over the low level of subscriptions and other donations. This concern subsided in 1874 when a legacy of £6,000 from Miss Millar of Earnock provided an annual sum in interest of £600.¹⁴⁴ Although the gift seemed to ease the difficulties of convalescent home finances for a while, it deteriorated in 1892, when another bequest from James Naysmith, a prominent engineer, enabled the Home to expand and provided a further forty beds. Neither the benefactor nor the managers made any allowance for the increased expenditure. Not surprisingly, in 1893, the year following the opening of the extension, expenditure for Corstorphine House shot up by £500.

In 1894, the Managers summarised the difficult financial position of Corstorphine House.

The Managers desire very specially at this time to draw attention to the funds of the convalescent house. The only capital belonging to that important adjunct to there is a sum of £5,706. Apart from the interest on that sum and the handsome half yearly payments by the trustees of the late Miss Millar of Earnock, the managers have only to look to the annual subscribers aided by an occasional legacy for the revenue necessary to keep the house open and in an efficient condition.¹⁴⁵

¹⁴³ LHB 1/4/70, *AR, RIE*, 1870-71, p. 6.

¹⁴⁴ LHB 1/4/73, *AR, RIE*, 1873-74, p. 6.

¹⁴⁵ LHB 1/4/94, *AR, RIE*, 1894-95, p. 25.

During the next ten years, the managers at the RIE regularly expressed concern over the expenditure involved in the running of their convalescent home. In 1911, matters reached crisis point when the infirmary managers revealed that the bank overdraft amounted to over £10,000. Agitation over finance from the infirmary managers was eventually subdued when the Law and Finance Committee of the Infirmary realised they had overlooked the original terms of Seton Brown's bequest. The agreement between the RIE and Seton Brown was that once Corstorphine House was handed over to the Infirmary they were to take responsibility for the upkeep. Following this revelation, the Hospital Managers decided to discharge the overdraft from the bank and thereafter make up any deficit incurred.¹⁴⁶ Nevertheless, the Infirmary continued to appeal for funds to support the convalescent home, and express concern over the deficit in the convalescent home accounts. For example, in 1931, the RIE annual report stated:

In view of the immense value of this adjunct to the infirmary in providing recuperative facilities for such a large number of patients it is to be regretted that the constantly recurring annual deficiency of over £2,000 on the maintenance of this establishment falls as an additional burden on the infirmary funds.¹⁴⁷

Yet again, in 1936 their annual report commented, 'unfortunately the income falls far short of the cost of maintenance and the balance has to be met from the funds of the infirmary.'¹⁴⁸ Although the financial problems of Corstorphine House were more severe than many other hospital convalescent homes, their nature was similar. It therefore helps to explain why most hospital convalescent homes did not manage to remain financially independent of the infirmaries.

¹⁴⁶ LHB 1/4/110, AR, RIE, 1910-11, p. 26.

¹⁴⁷ LHB 1/4/131, AR, RIE, 1931-32, p. 28.

¹⁴⁸ LHB 1/4/136, AR, RIE, 1936-37, p. 35.

Conclusion

The first part of this chapter considered the major influences surrounding the establishment of the convalescent homes during the nineteenth century. It revealed how prominent individuals such as Florence Nightingale, Henry Burdett and James Burn Russell encouraged the concept of establishing convalescent homes for the sick poor. The chapter also disclosed how Beatrice Clugston recruited and initiated support from all sections of society, through bazaars, public meetings and the distribution of numerous pamphlets throughout the West of Scotland. Although it is widely believed that Beatrice Clugston was the most prominent of the sponsors of convalescent homes, there were many others involved. During the later nineteenth century, the COS criticised some aspects of convalescent homes such as admission procedures and staffing. Although they were relatively unsuccessful in influencing the organisation of admission procedures, their publicised views over staffing may have influenced the introduction of a higher level of nursing and medical care into convalescent homes.

The second part of the chapter explored the mechanisms used to establish and maintain the convalescent homes. Three different methods were used to finance the convalescent homes. Firstly, through a sole benefactor; second, by establishing a fund drawn from donations through a range of individuals and organisations; thirdly, by beginning as a small concern and then developing into a larger organisation. The hospital convalescent homes mostly acquired their funding through a sole benefactor. However, this often led to problems when sole benefactors laid down conditions over their gift, such as the dedication of the convalescent home to a dead relative. These buildings were often unnecessarily elaborate and expensive to build and maintain. Although the providers of independent homes used all three methods, generally the buildings costs were less. Religious and temperance homes were mostly used the third method, starting small and growing into larger establishments. The buildings used by religious and temperance homes were also less expensive to construct and maintain. For example, Kilmun began as a relatively small operation, but after several years generated enough support to build a very large permanent home.

Nevertheless, the construction of the building cost half that of most hospital convalescent homes.¹⁴⁹

Hospital convalescent homes took far longer to establish than homes in other groups. Most hospital convalescent homes took around five years between the appeal for a benefactor and the final opening, whereas the time taken for homes in other groups was around a year. For example, GCH and the Dunoon Homes, both took around a year between the appeal for funds and opening of the home, whereas Corstorphine Home took around five years. Once established, the independent and religious and temperance homes achieved a greater level of financial stability than the hospital convalescent homes. Expenditure in most hospital convalescent homes greatly exceeded their income. The gap between income and expenditure became progressively wider during the twentieth century. The accounts for Corstorphine House suggest that the cause of their overspending was mainly due to the high maintenance costs of the building, although expenditure on food and staff was also high.

During the twentieth century the initial enthusiasm of hospital managers towards convalescent homes gradually subsided as the homes drained financial resources away from the infirmary funds. This partly explains the lack of growth in hospital convalescent homes. By contrast, most of the non-hospital homes prospered and many increased in size. This, together with the factors that influenced the general development of convalescent homes during the twentieth century will be the topic of the next chapter.

¹⁴⁹ Kilmun is now closed as a convalescent home. Nevertheless, the building has stood the test of time although it has been converted into several permanent residential flats. See illustration 5, p. 64.

Chapter Three

Development and Consolidation in the Twentieth Century

During the early part of the twentieth century, convalescent homes continued to stress the benefits they offered to the sick poor. For example in 1901, John Ritchie, the Medical Officer for the Dunoon Homes noted:

They have very great difficulty – as residents of crowded dwellings amid impure air – in having their convalescence perfected. When it is considered that the majority of these cases come from homes in which they can only command, with great difficulty, the comforts of life in a stinted fashion – in some cases only the barest necessities – you can easily see, as the Directors, that the Institution is nobly fulfilling its purpose.¹

Similarly, in 1922, the GCH argued that the nutritious diet, medical and nursing attention they offered to convalescent patients was unavailable in their own homes:

Patients recovering from operations in the Infirmaries or illness in their homes are provided with a comfortable home in the country within a short distance of the city, and they are furnished with good food, medical attention and nursing, which they could not obtain in their own homes.²

Although by the twentieth century there were some improvements made within Scottish cities, it fell far short of what was necessary to remedy the health problems resulting from overcrowding and poor social conditions.³ Initiatives, such as the slum clearance and new building undertaken by the Glasgow City Improvement Trust, created new tenement houses for 10,000 people. Yet, the rents in the new tenements

¹ ML G.362.160941435, *Thirty-Second Annual Report of the West of Scotland Convalescent Seaside Homes*, Dunoon, [hereafter *WSCSH*], 1901, p. 11. [Dunoon Homes].

² ML G.362.160941435, *Fifty Eighth Annual Report of the Managers of the Glasgow Convalescent Home* [hereafter *GCH*] to the Subscribers, 1922, p. 7.

³ T. Fergusson, *Scottish Social Welfare, 1864-1914* (Edinburgh, 1958), pp. 154-185.

were often too high for the poor, so the vast majority remained in overcrowded and insanitary housing.⁴ After the First World War, local authorities developed several new housing schemes in Scottish cities. However, increases in population constantly offset efforts to remedy problems caused by cramped living conditions. The new estates, such as those at Riddrie, Mosspark and Knightswood in Glasgow, therefore had only a minor impact on density levels.⁵

Dr W.A. Murray, when a general practitioner in Glasgow, described the commonplace experience of his patients during the inter-war period.

My patients were, as it happened, nearly all in the Gorbals area and round George Square. There we saw housing conditions, which were, at that time among the worst slums in Europe. We saw real deprivation, of a kind never seen nowadays. There were tenements in which perhaps four families occupied a very large 'single end' on one floor. Their only water supply for all purposes was a cold-water tap over a large cast-iron sink on the landing, in front of a window – usually broken. One WC on the same landing served all these families.⁶

A South African Midwife practicing during the mid 1930s described the poverty she found amongst the patients in similar neighbourhoods of Glasgow:

Some of the places I went to were so poor and dirty and lacking in any sort of conveniences. They lived in one room with a bed in the wall and a communal lavatory. I don't know where the water was. They didn't have it in their room..Some of the closes and tenements were awful. There was a place called Garngad which was worse than the Gorbals – slops in the street – very dirty. It was all so sad and pathetic. I had never seen people living in those sort of

⁴ B. Lenman, *An Economic History of Modern Scotland 1660-1977* (London, 1977), p. 203.

⁵ F. Wordsall, *The Glasgow Tenement* (Glasgow, 1979), p. 11.

⁶ Wellcome Centre for the History of Medicine Library, Glasgow, BZP (MUR), W. A. Murray, *A Life Worth Living* (n.d), p. 9.

conditions. Things may have been bad in our slums in Johannesburg and other places in South Africa but nothing as bad that.⁷

The situation was similar in other urban areas of Scotland.⁸ Poverty affected nutrition as well as housing, since it was difficult to sustain an adequate diet under such economic restraints.⁹ There was also a lack of knowledge of dietary nutrition within the general population. For instance, the discovery of vitamins in food did not occur until 1906 and in 1919, and professionals still disagreed over the causes of rickets.¹⁰ However, a major concern from some researchers during the inter-war period was the insufficiency of calorific intake amongst the poor. In 1922, Annabel Tully and Elizabeth Urie from the Institute of Physiology at Glasgow University studied the diets and economic conditions of labouring-class families in Glasgow. They concluded that 'the results reveal a distressing picture of under-feeding and under-nutrition.'¹¹ The situation had improved little by the 1930s when John Boyd Orr's investigation into nutrition estimated that four and a half million people in Britain were deficient in protein, fat, carbohydrates and vitamins. Boyd Orr also calculated that a further eighteen million people had a diet that was inadequate in some way.¹²

Although air pollution adversely affected all sections of the urban population, the poor suffered more than the middle-classes because they generally lived in areas with

⁷ Quoted in: L. Reid, *Scottish Midwives* (East Linton, 2000), pp. 25-26.

⁸ See: J. Doherty, 'Dundee – A Post Industrial City', in C. Whatley, ed., *The Re-making of 'Juteopolis' – and How It Was* (Dundee, 1992), pp. 24-29; C. Whatley, et al., *The Life and Times of Dundee* (Edinburgh, 1993), pp. 151-153, 161-174; C. Harvie, *No Gods and Precious Few Heroes* (Edinburgh, 1981), pp. 75-77; T. C. Smout, *A Century of the Scottish People, 1830-1950* (London, 1987), pp. 109-131.

⁹ See: M. Spring Rice, *Working Class Wives* (Second edition, London, 1981), pp. 155-187; A. MacGregor, *Public Health in Glasgow 1905-1946* (Edinburgh and London, 1967), pp. 37-42.

¹⁰ M. Steven, *The Good Scots Diet* (Aberdeen, 1985), pp. 100-113.

¹¹ A. Tully and E. M. Urie, 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow', *GMJ*, VI, (December, 1922), pp. 353-368.

¹² J. Boyd Orr, *Food Health and Income* (London, 1936), p. 49. Not everyone during the inter-war period agreed that poverty caused poor nutritional standards. Others such as Noel Paton, Regius Professor of Physiology at Glasgow University during the early twentieth century believed the cause was due to poor housekeeping or marketing standards. For a discussion on the contemporary debate over this issue see: D. F. Smith and M. Nicholson 'Poverty and Ill Health Controversies Past and Present', *Proc. R. Coll. Physicians Edin.*, 22 (1982) pp. 190-199.

higher levels of contamination from domestic and industrial chimney smoke. Murray also blamed industry for illnesses amongst the poor.

Sickness under treatment in the wards was generally of a severe nature with pneumonia, bronchitis, rheumatism and valvular disease of the heart as the most common. Glasgow and the West of Scotland were, even in those days, paying the price for heavy industry and the resultant smog.¹³

The respiratory illnesses, rheumatism and heart disease as described by Murray, were also the most frequent illnesses found amongst patients in convalescent homes.¹⁴

Thus, health problems resulting from poor social and environmental conditions that provided the catalyst for establishing convalescent homes during the nineteenth century still prevailed in the twentieth century. Nevertheless, several significant changes took place during the twentieth century that affected the overall development of convalescent homes. The first was that self-assurance schemes established new convalescent homes for adults as a benefit rather than a charity. The alleviation of the effects of poverty was therefore no longer the only justification for establishing a convalescent home. Secondly, many of the new convalescent homes were more flexible in their admission policies. The sponsors of many new children's convalescent homes often found it difficult to differentiate between children in convalescence, and those with health problems likely to benefit by a holiday at the sea or in the country. Providers of some adult convalescent homes were also willing to admit patients in order to prevent illness. The consequence of this relaxation in admission policies was a closer identification of convalescent homes with holidays. Thirdly, increased government intervention in health services also affected convalescent homes. During the inter-war period, the Scottish Department of Health undertook several investigations to establish the extent of medical provision in Scotland, including convalescent homes. The medical elites reporting on the

¹³ Murray, *Life Worth Living*, p. 12.

¹⁴ See Chapter Four on Illnesses.

investigations attempted to marginalise some convalescent homes by re-classifying them into either a medical or non-medical category.¹⁵

A fourth development was that the casualties of the First World War accelerated new rehabilitative techniques such as physical and occupational therapy. These new methods initiated changes in perception and expectations from convalescent homes, especially from the medical profession. In Scotland, the AAI, established in 1923, was particularly active in developing an experimental approach towards rehabilitative therapies. The immensely wealthy legacy responsible for financing the AAI made this possible. It allowed the institution to employ more doctors, nurses and therapists than was usual in traditional convalescent homes. The new methods used at the AAI gave substance to the views of medical elites that convalescent homes using traditional non-scientific methods were not medical institutions. Elizabeth Gardiner and John Bryant, contemporary authors on convalescence during the inter-war period, both noted the introduction of new processes and changing boundaries within convalescence. However, neither author attempted to segregate convalescent homes into medical or non-medical categories.¹⁶

This chapter explains the reasons for the new perspectives and divergences in the development of convalescent homes. Firstly, this chapter examines the changes that occurred within the existing homes. Secondly, this chapter explores the most significant factors affecting the general development of new convalescent homes between 1900 and 1939. These were: the effects of the increased interest in the welfare of mothers and children; the development of support and interest in convalescent homes by mutual assurance societies and the consequences of the First World War. Thirdly, the chapter includes a review of the issues relating to convalescent homes contained in the numerous official reports published by the

¹⁵ C. Heckman, *Convalescence*, Unpublished MA Dissertation (Kings College, London, 1995), p. 77. In her conclusion, Heckman observed similar attempts to reclassify convalescent homes in the London area, although she believed that this arose out of the needs of medical staff.

¹⁶ E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), pp. 81-82. J. Bryant, *Convalescence, Historical and Practical* (New York, 1927), p. 32.

Scottish Department of Health during the inter-war period. The chapter concludes with an analysis of a re-interpretation of the convalescent homes that occurred during the twentieth century.

Perspectives and Change in Existing Convalescent Homes

Despite the concern expressed by many hospital managers over the escalating costs of hospital convalescent homes, the annual reports of the infirmaries continued to stress their economic and medical benefits.¹⁷ For example, the annual report of Glasgow's Victoria Infirmary remarked on the advantages of their convalescent home, the Brooksby, stating, 'the Home at Largs continues to be a valuable adjunct to the Infirmary.'¹⁸ In 1929, the Dundee Royal Infirmary was more specific about the merits of their convalescent home, Broughty Ferry CH, in releasing beds for the more acutely ill. The report stated that, 'the Home continues to carry on its useful work. Every bed filled in the Home means the release of a bed for more urgent purposes at the Infirmary.'¹⁹ In 1933, the annual report of the RIE stressed the rest and good food, provided by Corstorphine House, in the following statement:

The convalescent house serves a very useful purpose and the beautiful situation looking directly over to the Pentlands makes a most desirable place for those patients, who after a period in the Royal Infirmary, required rest and good food before resuming their usual occupations.²⁰

In 1934, their annual report continued to record benefits, noting that 'there can be no doubt of the very material advantage obtained by patients who are able to come to the convalescent home.'²¹ Despite the value placed on the hospital convalescent homes, during the twentieth century there was little evidence of expansion of their premises. This lack of expansion was probably due to concern from Infirmary managers over

¹⁷ *A Scheme of Medical Service for Scotland*, 1920. Cmd. 1039 (MacAlister Report), p. 5.

¹⁸ *GMJ*, February 1915, p. 142.

¹⁹ THB 1/2/10, *Annual Report of the Dundee Royal Infirmary*, 1929, p. 291.

²⁰ LHB 1/4/33, *Annual Report of the Royal Infirmary of Edinburgh*, 1933, p. 32.

²¹ LHB 1/4/34, *AR, RIE*, 1934, p. 34.

escalating costs. By contrast, most of the larger independent homes and religious and temperance homes were in a far healthier financial position. This enabled them to engage in various programmes of expansion.²² At the Dunoon Homes, the largest of the independent convalescent homes, new extensions or renovation of their premises was almost an annual event. For example, in 1904, the managers erected an open-air shelter in the grounds.²³ In 1907, they opened a new wing containing additional fifty-seven bedrooms, directors and doctors' rooms, apartments for the matron and superintendent.²⁴ In 1911, they made extensive alterations to the kitchens,²⁵ and in 1915 they erected a pavilion in the gardens.²⁶ In 1924, the managers opened a new wing for mothers and children,²⁷ and in 1931 they built new servants quarters.²⁸ By 1939, the Dunoon Homes were three times larger than their original size, and cared for almost as many patients annually as the number of patients admitted each year to the hospital convalescent homes.²⁹

Expansion also occurred in other non-hospital convalescent homes. In 1906, the Mission Coast Home purchased a cottage next to the convalescent home.³⁰ In 1920, they renovated their bathrooms and installed a new set of hydropathic baths.³¹ In 1905, Kilmun renovated their existing building and built on a new extension.³² In 1914, the managers completed a further extension, containing three additional bedrooms, sitting room and bathroom, plus a remodelled kitchen.³³ In 1928, they opened the Cowie Annex, an extension for mothers and children.³⁴ Similarly, in 1926, the GCH built a day room for mothers and children and reported the

²² See Chapter Two for discussion on finance of convalescent homes, especially pp. 67-91.

²³ Argyle and Bute District Archives, Plans in the Dean of Guild series.

²⁴ *Lancet*, 15 September 1906, p. 765; *BMJ*, 22 June 1907, p. 1514.

²⁵ Argyle and Bute District Archives, Plans in the Dean of Guild series.

²⁶ *Ibid.*

²⁷ *GMJ*, 1 July 1924, p. 55.

²⁸ Argyle and Bute District Archives, Plans in the Dean of Guild Series.

²⁹ See Chapter One, p. 33.

³⁰ GCA T.Par 1.7, *Forty-Second Annual Report of the Mission Coast Home, Saltcoats, 1906-1907*, p. 6.

³¹ ML G.362.160941435, *Fifty-Sixth AR, Mission Coast Home, 1920-21*, pp. 3-4.

³² 'Kilmun Seaside Homes', *Lancet*, 6 May 1905, p. 1235.

³³ *GMJ*, October 1914, p. 295; GCA TD.432/13, *Annual Report of the Kilmun Seaside Home*, [hereafter *KSH*] 1915, p. 5. [Kilmun] See Appendix C for other titles given to this convalescent home.

³⁴ GCA TD.432/13, *Sixty-Second Annual Report of the Kilmun Convalescent Home [KCH, formerly KSH], 1928-29*, p. 5. [Kilmun].

modernisation of much of their equipment.³⁵ These various extensions enabled the West of Scotland convalescent homes to accommodate more patients and keep pace with the growing demand. In other parts of Scotland, where the independent and religious homes were smaller, there was less growth amongst the existing homes. Following the First World War, Nairn CH struggled to survive because many of the original supporters died and were not replaced.³⁶ Hawthornbrae CH, a small religious convalescent home near Edinburgh, continued to function, but during the twentieth century admitted only women and children.³⁷ Thus, most of the existing convalescent homes continued to thrive even when there was little expansion.

Welfare of Children and Mothers of Young Children

Many of the new convalescent homes established during the twentieth century were for children. This reflected the acceleration of national interest in the welfare of children that developed during the twentieth century. Similar attention also focused upon their mothers from around 1914. Although widely acknowledged, the growth of interest in child welfare has a number of explanations within current literature. For example, Harry Hendrick comments on the 'festival of reform' that occurred during the period 1890-1918. This 'festival' covered the education, health and welfare of children.³⁸ Other authors concentrated on specific issues. Roger Cooter, for instance, refers to the late Victorian and Edwardian preoccupation with childhood and the growth of institutions for the crippled child.³⁹ Many authors attribute the developing interest in the welfare of children to the general anxiety over persistently high mortality rates published by the Registrar General. Whilst accepting the contribution of these various issues, Debra Dwork and Anne Crowther also argue that the First World War stimulated national efficiency because of the need to replace the lost

³⁵ *GMJ*, March 1926, p. 227; ML G.362.160941435, *AR, GCH*, 1925, p. 7.

³⁶ D. Stewart and M. Edwards, *100 years of the Convalescent Home, Nairn* (c.1993), p. 5.

³⁷ *Hospital Year Book*, 1931, p. 532.

³⁸ H. Hendrick, 'Child Labour, Medical Capital and the School Medical Service, c.1890-1918' in R. Cooter, ed., *The Name of the Child* (London and New York), p. 45.

³⁹ R. Cooter, *Surgery and Society in Peace and War* (Basingstoke and London, 1993), pp. 53-78.

generation.⁴⁰ Others believe that the publication of numerous government reports was a major factor in initiating the improvement of the health of children, because these reports highlighted the poor health of the nation.⁴¹ J. R. Hay summarises a number of explanations from Gilbert Slater who explored the reasons for the interest in child health and welfare. These reasons included: the 'growth of scientific sociology; the strengthening of democracy in political and industrial life; the rise of feminism; the rise in status of medical experts; the fact that children were more highly valued as the birth rate fell and the shock to complacency brought about by the Boer War.'⁴² Overall, the literature concluded that anxiety over the health of the nation, particularly children, induced by justifiable but unfavourable publicity, encouraged the establishment of new initiatives for children and mothers of young children. The numerous new convalescent homes for children are embedded within this context.

Between 1900 and 1939, ten new convalescent homes specifically for children were identified. Together, these convalescent homes for children or mothers with young children represented almost half of all new convalescent homes established during the twentieth century. Four of the new children's convalescent homes established during the twentieth century were established by voluntary hospitals. The Edinburgh Children's Hospital established the largest of these homes, Muirfield, in 1909. During the 1930s, the Edinburgh Children's Hospital also opened Fortevoit Home, another specialist convalescent home for children under two years of age. This was similar to Thorngrove Babies Home opened by the Aberdeen Royal Infirmary during the same period. Finally, around 1935, Mrs James Currie financed a fourth hospital convalescent home for the children of Leith Hospital at North Berwick.⁴³

⁴⁰ Smout, *Century of the Scottish People*, pp. 122-3; E. M. L. Thompson, *The Rise of Respectable Society* (London, 1988), p. 115; J. Walker-Smith, 'Sir George Newman, Infant Diarrhoeal Mortality and the Paradox of Urbanism', *Medical History*, 42 (1998), pp. 347-361; D. Dwork, *War is Good for Babies and other Young Children* (London, 1987), pp. 3-6, 208.

⁴¹ H. Jones, *Health and Society in Twentieth Century Britain* (New York, 1994), p. 25. Helen Jones refers to the Report on the Inter-Departmental Committee on Physical Deterioration of 1904 that concluded improvements in health were possible through changes in social habits and management such as better diet, overcrowding and cleanliness.

⁴² J. R. Hay, *The Origins of the Liberal Welfare Reforms* (London and Basingstoke, 1975), p. 20.

⁴³ J. S. Marshall, *Leith's Greatest Charity* (Edinburgh, 1978), p. 25.

Outside the hospitals, a variety of organisations or individuals established children's convalescent homes. Many were trusts, such as the Dunfermline Carnegie Trust and the Trustees of Lord Armitstead's estate, seeking ways to donate money to worthy causes. These trusts financed Bandrum in 1928 and Armitstead CH in 1930. Other children's convalescent homes including Linn Moor and Newport originated from organisations providing poor and sick children with country holidays. The senior pupils at Leonards Girls School⁴⁴ opened St Leonards CH for children in 1903. This was unique amongst sponsors and the only school involved in establishing a convalescent home. However, there is evidence of philanthropic activity amongst pupils in other schools. For instance, in 1913, seniors at Park School supplied Ravenscraig CH with clothing.⁴⁵ In addition, in 1913, pupils at Laurel Bank School in Glasgow ran the Phoenix Park Kindergarten for Glasgow children.⁴⁶

Whatever their origins, a significant development emerged amongst both new and existing children's convalescent homes during the twentieth century: their function became much broader than simply providing convalescence. Outside the hospitals, many of the new children's convalescent homes were less inclined to discriminate between children who were in convalescence or referred to as 'ailing', and those in need of a country or seaside holiday. 'Ailing' was a commonly used term for sick children suffering from the effects of environmental pollution, poverty or malnutrition.⁴⁷ This trend was observed when the Newport Children's Home at Leuchars in Fife, opened in 1893. They accepted children with a range of health problems. Annie S. Swan wrote a promotional pamphlet indicating the diversity of reasons for sending children to Newport:

⁴⁴ J. S. A. McCaulay, *St Leonard's School* (St Andrews, 1977), pp. 15, 38.

⁴⁵ ML G.362.16476368, *Annual Report for the Ravenscraig Children's Convalescent Home, 1936-7*, p. 2.

⁴⁶ *Scheme for Maternity and Child Welfare*, (Glasgow, 1926), pp. 44-47.

⁴⁷ ACL 362/78/L64, *Annual Report for the Children and Fresh-Air Fortnight, Report of the Fifty-five Years Work, 1939*, p. 8 [Linn Moor]; 'Convalescent Home for Dundee Children', *People's Journal*, 11 January, 1930, p. 1.

The Newport Children's Home was opened two years ago to provide, free of expense, rest and change for the poor and convalescent children of Dundee and neighbourhood. Since the opening, 280 boys and girls have received a fortnight's stay at Comerton, away from the din and the smoke of city life, and cannot fail to have greatly benefited by the holiday. Only those who stand in need are received.⁴⁸

Similarly, Linn Moor, in Aberdeen, established through a Fresh Air Fortnight Society, was responsible for an even stronger association between convalescence and holidays. Fresh air fortnight societies were organisations that sprung up during the late nineteenth century to provide holidays for poor city children.⁴⁹ An exploration of the early years of the Fresh Air Fortnight Society in Aberdeen provides an example of their transition to a Home for both convalescent and ailing children. The initiative for the Society emerged around 1888, from a small circle of acquaintances that were apparently seeking some action to alleviate the poor social conditions of the city. Their first annual report stated:

The idea was projected at a private meeting of a few friends interested in the work of social amelioration, and it was resolved to endeavour to realise it.

The matter was placed under the consideration of Dr Matthew Hay, Medical Officer of Health, and he, with the most encouraging kindness, commended it.⁵⁰

⁴⁸ Dundee Central Library, 43 (28). Annie S. Swan, *The Child-Angel, An appeal on behalf of Children's Summer Trips and Children's Country Homes* (c.d. 1895). Annie S Swan (1859-1943) was a popular novelist, married to a doctor. The extent of her involvement in Newport is unknown and her autobiography, *Annie S Swan, My Life* (London, 1934), does not mention the Home. However, she eventually sold her house at Bandrum to the Dunfermline Carnegie Trust as a children's country and convalescent home.

⁴⁹ Fergusson, *Scottish Social Welfare*, p. 574. Fergusson notes that the Glasgow Poor Children's Fresh Air Fortnight Society was founded in 1885 and the Edinburgh Holiday Fund in 1887.

⁵⁰ ACL 362/78/L64, *The Children's Fresh-Air Fortnight. Report of the First Season's Work, 1889-90*, p. 7. [Linn Moor]. At this stage this organisation had not acquired their permanent property, Linn Moor, so did not have the name in the title of their organisation.

Their annual report does not specifically indicate why they chose this particular action in their search for social amelioration. Nonetheless, removing children to the countryside was a popular type of scheme, particularly amongst medical officers of health.⁵¹ It is likely therefore that the involvement of Matthew Hay, Medical Officer of Health for Aberdeen, and his concern for the health of children influenced this decision.⁵² Hay was involved in a number of welfare schemes for children. They included an attempt to introduce a 'Schools Medical Inspection Service' in Aberdeen in 1905,⁵³ a mother and babies club in 1906, and a maternity welfare scheme in 1917.⁵⁴

In their first year, the Fresh Air Fortnight Society sent five hundred and fifty-five children to stay in the homes of rural families for two to three weeks at a time. The Society was therefore dealing with relatively large numbers of children. Shortly after sending the first batch of children to the country, a crisis arose following numerous complaints from their hosts regarding the poor physical condition of the children. The Society thereafter decided to take over the task of bathing and reclothing the children before sending them to their respective holiday homes in the country rather than leaving it to their parents. According to their first annual report in 1889, this made a great difference.

With all their resources the Committee found it impossible to clothe the children as they wished, but they did the best they could, and it was made evident to them that most of the children for the first time in their lives had the experience of being quite clean and comfortably clothed. Some of the transformations in the appearance of the bairns were wonderful, and surprised those who saw them in a way that was very touching. A ragged, barefooted, and dirty-looking lassie would go down to the bath-room and come up again

⁵¹ See J. B. Russell, *The Children of the City, What can we do for them?* (Glasgow, 1888). In this paper, Russell actively suggests removing children from the city for short periods.

⁵² L. A. Wilson, 'Matthew Hay (1855-1932)', in George P. Milne, ed., *Aberdeen Medico-Chirurgical Society, A Bicentennial History* (Aberdeen, 1989), pp. 190-198.

⁵³ Fergusson, *Scottish Social Welfare*, p. 568.

⁵⁴ Wilson, 'Matthew Hay (1855-1932)', pp. 193-4.

completely changed in outward aspect, and evidently with a feeling of pride in her bodily conversion.⁵⁵

Taking responsibility for bathing and re-clothing the children alerted the organisers to a large number of sick children, some ailing, and others recovering from illness, but all needing a holiday in the country. At the same time, it became harder to find suitable or willing people to take the children. This encouraged the society to raise funds for a permanent home for ailing and convalescent children. In 1908, they moved into their own home called Linn Moor, at Peterculter, near Aberdeen.⁵⁶

Ashgrove CH, established in 1895 around the same time as Linn Moor also had links with a Fresh Air Fortnight Society. Although the early history of the Home is not clear, by 1930 it was under the direction of the Glasgow Poor Children's Fresh Air Fortnight and Crippled Children's League and described as a convalescent home.⁵⁷ The organisation, run by the Glasgow United Evangelistic Association, either owned or acted as an agency for a number of different types of home, including several fresh air fortnight homes and a home for cripples (Biggart), but all those sent to Ashgrove CH were convalescent patients. Ashgrove CH was therefore slightly different to Linn Moor, in that all the children were supposedly convalescent patients. Nevertheless, the aims of the Society in providing holidays and convalescence for children furthered the links between holidays and convalescence.

Other similar homes that accepted both convalescent and ailing children were: St Leonard's Convalescent Home, in St Andrews⁵⁸ and Armitstead Children's Convalescent Home (Armitstead CH) established by the Armitstead Trust.⁵⁹ From

⁵⁵ ACL 362/78/L64, *First AR, Children's Fresh-Air Fortnight*, 1889-90, p. 7. [Linn Moor].

⁵⁶ *Ibid.*, p. 11; ACL 362/78/L64, 'History of Linn Moor Home, 1888-1948', *Sixtieth Annual Report of the Linn Moor Home for Ailing Children and Fresh Air Fortnight*, Culter, 1948, p. 10. [Linn Moor]

⁵⁷ 'Ashgrove Convalescent Home, Maybole', *Forty-Eighth Annual Report of the Glasgow Poor Children's Fresh-Air Fortnight and Cripple Children's League*, 1932, p. 9. [Ashgrove CH].

⁵⁸ J. S. A. McCaulay, *St Leonard's School* (St Andrews, 1977), pp. 15, 38.

⁵⁹ 'Convalescent Home for Dundee Children', *People's Journal*, 11 January 1930, p. 1. Lord Armitstead was a flax merchant and Dundee MP. He died in 1915. According to this newspaper

1916, the Carnegie Dunfermline Trust rented a house for the summer providing country breaks for convalescent and ailing children of Dunfermline. In 1927, they purchased a property near Dunfermline called Bandrum as a permanent country home for convalescent and ailing children of Dunfermline.⁶⁰ By 1936, the aims of the Scottish Children's Convalescent Home, at Milngavie, Glasgow, originally opened around 1906, were typical of other children's convalescent homes and included both preventing illness and convalescence.⁶¹ Their annual report stated:

We call ourselves a convalescent home, but I should like to call it more than that – one which also keeps the children from being ill by providing trained supervision, medical attention if necessary, regular meals and pleasant surroundings. Prevention is just as important as cure.⁶²

Despite the blurring of the lines between preventing illness and convalescence at children's convalescent homes, Newport, Linn Moor, Bandrum and Armitstead CH they were all recognised as convalescent homes in either the *Hospital Year Book* or the *Scottish Hospital Survey*.⁶³

During the 1930s, local authorities added to the confusion over the definition of a convalescent home by providing country homes that accepted children with a wide range of problems, not just for convalescence. Three country homes in the Glasgow area were, Mount Vernon, Scotstoun and Mount Blow. Patients sent to these country

report the Trustees decided upon a convalescent home for the children of Dundee because they thought such a scheme was consistent with the philanthropic and charitable interests of Lord Armitstead.

⁶⁰ Following the death of her husband Annie S. Swan sold Bandrum House to the Carnegie Dunfermline Trust.

⁶¹ 'Teacher and Inventor', *Glasgow Herald*, 6 August 1931, p. 11. There are few records currently available that reveal the origins of the Scottish Children's Convalescent Home, apart from its situation at Milngavie, north of Glasgow and dedication to the memory of Isabella and Archibald Barr in 1906. Archibald Barr was Professor of Engineering at the University of Glasgow, from 1889-1913. He was also co-inventor of the Barr and Stroud Rangefinder.

⁶² ML G.362.16476368, *Annual Report of the Scottish Convalescent Home for Children*, 1939, p. 5.

⁶³ See *Hospital Year Book* (1931), pp. 532-535 and *Scottish Hospital Survey*, HMSO (1946). Newport and Linn Moor were described as convalescent homes in the *Hospital Year Book* (1931). Armitstead CH, Bandrum and Linn Moor were similarly described in the *Scottish Hospital Survey*, Armitstead CH, Eastern Region, p. 28, Bandrum, South Eastern Region, p. 66, Linn Moor, North Eastern Region, p. 35.

homes included children suffering from recognisable conditions such as rickets and malnutrition, together with a few long-term convalescent patients.⁶⁴ The regime of these country homes was rest, fresh air and a healthy diet, but the children stayed for longer periods, often as long as three months.⁶⁵ This, combined the admission of children with active illness, made them different to the conventional convalescent home, even those associated with fresh air fortnights. Alexander MacGregor, MOH for Glasgow (1925-1946) remarked that by the late thirties rickets had declined and instead these country homes admitted far higher numbers of convalescent children. Although these homes had features similar to convalescent homes, such as the focus on fresh air and diet, they were excluded from the survey because until the late 1930's they admitted mostly children with active illness.⁶⁶ Nevertheless the local authority country homes represented a significant factor in reducing the distinction between homes for convalescent and ailing children. Local authorities also became involved in convalescent homes through the School Medical Inspection Service. The authorities involved with the Service often identified and recommended some of the children sent to convalescent homes.⁶⁷

An increase in concern for maternal and child welfare was also evident in some of the existing convalescent homes, such as the Dunoon Homes⁶⁸, Mission Coast Home⁶⁹ and Kilmun.⁷⁰ During the twentieth century they all built special wings to accommodate mothers and children. Another response was the establishment of several maternity convalescent homes, specifically for mothers recovering from childbirth rather than illness. They were quite small with around six beds, but the

⁶⁴ A. K. Chalmers, *The Health of Glasgow 1818-1926* (Glasgow, 1930), p. 150; A. MacGregor, *Public Health in Glasgow 1905-1946* (Edinburgh and London, 1967), pp. 128-129.

⁶⁵ *Scheme for Maternity and Child Welfare* (Glasgow, 1926), pp. 44-47.

⁶⁶ In common with the local authority country homes, the long periods spent by patients in the AAI was one of the reasons for excluding it from overall statistics on convalescent home provision in Chapter One.

⁶⁷ The Carnegie Dunfermline Trust part funded the School Medical Inspection Service in Dunfermline until 1927.

⁶⁸ 'Glasgow and the West of Scotland Convalescent Seaside Homes', *GMJ*, July 1924, p. 55.

⁶⁹ GCA T.Par 1.7, *Forty-Second AR, Mission Coast Home, 1906-1907*, p. 6.

⁷⁰ GCA TD.432/13, *Annual Report of the Glasgow-Kilmun Convalescent Home [hereafter GKCH, formerly KCH], 1934*, p. 5.

period allowed in these homes was the same as a convalescent home, that was, around two weeks. Increased attention to maternal and child health was reflected in a speech given at the opening ceremony of Airdmhor, in 1914. This was a convalescent home established for mothers and children by Scottish Co-operative Women's Guild:

The importance of the child is now being recognised by our legislators and educators and the medical inspection and treatment of school children are now essential parts of the work of School Boards. There is, however, a fundamental duty which ought to be undertaken, if not before, at least the same time as the care of the children; that is the care of the mothers and at the same time due attention to their economic and physical condition.⁷¹

Another aspect of Airdmhor was that, in common with the children's convalescent homes, their admission policy did not discriminate between adult patients recovering from illness or those in need of recuperation from other causes, such as overwork. However, as members of the Co-operative Society, the clientele at Airdmhor were less likely to be suffering from the effects of malnutrition that led many women and children into convalescent homes. The *Scottish Co-operator* also described Airdmhor as a 'home of rest' rather than a convalescent home. Moreover, it recorded that Co-operative Society members were encouraged to use the convalescent home for both preventing illness and convalescence.⁷² This assisted in blurring the lines between convalescence and holidays. In 1922, the *Scottish Co-operator* published a short poem illustrating this association.

Hotels there are galore,
And hydros by the score,
Where lords and ladies spend their wealth and leisure;
But down at fresh Airdmhor
Each co-operative store

⁷¹ 'The Mothers of the Race', *Scottish Co-operator*, 6 May 1914, pp. 445-47.

⁷² *Ibid.*

Has a Home that beats them all for health and pleasure.

The air is always pure,
Alone it works a cure,
While within the Home is dainty and complete;
The board with Hunter Dew,
And the pioneer Seymour,
Would make any holiday anywhere a treat.

Misses Smith and Dick
Up to every kindly trick,
And a staff of bonnie lassies neat and spry,
Make your convalescence quick,
Make you well when you've been sick,
And you leave Airdmhor on Friday with a sigh.⁷³

Although Airdmhor demonstrated greater flexibility in their admission policies by allowing the admission of patients recovering from the effects of overwork, this initiative was not entirely innovative. This was a trend first observed when Alexander Hay Moncur established Bannatyne Home of Rest, at Dundee in 1892. This home was specifically for 'tired working girls' of Dundee.⁷⁴ Despite the title, 'Bannatyne Home of Rest' and willingness to admit females recovering from overwork and illness, it was still known as a convalescent home.⁷⁵ In common with other convalescent homes it had a matron in charge⁷⁶ it and some of their patients were admitted from the infirmary.

⁷³ *Scottish Co-operator*, 12 May 1922, p. 439.

⁷⁴ 'Bannatyne Home', *Dundee Advertiser*, 21 May 1892.

⁷⁵ It was also referred to as a convalescent home in the *Scottish Hospital Survey*, Eastern Region, (1946), pp. 28-29, 48.

⁷⁶ 'Matronship of Bannatyne Home of Rest,' *Dundee Advertiser*, 24 July 1909, p. 8.

However, in other convalescent homes established in the nineteenth century there was less relaxation of admission policies. When the Dunoon Homes opened their new wing for mothers and children in 1924, they still insisted that patients should be convalescing from illness, not simply needing a rest. The *GMJ* stressed this point in a report on the opening of the new wing at the Dunoon Homes stating, 'one of the chief objects of this addition is to enable mothers recovering from illness to have young children with them whom they cannot well leave at home.'⁷⁷

Support and Sponsorship by Mutual Assurance

Another major factor affecting convalescent homes during the twentieth century was the shift of support and sponsorship away from charity towards mutual-assurance organisations. Although this was apparent mainly through the sponsorship of new homes by mutual assurance societies, financial support amongst the existing homes shifted from the domination of subscriptions from employers and private subscribers to a monopoly from employee's contributions. For instance, in 1894 at the Dunoon Homes, general subscriptions amounted to £2,679 whereas subscriptions from employees in public works were less at £2,224.⁷⁸ This began to change early in the twentieth century and in 1901, general subscriptions at the Dunoon Homes were £2,724 whereas subscriptions from employees in public works were £3,353.⁷⁹ By 1933, the difference was even greater with general subscriptions at £3,348 and public works subscriptions at £4,525.⁸⁰ The situation was similar at Kilmun where the proportion of subscriptions from employees in public works rose even higher during the twentieth century. In 1915, ordinary subscriptions at Kilmun were £562, whereas subscriptions from employees of public works were £590.⁸¹ However, by 1939, the proportions had risen from £1,905 for ordinary subscriptions and £3,899 for

⁷⁷ *GMJ*, 1 July 1924, p. 55.

⁷⁸ ML G.362.160941435, *Twenty-Fifth AR, WSCSH*, 1894, p. 9. [Dunoon Homes].

⁷⁹ ML G.362.160941435, *Thirty-Third, AR, WSCSH*, 1901, p. 9. [Dunoon Homes].

⁸⁰ ML G.362.160941435, *Seventieth, AR, GWSCSH*, [formerly, *WSCSH*], 1939, p. 12. [Dunoon Homes].

⁸¹ GCA TD.432/13, *Forty-Seventh Annual Report for Kilmun Seaside Home for Convalescents, [KSHC]*, 1914-1915, p. 9. [Kilmun].

subscriptions from the public works employees.⁸² Despite the dominance of employee subscriptions, the management committee remained a middle-class function. In a parallel situation, Lorraine Walsh also noted the lack of working class representation with the Management at the Dundee Royal Infirmary. She argued that the Board resisted working class infiltration and that ‘the middle-classes were determined to withstand working class efforts to infringe traditional middle-class territory.’⁸³

This contrasted with homes sponsored by mutual assurance societies where there was considerable control or representation from within the organisations. There were three different types of mutual assurance groups responsible for sponsoring convalescent homes. These were:

- ◇ occupational schemes
- ◇ Co-operative societies
- ◇ friendly societies.

As a basis for understanding the role of mutual assurance groups in establishing convalescent homes, Table 3.1 attempts to clarify the variations in their definition, admission policies and the financial contribution between the three groups. Row one defines the three groups.

⁸² GCA TD.432/13, *Annual Report of the Glasgow-Kilmun Convalescent Home*, [GKCH], 1939, p. 6. [Kilmun].

⁸³ L. Walsh, ‘“From the Grampians to the Firth of Forth”, the Development of the Dundee Royal Infirmary’, in L. Miskell, C. Whatley and B. Harris, eds., *Victorian Dundee: Image and Realities* (East Lothian, 2000), pp. 100-103.

Table 3.1. Major differences between occupational, Co-operative Society and friendly society convalescent homes.

	Occupational Homes	Co-operative Society Homes	Friendly Society Homes
Definition of Sponsor	Defined as a Home organised through an employer or employee related scheme	Co-operative convalescent home defined as part of retail Retail and Wholesale Co-operative Society	Convalescent home organised and sponsored by friendly society
Admission	Admission through contributory or non-contributory employer/employee scheme	Admission through membership of Co-operative Society	Admission gained through membership of friendly society.
Financial Contribution	Contributions were mostly through the occupational schemes and compulsory	Nothing other than membership of a co-operative society	Some subscriptions paid by members

Sources: *Annual Reports of Co-operative Society Convalescent Homes*; *Annual Reports of the Miners' Welfare Fund*; *Lancet*; *BMJ*; *Whitehouse, Railway Convalescent Homes*.

The definition of an occupational convalescent home was one that was organised through an employer or employee related scheme. Although the Co-operative Society began as a trade organisation, during the later nineteenth century it expanded into manufacturing and other types of services, including convalescent homes.⁸⁴ Friendly societies differed from the other two groups because they were concerned mainly with various types of insurance.⁸⁵ Membership of friendly societies grew during the twentieth century particularly after the National Health Insurance Act of 1911. The Act established a scheme of rudimentary medical care for compulsorily insured workers. The provision of a convalescent home might also have encouraged membership as various approved societies administered the scheme and many were friendly societies.⁸⁶

⁸⁴ P. H. J. H. Gosden, *Self-Help* (London, 1973), p. 180. Gosden defined co-operative societies as 'retail buyers, which went into the market to get what its members wanted at wholesale prices and returned the surplus or profit to them by way of dividend'.

⁸⁵ J. C. Riley, *Sick, not Dead. The Health of the British Working Man* (London, 1997), pp. 27-44.

⁸⁶ *Report of a Working Party on Convalescent Treatment*, HMSO (London, 1959), p. 6; M. Sorsby, ed., *The National Health Service* (Edinburgh, 1953), p. 3.

Row two describes access to the different types of mutual assurance convalescent homes. Admission to an occupational home was usually restricted to the employees or their families within that occupation. Similarly, friendly societies usually only admitted their own members. Admission to the Co-operative Society convalescent homes was also restricted to their members. However, unlike occupational and friendly society homes there was no discrimination or restriction on membership to a Co-operative Society. Nevertheless, application for admission to a Co-operative Society convalescent home was still through recommendation of a branch secretaries and not automatic. Whether or not entry to friendly society and occupational convalescent homes was automatic upon application is not clear but high demand for admission makes it likely that they also had conditions.

Finally, row three describes the various contributions payable by members. In the occupational groups small weekly sums were often compulsory through work-related schemes. The exception was Broomfield House, established by shipbuilder, A. F. Yarrow. This was classified as an occupational home because it was mainly for the benefit of the wives of Yarrow workers although they also accepted some patients from the Royal Maternity and Women's Hospital.⁸⁷ There was no evidence of direct contribution from Yarrow workers towards the maintenance of this convalescent home. The only contribution necessary for admission to a Co-operative Society was membership. Nevertheless, the Co-operative Society convalescent homes also accepted a limited number of paying patients. There is some evidence of additional contributions from the Rechabites towards the convalescent home at Kirn.⁸⁸ The next section describes how the various mutual assurance homes were established.

⁸⁷ 'New Convalescent Home', *GMJ*, July 1914, p. 64.

⁸⁸ Norma Davies Logan, *Drink and Society in Scotland, 1870-1914*, Unpublished PhD Thesis, (University of Glasgow, 1983), pp. 197. According to Norma Logan the Rechabites paid one shilling per head towards the cost of the convalescent home.

Occupational CHs

The most prominent group organising convalescent homes through an occupational scheme were the miners. These convalescent homes were all established after the First World War and mostly set up and financed through the Miners' Welfare Fund. In the vast amount of general literature on the mining industry, there is surprising little attention paid to the Miners' Welfare Fund, despite Barry Supple's comment that, 'the Welfare Fund, although its extent was obviously limited, made a remarkable difference to the fabric of mining communities and to the social and educational amenities and working condition of miners'.⁸⁹ For example, Alan Campbell, in his authoritative work on the Scottish miners' provides a background to social issues such as housing and gender relations, but he does not explore the Miners' Welfare Fund.⁹⁰ However, Campbell's earlier work on *Lanarkshire Miners* does explore the tensions between employers and employees leading to the Sankey Commission's recommendations which initiated the process that set up the Miners' Welfare Fund.⁹¹ The Sankey Commission was established after the First World War to consider the future management of the mining industry. It included representatives from both employers and employees. The miners saw an extension of the wartime control of mines through nationalisation as the solution to their problems of low wages and poor working conditions. The recommendations of the Sankey Commission supported nationalisation, higher wages and improved welfare facilities.⁹² The government did not accept these recommendations in their entirety and, rather than outright nationalisation, proposed public ownership of royalties, regional mergers of colliery companies and worker representation on area boards. Nevertheless, they did support higher wages and also proposed the Welfare Fund, to improve social and working

⁸⁹ B. Supple, *The History of the British Coal Industry, Vol. 4. 1913-1946* (Oxford, 1987), p. 477.

⁹⁰ A. Campbell, *The Scottish Miners, 1874-1939. Vol. 1. Industry Work and Community* (Aldershot, 2000).

⁹¹ A. Campbell, *The Lanarkshire Miners* (Edinburgh, 1979). Weindling, P., ed., *Linking Self Help and Medical Science: The Social History of Occupational Health* (Beckenham, 1987), p. 2. Weindling notes that employee welfare schemes spread during the 1920s as employers assumed a greater responsibility for health and safety.

⁹² Supple, *British Coal Industry*, p. 138

conditions.⁹³ Supple points to the discontent surrounding the introduction of the Welfare Fund, noting that:

At any other time and in other circumstances, this might have been considered a fairly radical programme. But in the context of 1919 its tone disappointed political observers and outraged the miners, whose parliamentary representatives argued that they had been duped and deceived, and that the government had gone back on a virtual commitment to nationalisation.⁹⁴

In spite of this, the Fund eventually seemed to have gained support amongst the miners and provided many social improvements, including convalescent homes.

The Miners' Welfare Fund, financed through a levy on coal production of a 1d on every ton of coal, was established by the Mining Industry Act of 1920. From 1926 onwards the Inland Revenue collected a further shilling in the pound of mining royalties.⁹⁵ Although the government reduced the levy of 1d per ton to a halfpenny in 1932, the Fund continued to accumulate a substantial amount of money. Between 1920 and 1935 the total sum in the Fund amounted to £15,247,118.⁹⁶ The Fund was used to establish various projects relating to the health or social welfare of miners including mining research, health, education and recreation. Convalescent homes were therefore only one of the various projects funded by the Miners' Welfare Fund. Other schemes included: pithead baths; university scholarships; mining schools; recreational schemes; canteens and cycle stores.⁹⁷ Supple estimated that between 1921-1945 about one third of the Fund's £23 million total expenditure went on health projects. Three quarters of these health projects were convalescent homes although clearly not all these were in Scotland.⁹⁸

⁹³ R. Page Arnot, *The History of Scottish Miners* (London, 1955), pp. 147-149; C. L. Mowat, *Britain Between the Wars, 1918-1940* (London, 1955), pp. 30-36.

⁹⁴ Supple, *British Coal Industry*, p. 147

⁹⁵ P. Gee, *The Other Side of the Miners' Life* (London, 1936), p. 14.

⁹⁶ *Ibid*; Gee, *Miners' Life*, p. 14.

⁹⁷ NLS GMC 11, *Eighteenth AR, Miners' Welfare Fund*, 1939, pp. 31-34.

⁹⁸ Supple, *British Coal Industry*, p. 448.

An important aspect of the Miners' Welfare Fund was that employees had some representation over the distribution of the monies and the decision whether or not to establish a convalescent home. The decision-making process was through a central administration known as the Miners' Welfare Committee consisting of representatives of the mining company employees and the mine owners.⁹⁹ Overall, the miners and mine owners each had around fifty per cent representation on the committees involved in distribution of the Fund. The dispersal of the Fund was through twenty-five mining administrative districts, each with a District Committee. In Scotland, there were four districts: Fife and Clackmannanshire; the Lothians; Lanarkshire and Ayrshire. In common with the Central Committee, representatives on the District Committees also included owners and miners. They vetted applications for various grants from the miners and the Central Committee put forward successful applications for consideration.¹⁰⁰ To access the funds, any community of miners could apply for a grant from the appropriate District Fund, provided the intended purpose fell within the definition of the Act. Many districts decided to apply for grants to establish convalescent homes, whereas others decided on different projects such as welfare centres.

The Miners' Welfare Fund usually provided most of the funds for the purchase of the building, often with additional funds for maintenance. The Ayrshire District was the first to establish a convalescent home for Scottish miners in 1923. The total cost of £12,000 included the purchase of Kirkmichael Mansion House, Dyrock Dower House, several lodges, a gamekeeper's house, three dwelling houses, stables, laundry and large gardens. Kirkmichael contained fifty beds and separate accommodation for miners' wives in the Dower House.¹⁰¹ Structural alterations, furnishing and equipment at Kirkmichael cost an additional £8,000 (totalling £20,000). The inflation that occurred during the First World War makes it difficult to undertake a cost-

⁹⁹ Ibid., p. 447.

¹⁰⁰ Scottish Mining Museum. EDO 338, Rt Hon Viscount Chelmsford, 'the Miners' Welfare Fund'.

¹⁰¹ NLS GMC 11, *First AR, Miners' Welfare Fund*, 1921/22, p. 25.

comparison between Kirkmichael and convalescent homes established during the nineteenth century. In 1924, the Ayrshire District Committee supported an application for a further grant to establish a separate convalescent home for miners' wives at Troon, leaving Kirkmichael House for miners only. Robert L. Angus donated an additional £1,700 to purchase the house known as Portland Villa at Troon in memory of his father, Robert Angus, who was associated for 50 years with the iron and coal industry in Ayrshire.¹⁰² On this occasion, no problems appeared to arise from the gift. Another convalescent home for miners was also opened in 1926 at Saltcoats. The extent of involvement of the Miners' Welfare Fund in establishing this convalescent home is not entirely clear. Nevertheless the Fund provided some funds towards the upkeep of the Home.¹⁰³

In 1927, the Fife Coal Company supplemented funding for the Charles Carlow Convalescent Home for Miners, established for the miners of Fife, Clackmannan, and Kinross District. Although the Fife Coal Company provided the house and also spent £10,000 on the adaptation and equipment, the gift was not entirely for the benefit of the miners. It was also given as a memorial to their deceased chairman and managing director Charles Carlow. Moreover, maintenance costs were not met by the company but from an additional weekly subscription of 1d from the miners. Although 1d seems a small sum of money, it amounted to four shillings and four pence per annum. Despite the higher average wages of some Scottish miners meant they were perhaps better able to afford it than miners in other regions of Britain, it was still a substantial part of their annual wage. This varied between districts, George Orwell estimated that in 1935, the average gross wages of Scottish miners' was £133 2s 8d. He also emphasised that this was only an average and some miners earned far less than this amount. Orwell calculated that £105 per annum was a more accurate average figure for miners' wages the whole of Britain. There were also a number of weekly sums stopped from miners' wages, such insurance, tools and lamps. Orwell calculated that

¹⁰² NLS GMC 11, *Sixth AR, Miners' Welfare Fund*, 1927, p. 45.

¹⁰³ NLS GMC 11, *Eighteenth AR, Miners Welfare Fund*, 1936, p. 52.

these were around 4s 5d per week.¹⁰⁴ A further £30,000 from the Miners' Welfare Fund provided an endowment fund estimated to produce £1,000 per annum for the Home. Within this context therefore the generosity of the Fife Coal Company towards the miners' convalescent home seems less munificent, particularly as the mining company gained considerable wealth from the hazardous work of the miners.¹⁰⁵

Unlike the miners' convalescent homes, the railway owners played no part in either setting up the homes or their organisation. The only railway convalescent home in Scotland was at Ascog, on the island of Bute.¹⁰⁶ When the Railway Convalescent Homes Association established Ascog Mansion in 1924, there were already five in England.¹⁰⁷ It was therefore part of a relatively large organisation. John Whitehouse records that E. Passmore Edwards (a wealthy philanthropist, editor and proprietor of the *London Evening Echo*) sponsored the first Railway Convalescent Home established at Herne Bay in 1902. However, the idea of a convalescent home for railway workers was not his, but the initiative of John Nichols, Chief Cashier of South Eastern Railways. According to Whitehouse, through his involvement with friendly societies, Nichols became acquainted with J. Passmore Edwards who had already sponsored three friendly society convalescent homes. When approached about financing a convalescent home for railway workers, Passmore Edwards was reluctant to become involved with a fourth. Nevertheless, Nichols persuaded Passmore Edwards to part with three acres of land to the rear of the convalescent homes at Herne Bay, plus £6,000 for the construction of the home.¹⁰⁸ He agreed reluctantly, providing that Nichols could find men of good standing to act as Trustees, one from each of the nine Railway Companies with a terminus in London. The first Trustees were drawn from the railway workers and included a stationmaster, four

¹⁰⁴ G. Orwell, *Road to Wigan Pier* (First edition, 1937, Penguin edition, 2001), pp. 36-37.

¹⁰⁵ *Ibid.*, 1928; A. Cunningham, *Report of the Opening Ceremony of the Charles Carlow Convalescent Home*, (1927), p. 1.

¹⁰⁶ See Map 1.

¹⁰⁷ J. Whitehouse, *The Unfinished History of the Railway Convalescent Homes* (Portsmouth, 1986), pp. 19-20.

¹⁰⁸ *Ibid.*, p. 3

inspectors, a foreman, a chief ticket examiner, and a checker in the goods department.¹⁰⁹ There were no railway owners amongst these Trustees. The Trustees then took on the responsibility of raising further funds for the home. The first railway convalescent home at Herne Bay finally opened on 8 June 1901.¹¹⁰ It was not until 1924 that the Trustees purchased Ascog Mansion as a Railway Convalescent Home on the Island of Bute, from the Marquis of Bute, for a total cost of £9,800.¹¹¹

Most of the funds for the maintenance of the railway homes came from subscriptions collected from railway workers at a halfpenny per week.¹¹² The Trusteeship of the railway homes always remained with the railway workers and not the managers, thus contrasting with the miners' convalescent homes, where the mine owners were prominent on decision-making committees. The lack of involvement from the railway owners or managers represented a significant difference between the convalescent homes for the miners and those for the railway workers.

Co-operative Society CHs

Although there were only three Co-operative Society convalescent homes opened in Scotland before the Second World War, they were important because they were relatively large establishments. By the 1920s they admitted almost as many patients annually as the hospital convalescent homes.¹¹³ Before opening their own homes, individual co-operative societies provided convalescent care for their members through subscriptions to convalescent homes such as the Dunoon Homes. In 1885, the Dunoon Homes received subscriptions from twelve different co-operative societies, varying between one and twenty-six guineas.¹¹⁴ In addition, many co-operative societies continued to subscribe to other convalescent homes even after the opening of the Co-operative Society convalescent homes. An awareness of the

¹⁰⁹ Ibid., p. 4.

¹¹⁰ Ibid, p. 11.

¹¹¹ J. Salmon, *A Proud Heritage* (London, 1954), p. 84.

¹¹² Whitehouse, *Railway Convalescent Homes*, pp. 16, 18-19.

¹¹³ See Chapter One, p. 32.

¹¹⁴ ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, pp. 15-25. [Dunoon Homes].

benefits of convalescent homes may therefore have assisted the Co-operative Society when raising support and funds for its own homes.

Co-operator, George Seymour, was the principle promoter of the first Co-operative convalescent home. In 1891 at a quarterly meeting of the Ayrshire District in Ardrossan, he read a paper on 'Seaside Homes'. Seymour subsequently repeated the reading of the paper at another meeting in Renfrew. He received enough support at these meetings to form a committee 'to endeavour to bring the scheme to a practical conclusion'.¹¹⁵ The following year, the *Scottish Co-operator* reported that a building fund had been established and raised £1,100.¹¹⁶ By 1893, the fund, extracted from the collective subscriptions of different societies, had risen to £2,000.¹¹⁷ Some of the larger co-operative societies, such as that at Kilmarnock, took responsibility for the furnishing of one room. In addition, the Scottish Co-operative Women's Guild raised further funds by holding a traditional bazaar.¹¹⁸ Professor Tom Devine notes that 'the main work of the Guilds was concerned with fund-raising for convalescent homes and meetings were devoted to such domestic issues as cookery and dress-making.' He further remarks that 'unlike the suffrage societies of the middle-classes which implicitly challenged the notion of separate spheres, the Guilds could be seen as confirming the domestic role of women as wives and mothers.'¹¹⁹ Eleanor Gordon observes that the women in the Co-operative Guilds were also active in politics.¹²⁰ However, their role in the convalescent home movement suggests they operated within the accepted sphere of women by focusing upon raising money to furnish bedrooms and fundraising through such traditional methods as 'the bazaar'. Nevertheless, a report of the opening ceremony at Airdmhor noting that 'they had had

¹¹⁵ 'Reports of the District Conference', *Scottish Co-operator*, 1891, p. 77.

¹¹⁶ 'Reports of the District Conference', *Scottish Co-operator*, 1892, p. 93.

¹¹⁷ 'Reports of the District Conference', *Scottish Co-operator*, 1893, p. 92.

¹¹⁸ 'A Co-operative Bazaar', *Scottish Co-operator*, May 1893, p. 7.

¹¹⁹ T. M. Devine, *The Scottish Nation 1700-2000* (London, 1999), p. 541.

¹²⁰ E. Gordon, 'Women's Spheres', in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990), p. 231.

many obstacles placed in their way and conditions had been asked to which they could not agree' suggests that they were not a passive group of women.¹²¹

In 1896, the Co-operative Society opened its first convalescent home at Seamill on the Ayrshire coast.¹²² There was also a degree of philanthropy in the foundation with a very large donation of £2,000 given by William Maxwell towards Seamill.¹²³

However, unlike other convalescent homes funded by philanthropic gestures, he did not impose any conditions or restrictions on his gift. A few years later, in 1905 a second Co-operative Society convalescent home opened at Abbotsview, Galashiels.¹²⁴

According to William Maxwell this was partly due to the increased demand for convalescent home care, particularly from members of the Co-operative Society in the East of Scotland.¹²⁵ Andrew Young undertook the organisation for Abbotsview.

His speech at the opening ceremony revealed two new issues relating to the convalescent homes. Firstly, his remark that 'Co-operators should put their fellows on an equality with those who came to Melrose Hydropathic and Peebles

Hydropathic. That day they would not recriminate – they would not look back', suggests that in addition to their function in the aftercare of the sick, Co-operative Society members also valued convalescent homes as an expression of equality.

Secondly, their identification with the hydropathics, that by 1900 had mostly become exclusive hotels where the recreational had come to dominate their curative functions.

This provides another association between convalescent homes and holidays.¹²⁶ In

1914, similar comments were reported at the opening of Airdmhor House that,

'expressions of delight were heard on all sides, one lady going so far as to say that it was not a convalescent home at all, but a hydropathic.'¹²⁷

¹²¹ 'Visit to Airdmhor House', *Scottish Co-operator*, 13 June 1914, p. 592.

¹²² 'Opening of Seaside Homes', *Scottish Co-operator*, July 1896, pp. 523-25.

¹²³ W. Maxwell, *History of Co-operation in Scotland. Its Inception and its Leaders* (Glasgow, 1910), pp. 358-361.

¹²⁴ 'Opening of Abbotsview Homes', *Scottish Co-operator*, 6 April 1906, p. 321.

¹²⁵ Maxwell, *Co-operation in Scotland*, p. 360.

¹²⁶ P. Hembry, *British Spas from 1815 to the Present. A Social History* (London, 1997), p. 214. See also, I. Brown, *A Summer in Scotland* (London, 1952), pp. 176-80.

¹²⁷ 'The Mothers of the Race', *Scottish Co-operator*, 6 May 1914, pp. 445-47.

Friendly Society CHs

Despite the establishment of only three relatively small to medium sized Scottish convalescent homes established by friendly societies between 1900 and 1939 they each had some new feature that influenced the overall development of homes. The first, Ashgrove House, opened in 1903, near Dunoon. Although their sponsoring organisation was a temperance organisation, the Rechabites, Ashgrove House emerged as a significantly different convalescent home to Kilmun, established by the Glasgow Abstainers Union, another temperance society.¹²⁸ When the Glasgow Abstainers established Kilmun forty years previously they focused upon providing convalescence for the poor and destitute, whereas the Rechabites established Ashgrove House as a privileged benefit for their members.

The other two friendly society convalescent homes were also established as a benefit for members. The second of these opened in Scotland was Orwell House. This was established in 1909 at Kinbuck, near Dunblane by the Scottish Foresters' Convalescent Home Benevolent Society.¹²⁹ The Scottish Foresters' Federation provided an initial sum of £1989 to establish Orwell House, but the members raised the remainder of the necessary funds.¹³⁰ The admission policies at Orwell House were also more flexible than the older convalescent homes and admitted those 'who desire a restful health promoting holiday, so far as not places are not required by convalescent patients'.¹³¹ Thus, Orwell House contributed to the association of convalescent homes with holidays. The third friendly society home was the Alderston CH situated near Edinburgh. The Scottish National Benevolent Association for the benefit of the Scottish Rural Workers Friendly Society founded this convalescent home in 1925.¹³² The rural clientele of Alderston CH represented a further development in the provision of convalescent homes. Previously, patients in

¹²⁸ Smout, *Scottish People*, p. 142; T. M. Devine, *The Scottish Nation* (London, 1999), p. 354. Although the Rechabites was a temperance organisation, their primary function was as a friendly society.

¹²⁹ 'Ancient Order of Foresters', Convalescent Home', *BMJ*, 23 October 1909, p. 1248.

¹³⁰ 'Proposed Foresters' Convalescent Home for Scotland', *Lancet*, 15 June 1907, p. 1677.

¹³¹ GCA T.Par 120, *Annual Report of the Scottish Foresters' Convalescent Home Benevolent Society*, 1913, p. 14.

¹³² *BMJ*, 31 October 1925, p. 814.

convalescent homes were mainly from urban areas, but at Alderston CH, the rural occupation of the members meant that the convalescent home patients were likely to originate from the countryside.

Yet these three convalescent homes do not present the complete picture of provision of care in convalescent home by friendly societies. During the twentieth century, many subscribed to the larger independent homes such as the Dunoon Homes. Thus, even friendly societies without a convalescent home of their own, were still able to provide convalescence for their members. An examination of the lists for convalescent homes in the West of Scotland revealed only one or two subscriptions from insurance and friendly societies during the nineteenth and early twentieth century. Table 3.2 illustrates how the picture had changed by the 1930s.

Table 3.2. Subscriptions from insurance and friendly societies at the Dunoon Homes in 1933, GCH and Mission Coast Home in 1936 and Kilmun in 1938.

Name of Friendly Society/Union	£ nearest	Convalescent Home	Year
Engineering, Amalgamated Union, Approved Society, No. 334.	11.00	Dunoon Homes	1933
General Federation of Trade Unions Approved Society, No. 110	20.00	Dunoon Homes	1933
Grand Order of Israel Friendly Society, Scottish Subsidiary Grand Lodge 1932	1.00	Dunoon Homes	1933
Hearts of Oak Benefit Society, London	5.00	Dunoon Homes	1933
Oddfellows, (Independent Order of Caledonia Lodge) Manchester Union Friendly Society)	2.00	Dunoon Homes	1933
National Amalgamated Approved Society, London	186.00	Dunoon Homes	1933
National Beneficent Society Ltd.	10.00	Dunoon Homes	1933
Seamans National Insurance Society, London	35.00	Dunoon Homes	1933
Caledonia Lodge, Oddfellows	1.00	GCH	1936
Prudential Assurance Co Ltd. Renfield St	10.00	GCH	1936
Prudential Assurance Co., Ltd. London	2.00	GCH	1936
Iron Trades Employers Insurance Association Ltd.	5.00	GCH	1936
Scottish Girls Friendly Society – Gateside and Beith Branch	.5	Mission CH	1936
Caledonia Lodge of Oddfellows	2.00	Kilmun	1938
Prudential Approved Societies	14.50	Kilmun	1938
Scottish Meat Traders Friendly Society	6.00	Kilmun	1938
Tailors and Garment Workers Health Insurance Society	2.00	Kilmun	1938

Source: ARs, *Dunoon Homes*, 1933; *GCH*, 1936, *Mission Coast Home*, 1936, *Kilmun*, 1938.

Table 3.2 also revealed that the Dunoon Homes received the highest proportion of subscriptions from the friendly societies, perhaps because it was the largest home. Nevertheless, friendly societies also subscribed to Kilmun, the Mission Coast Home,

and the Glasgow Convalescent Home. The number of patients recommended for admission to a convalescent home depended on the amount subscribed. This was usually approximately one patient per pound annual subscription. Thus, the National Amalgamated Approved Society, which subscribed £186 per year, was entitled to recommend one hundred and eighty-six members to the Dunoon Homes. By contrast, Grand Order of Israel Friendly Society, with an annual subscription of one pound was only entitled to recommend one patient annually.

The First World War and the Development of Scientific Convalescence

The military activities of the First World War had a number of major implications for convalescent homes. One of the consequences was that staff shortages occurred in some convalescent homes as many employees left for war service. This precipitated the closure of one home and probably one other. These homes were Bona, the convalescent home belonging to the Royal Northern Infirmary, and the Cottage Homes for Children in Helensburgh. In 1918, the Annual Report of the Royal Northern Infirmary stressed the shortage of staff amongst the reasons for the closure of Bona:

Owing to the Matron having left for military service, and for other reasons the Convalescent Home had to remain closed to patients during the year but the directors succeeded in letting it for two months in the summer. A number of patients were sent to the Nairn Convalescent Home during the summer and autumn months. As a result of a recent Conference with the Medical Staff in regard to the Convalescent Home, the Directors decided to sell the house at Bona and they have appointed a Committee to look out for a suitable building in a more elevated situation, and less difficult of access, to be used as a convalescent home, in accordance with the Medical Staffs' recommendation.¹³³

¹³³ HHB 1/5/4, *AR of the Royal Northern Infirmary*, 1918, p. 7. Although this extract clearly indicates that they intended to open a new convalescent home after the War this did not happen. Consequently, Nairn continued to be the only convalescent home available to Northern Infirmary patients.

Bona was the only hospital convalescent home closed due to wartime activities. However, the disappearance from the Post Office directory, of an independent home, the Cottage Homes for Children at Helensburgh, at the beginning of the War in 1914, suggests that the reason for the closure of this home might have been a shortage of staff.¹³⁴ Staff shortages due to the First World War were possibly responsible for the discontinuation of the post of resident medical officer at Corstorphine House, since this also occurred at the beginning of the War in 1914. From the end of the nineteenth century there had been a resident medical officer at Corstorphine House, normally seconded from the Infirmary.¹³⁵

Another significant effect of the First World War upon convalescent homes was that it raised their profile within the community. The rush of sympathetic and wealthy owners who, at the start of the First World War, offered country houses and castles for use as convalescent homes indicates an increase in awareness of the importance of convalescence. However, the military authorities eventually refused many country properties. Yet, remarks in the *British Journal of Nursing*, referring to the decline of offers of country houses for use as convalescent homes, seemed to be associated with the inadequacy of their facilities rather than an excess of suitable buildings. The journal noted that 'we heartily congratulate the War Office upon this decision, which is no doubt the result of the investigations which have recently been made into the management of these hospitals.'¹³⁶

Although the military authorities in Scotland turned down the offers of many country houses for use as convalescent homes, others were accepted. Examples include Hyndwood and Keir House, both situated at Bridge of Allen in Stirling. The authorities also accepted Glamis Castle, the childhood home of the late Queen Elizabeth the Queen Mother and Inverary Castle, the home of the Duke of Argyll, as

¹³⁴ *Helensburgh Directory*, 1913-14 (Helensburgh, 1913), p. 56.

¹³⁵ Corstorphine House was the only convalescent home known to have a resident medical officer.

¹³⁶ *British Journal of Nursing*, 17 July 1915, p. 50.

convalescent homes.¹³⁷ Unfortunately, few records remain for most of the temporary wartime military homes. Accurate assessment of the numbers and scope is therefore not feasible. Military convalescent homes were therefore not included in the survey.

Another effect of the First World War was that it gave supporters of convalescent homes the opportunity to promote the homes by commenting on their contribution to the medical services of the First World War. One such supporter was Lord Newlands, the son of the founder of the Hozier Home, William Hozier. At a ceremonial speech to mark the completion of a top-up endowment of £25,000, Lord Newlands reportedly said:

At the present moment its work was, if possible, more valuable than ever, because thanks to the wisdom of the Managers, it was at the present moment devoted to the restoration to health of convalescent soldiers and sailors, amongst whom they were indeed delighted to welcome a large number of our glorious Belgian Allies...Long might the Home continue to be able to claim with justice and with truth to have as its motto the great motto of the Royal Scots Greys 'second to none'.¹³⁸

Although the provision of convalescent facilities was not entirely new to the British Army, the scale of the casualties emphasised the importance of convalescence.¹³⁹ During the First World War, in an attempt to restore the health of soldiers more quickly, doctors used the type of treatment now associated with either physical or occupational therapy. According to Roger Cooter, 'it was difficult to erase the benefits seen in the War of physiotherapy in speeding up convalescence.'¹⁴⁰ The large

¹³⁷ *Ibid*, 10 April 1915, p. 295.

¹³⁸ *GMJ*, February 1915, p. 141.

¹³⁹ For reports of earlier military convalescence see: 'Convalescent homes for Soldiers', *Lancet*, 28 February 1899, p. 526; 'Army Convalescent Homes', *Nursing Record and Hospital World*, 25 February 1899, pp. 154-155.

¹⁴⁰ R. Cooter, *Surgery and Society in Peace and War. Orthopaedics and the Organisation of Modern Medicine* (Basingstoke and London, 1993), p. 134.

number of articles describing new convalescent techniques published during and after the First World War, particularly physiotherapy, supports Cooter's observation.¹⁴¹

When the RIE established the AAI after the First World War, they employed some of the more intensive type of rehabilitative techniques developed for convalescent soldiers. Some of these methods were inevitably more expensive since they required skilled staff and technical equipment. However, this was not a problem because the legacy left by David Ainslie provided the home with immense wealth. By the end of the First World War the accumulated wealth of the legacy amounted to £600,000.¹⁴²

The managers of the RIE did not consider using the bequest from David Ainslie to extend Corstorphine House since this would have compromised the terms of the legacy. This stated that it was for a new convalescent home, not for the refurbishment or extension of an existing one. Instead, the managers retained Corstorphine House 'for patients requiring a short convalescent period before returning to normal life'.¹⁴³ The governors of the AAI decided to use the new convalescent home for patients requiring longer care and supervision, or occasionally infirmity patients who needed building-up for surgery. Even more importantly, they planned to cultivate convalescent techniques 'scientifically'.

However, the following extract from a circular issued by the Governors of the RIE, also published in the *Lancet*, contained a request that staff might contribute suggestions on 'the lines of investigation'.

The governors are desirous that the opportunities afforded by the institution for the scientific study of the process of convalescence from different diseases should be systematically utilised and they would welcome the co-operation of the members of the staff of the Royal Infirmary in suggesting and directing

¹⁴¹ Chapter Five deals with occupational and physical therapy in greater detail.

¹⁴² LHB 1/4/121, AR, RIE, 1921, p. 38; 'The Care of the Convalescent. A New Departure', *Lancet*, 10 November 1923, p. 1053.

¹⁴³ E. F. Catford, *The Royal Infirmary of Edinburgh, 1929-1979* (Edinburgh, 1984), p. 21.

lines of investigation towards this end. It is hoped that the scientific study of the processes underlying recovery of health after illness may lead to improvement in the methods employed in the treatment of the convalescent stage.¹⁴⁴

Their statement reveals considerable uncertainty over their treatment and the need to innovate. Whereas Corstorphine House arose out of the needs of the RIE, the governors had to actually find a purpose for the AAI. The most prominent of the organisers of the AAI were Professor Sir Robert Philip, a leading tuberculosis physician, Alexander Miles, a leading surgeon at the Royal Infirmary of Edinburgh and James Ritchie, Professor of Bacteriology at the RIE.¹⁴⁵ Given the immense wealth of the AAI legacy, together with involvement of three prominent doctors, at a time where there was considerable interest in new rehabilitative techniques, the development of 'active convalescence' at the AAI was almost inevitable. In summary, the rehabilitative techniques developed at the AAI broadened and diversified the concept of convalescence. Chapter Five discusses the regime at the AAI in more detail.¹⁴⁶

Two other hospitals that admitted patients at an earlier stage of convalescence were Cannisburn, the auxiliary/convalescent home attached to the Glasgow Royal Infirmary and Philipshill, an auxiliary of Glasgow's Victoria Infirmary. Cannisburn, in common with the AAI, took patients at a far earlier stage of convalescence than those admitted to traditional convalescent homes, but was not opened until 1938.¹⁴⁷ Although Philipshill was intended to be a type of convalescent home when it opened in 1930, it eventually specialised in orthopaedics.¹⁴⁸ Orthopaedics was a relatively new branch of medicine and used many of the rehabilitation techniques and therefore had some association with scientific convalescence. The trend was towards

¹⁴⁴ 'Edinburgh: The Care of the Convalescent, A New Departure', *Lancet*, 10 November 1923, p. 1053.

¹⁴⁵ Paterson, *Occupational Therapy in Scotland*, p. 122.

¹⁴⁶ See Chapter Five, pp. 203-5.

¹⁴⁷ Jenkinson et al, *The Royal*, pp. 181-2.

¹⁴⁸ S. Slater and D. Dow, *The Victoria Infirmary of Glasgow 1890-1990* (Glasgow, 1990), pp. 89-98.

establishing auxiliary hospitals for longer convalescence or rehabilitation or those requiring bed rest. Photographs of patients at the Grove CH, owned and managed by the Dumfries Royal Infirmary and opened in 1938, illustrate numerous patients at the Home in bed during the day. This suggests that the infirmary managed the home more along the lines of an auxiliary hospital than a traditional convalescent home, as daytime bed rest was not normally allowed in traditional convalescent homes.¹⁴⁹

Government Reports

Although doctors greeted the new concept of active convalescence with some enthusiasm, there was growing criticism over the lack of adoption of the new methods by traditional homes. This was particularly apparent within the content of numerous reports, mostly commissioned by Scottish Department of Health, during the period following the First World War. These reports not only expressed the rejection of non-hospital convalescent homes as medical institutions, but also unease over the lack of control by the medical profession. The reports suggested introducing some kind of classification of convalescent homes according to whether or not they considered that they offered treatment and rehabilitation. Yet, the findings described in the reports suggest that the effectiveness of the regime in the traditional convalescent homes were not fully scrutinised. In some cases, the medical elites made assumptions about traditional convalescent homes without even visiting or contacting them.

The first of these reports was published in 1920: *A Scheme of Medical Services for Scotland* (MacAlister Report). Although this report gave overall approval for convalescent homes, and even suggested an increase in their number, they recommended dividing convalescent homes into three categories.¹⁵⁰ The first category (a) was an auxiliary home, located near enough to the general hospital to transfer patients a few days after surgery or when the acute phase of a medical illness had passed. The report defined an auxiliary home as similar to that of a hospital but with a lower level of staffing and equipment. The second category of home described

¹⁴⁹ *The Dumfries and Galloway Royal Infirmary, A Brief Pictorial Survey, 1776-1948*, n.d. Patients in traditional convalescent homes were not allowed to remain in bed during the day.

¹⁵⁰ *A Scheme of Medical Service for Scotland, 1920*, Cmd. 1039 (MacAlister Report), pp. 15-16.

in this report (b) was the conventional type of convalescent home for patients recovering from surgery or illness who were not sufficiently recovered to return to normal work. The third category of convalescent home (c) suggested was a 'preventative' or 'rest home' type of home for those run down in health such as mothers and children who were ailing but not actually ill. The Committee thought that although in principle it was possible to accommodate class 'c' patients in a type 'b' home, in practice, the two types of patients did not really mix well and it was better to keep them separated.¹⁵¹ However, the report did not reveal how it reached this conclusion.

Although published only six years later in 1926, *The Report of the Hospital Services (Scotland) Committee* (Mackenzie Report) focussing on Scottish Hospitals, had a different set of recommendations.¹⁵² Unlike the *MacAlister Report*, the *Mackenzie Report* did not suggest dividing convalescent homes into three categories. Instead, it excluded 'rest homes' from the report noting that 'rest homes are not included as most of them are in the nature of holiday homes.'¹⁵³ However, their definition of a 'rest home' was not sufficiently clear to identify precisely those convalescent homes that fell within this category. At the same time, the *Mackenzie Report* ambiguously viewed the object of a convalescent home 'generally to give patients a short convalescent period in the country (usually a fortnight) before returning to their own homes'.¹⁵⁴ The *Mackenzie Report* made an interesting comment about convalescent homes, saying, 'they do not relieve to any great extent the pressure on hospital beds.'¹⁵⁵ This was despite regular remarks from hospital managers in the annual reports of the infirmaries stating the opposite view. For example, in 1929 the annual report of the Dundee Royal Infirmary commented: 'Every bed filled in the Home means the release of a bed for more urgent purposes at the Infirmary.'¹⁵⁶ In the same year, the ERI noted that, 'the valuable branch of the hospital continues to be of

¹⁵¹ Ibid., p. 15.

¹⁵² *Report of the Hospital Services (Scotland) Committee*, HMSO, 1926 (Mackenzie Report)

¹⁵³ Ibid., para. 49.

¹⁵⁴ Ibid.

¹⁵⁵ Ibid.

¹⁵⁶ THB 1/2/10, *Annual Report of the Dundee Royal Infirmary*, 1929, p. 291.

greatest possible benefit in relieving pressure on the beds of the Royal Infirmary.’¹⁵⁷

The *Mackenzie Report* also commented rather ambiguously saying, ‘the auxiliary hospital is intermediate between the convalescent home and the general hospital and it is intended expressly to relieve the wards of the parent hospital.’¹⁵⁸ It also suggested converting some of the existing convalescent homes into auxiliary hospitals. They seemed particularly impressed with the Broughty Ferry CH, a hospital convalescent home, where twenty-three of the eighty beds were set aside for ‘lying’ cases.¹⁵⁹ It is somewhat curious that the authors of the Report did not mention the AAI and their pioneering rehabilitative techniques. Overall, the recommendations in the *Mackenzie Report* did not seem particularly interested in developing the traditional type of convalescent homes.

In 1936, the Scottish Department of Health published the *Cathcart Report* indicating yet another perspective on the convalescent homes. The authors reported that they ‘were greatly impressed by the evidence submitted to us on the value of modern convalescent treatment both for the full recovery of patients and for the relief of pressure on the hospitals’.¹⁶⁰ The *Cathcart Report* went to great lengths to describe the merits of the AAI concluding:

The evidence before us indicates that the use of available convalescent hospitals on modern lines would not only be for the benefit in general hospitals, and by ensuring more complete recovery would prevent relapses and consequent return to hospital.

This was similar to comments made by the managers of the Edinburgh Royal Infirmary eighty years previously, when they were establishing Corstorphine

¹⁵⁷ LHB 1/4/29, AR, ERI, 1929-30, p. 26.

¹⁵⁸ (Mackenzie Report), para. 50.

¹⁵⁹ Ibid., para. 52.

¹⁶⁰ *Report of the Committee on Scottish Health Services*, 1936, Cmd. 5204, (Cathcart Report), p. 245.

House.¹⁶¹ The *Cathcart Report* clearly approved of developing rehabilitative type convalescent homes such as the Astley Ainslie. Nevertheless, in common with the *Mackenzie Report*, the *Cathcart Report* tended to discredit convalescent homes that did not offer active convalescence, particularly those outside the hospital system.

Finally, shortly before the Second World War, the Scottish Department of Health conducted the *Scottish Hospital Survey*, a review of all hospitals throughout Scotland. The intention of the Survey was to 'to study facilities offered by regions'.¹⁶² It included all hospitals, some convalescent homes and sanatoria. The *Scottish Hospital Survey* was divided into five administrative areas:

1. Western, (Glasgow area, including Stirling and Dumfries),
2. South Eastern, (Edinburgh area),
3. Northern, (Inverness and North),
4. Eastern (Dundee area),
5. North Eastern (Aberdeen area).

The surveyors were Professors R. S. Aitken, C. F. W. Illingworth, J. M. Mackintosh, Mr. J. W. Struthers and Drs. R. J. Peters, H. E. Seiler and H. Hyslop.¹⁶³

Each institution included in the *Scottish Hospital Survey* received a questionnaire together with a follow-up visit from members of the survey team. The surveyors grouped in twos and threes to visit the convalescent homes. Topics of interest to the surveyors were: the structure of the building; and the type and number of medical staff, together with medical and other facilities offered to the patients. The survey team posted the questionnaires and made visits to some institutions before the outbreak of the Second World War in 1939. They apparently continued the visits throughout War, and the published report finally appeared in 1946. Their comments

¹⁶¹ Ibid., p. 245.

¹⁶² 'General Introduction', *Scottish Hospital Survey*, HMSO, 1946.

¹⁶³ J. Kinnaird, 'The Hospitals' in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987), p. 242.

are therefore sometimes confusing, as some convalescent homes changed their function during this wartime period. For example, some convalescent homes became Emergency Medical Service (EMS) hospitals during the War, while others changed from child to adult convalescent homes, closed or obliterated by enemy action. The survey did not always record these changes.¹⁶⁴

The Western Area (containing the Glasgow area) had a far greater number of different types of hospitals than other areas. The Glasgow area also contained half the convalescent homes in Scotland together with homes in sub-divisions as far apart as Dumfries and Stirling. In total, the Surveyors of the Western Area examined two hundred institutions, but in addition to convalescent homes, these included hospitals and sanatoria. Despite the current identification of around thirty convalescent homes in the Western Area, the Surveyors of the Western Area examined only ten.¹⁶⁵ These were mostly convalescent homes attached to hospitals, including the Schaw Home, the Brooksby, Hozier Home, Sunnybank House, Chartershall and the Grove. They ignored many of the largest convalescent homes in Scotland not run directly by the hospitals, such as the Dunoon Homes, Kilmun and the Mission Coast Home. However, the reason why Charles Illingworth and the other Western Region surveyors excluded many convalescent homes from the Survey cannot be the lack of affiliation to an infirmary, since they included the GCH, an independent home. It is also difficult to accept the Western Region surveyors' conclusion that 'active treatment is not usually given at these homes, and it is doubtful if in any of them organised attention is given to rehabilitation' when a further statement saying, 'we have not visited all these convalescent homes and several of them have not replied to our questionnaire', clearly indicates that their assumptions were based on inadequate information.¹⁶⁶ Their failure to include these homes in the survey indicates that the surveyors had a lack of appreciation of the importance of these homes within the

¹⁶⁴ For example, the *Scottish Hospital Survey* described Nairn as: 'poorly equipped and too small to serve as a convalescent home and it has already been out of use for some years'. The surveyors were unaware that the Home did open shortly after the Second World War. According to D. Stewart and M. Burnett it also underwent some refurbishment afterwards. See: D. Stewart and M. Burnett, *100 years of the Convalescent Home, Nairn* (Nairn, 1993), p. 8.

¹⁶⁵ See Map 1 for distribution of convalescent homes in 1939.

¹⁶⁶ *Scottish Hospital Survey*, Western Region, HMSO, 1946, p. 57.

hospital system, and that the hospitals sent many of their patients directly to these convalescent homes.

Table 3.3 Number of patients at the Dunoon Homes from hospitals in Scotland between 1902 and 1936

Name of Hospital	No. of patients		No. of patients 1936
	1902	1933	
Royal Infirmary	312	233	169
Western Infirmary	213	163	121
Victoria Infirmary	99	52	56
Eye Infirmary	82	18	8
David Elder Infirmary	none	14	11
Royal Samaritan Hospital	none	64	29
Royal Maternity Hospital	none	27	25
Royal Hospital for Sick Children	26	8	13
Ear, Nose and Throat Hospital	none	7	14
City Hospitals	none	434	366
Broadstone Hospitals	none	7	3
Coatbridge Hospital	none	9	3
Dumbarton Hospital	none	none	8
Falkirk Hospital	none	2	none
RIE	21	14	4
Greenock Infirmary	7	62	18
Motherwell Hospital	none	none	3
Kilmarnock Hospital	45	none	none
Paisley Infirmary	76	21	13
Port-Glasgow Hospital	none	none	3
Various other Hospitals	211	35	18
London Hospitals	none	none	2
Total	1155	1180	895

Source: *Annual Reports of the West of Scotland Seaside Homes, Dunoon, 1902, 1933, 1936.* [Dunoon Homes]

Table 3.3 illustrates that throughout the twentieth century, the Dunoon Homes admitted around one thousand patients annually directly from a range of hospitals, mostly in the West of Scotland. Overall, the number of patients admitted by 1936 had decreased slightly, but they accepted patients from a wider range of hospitals. The Surveyors on the Western Region also excluded from their report the following: several miners' convalescent homes; two Co-operative Society homes; and the Railway Convalescent Home at Ascog. All these homes were also contained in their area.

In his autobiography, Charles Illingworth, the surveyor of the Western Region, described the arrangements and methodology he used when visiting the institutions

with Professor J. M. Mackintosh and Dr R. J. Peters.

My ancient Morris provided rattletrap transport and during more than a year we visited nearly two hundred hospitals. James conducted the proceedings, endeared himself to the hospital matron and softened the dour suspicions of the Boards of Governors. I established contact with members of the medical staff and discussed clinical matters. Robert did the real work, studying architects' plans, inspecting the state of repair of the buildings, the disposition of the wards, the effectiveness of the heating plant.¹⁶⁷

The slow mode of transport combined with the enormity of their task that included examining the architects' plans, the structure of the buildings and discussing medical and clinical matters with the staff of each institution probably explains why the surveyors of the Western Region excluded so many of the convalescent homes in their area.

The investigations from surveyors of other regions were far more thorough and included all convalescent homes, whether or not they were attached to a hospital. The Surveyors of the South Eastern region (Edinburgh area) even over-estimated the number of convalescent beds in their region by including some temporary wartime convalescent homes. They calculated that their area contained twenty-two convalescent homes with 737 beds of a 'convalescent type'.¹⁶⁸ Unfortunately, it is difficult to comment further on these convalescent homes since the surveyors of South Eastern region did not describe, or even name all the homes. They only named Abbotsview (a Co-operative Society home), Alderston CH (a friendly society home) the AAI (a rehabilitation home), Bandrum (a home for ailing and convalescent children), Muirfield CH and Corstorphine House (both hospital convalescent homes).¹⁶⁹ The Surveyors of the Eastern Region commented upon eight convalescent homes in their area. This figure is consistent with those identified by the estimate in

¹⁶⁷ Charles Illingworth, *There is a History in all Men's Lives* (1988), p. 88.

¹⁶⁸ *Scottish Hospital Survey*, South Eastern Region, p. 16.

¹⁶⁹ *Ibid*, p. 66.

the survey described in Chapter One. This was also the case with the North Eastern (Aberdeen) region that had only four in the area: Aberdeen Convalescent Hospital, Thorngrove Babies Home, Linn Moor and Newhills. They reported on all of them. Reporting was relatively simple for the Northern Region because they had only one convalescent home in their area: the Nairn Convalescent Home.

Despite Professor Illingworth's view that 'we compiled a very dull report, which disappeared into the archives of St Andrew's House but re-appeared in due course when the Health Service was about to be established', the *Scottish Hospital Survey* revealed much about the perception of medical professions towards convalescent homes.¹⁷⁰ Although the recommendation of the surveyors varied in each area, most agreed that convalescent homes should provide more active methods of rehabilitation.

Surveyors of the Eastern Region commented that:

A convalescent home should provide varied physical activities, for its patients in all stages from those still confined to bed up to those fit for a full day's exercise. These activities require a measure of supervision and guidance and a certain amount of equipment. The home should provide opportunities for mental occupation and recreation. Home-like amenities are desirable, and a cheerful and encouraging atmosphere is essential. A good kitchen has an educational as well as a therapeutic value.¹⁷¹

Similarly, the North-Eastern surveyors recommended:

The regional convalescent home should provide not only rest and good feeding (including simple modified diets), but also graduated exercise,

¹⁷⁰ Illingworth, *All Men's Lives*, p. 88.

¹⁷¹ *Scottish Hospital Survey*, Eastern Region, p. 29.

recreation and occupational therapy, under appropriate supervision by medical and auxiliary staff.¹⁷²

The presence of the AAI in the South-Eastern region may have given their surveyors a benchmark in suggesting their ideal convalescent home. They reported enthusiastically about the AAI, that 'it is a special type of hospital dealing with convalescence and is a unique example of its type.' It concluded, 'this institution will play an important part as a rehabilitation centre in the future hospital scheme in the South-Eastern Region.'¹⁷³

They were less than complimentary about Corstorphine House, the first convalescent home attached to an infirmary established eighty years previously.

In the pre-war days, the convalescent home was not altogether well adapted for its purpose. For those in need of active rehabilitation there was a lack of opportunity for physiotherapy or occupational therapy or any organised supervision of convalescence while for those in need only of rest in pleasant surroundings the home lacked comfort and homeliness.¹⁷⁴

Overall, the South-Eastern Region surveyors attempted to divide convalescent homes into two types.

a) Convalescent homes associated with and administered by voluntary hospitals and (b) Homes which have originated in connection with charitable organisations, bequests or approved societies and which are not directly associated with hospitals. Some of the latter admit patients after hospital treatment but for the most part they act as holiday or rest homes and admit particular classes of the community, such as unmarried mothers before and

¹⁷² Ibid., North Eastern Region, p. 35.

¹⁷³ Ibid., South Eastern Region, p. 17.

¹⁷⁴ Ibid, p. 67.

after confinement, deserted children and children living under undesirable home conditions. They are in the most part small units placed in adapted private dwellings.¹⁷⁵

The Northern Region surveyors recommended ‘that one or two more mansion houses be acquired and adapted for permanent use as convalescent homes’, but did not suggest that they exercised any rehabilitation methods.¹⁷⁶ The Western Region, the area with the largest number of convalescent homes, but with the smallest investigations, made little comment on the future of convalescent homes in their area. A major outcome of the *Scottish Hospital Survey* was that it illustrated a perception by medical professionals of two different types of convalescent homes, the recuperative holiday home, and those offering medical convalescence. Yet, apart from the AAI, none of the convalescent homes were categorised either as a recuperative holiday home or as a medical institution. Neither was there sufficient evaluation of the therapy undertaken in the existing convalescent homes.

Re-interpretation of convalescent homes

The exploration of the origins and development of convalescent homes in Chapter Two revealed that until the twentieth century they were perceived as a type of medical institution where the poor might recover from illness or surgery in pleasant surroundings for two or three weeks. The results of the investigation into the development of convalescent homes during the twentieth century indicate that a far wider definition had evolved from their origin during the mid-nineteenth century. Table 3.4 attempts to provide an analysis of the various explanations for the broader interpretation of the post-1900 Scottish convalescent homes.

¹⁷⁵ Ibid., South Eastern Region, p. 16.

¹⁷⁶ Ibid., Northern Region, p. 29.

Table 3.4

Comparison of pressures for convalescent homes to develop as medical institutions and recuperative holiday homes

Towards Medicalisation	Towards Holidays
Pressure from Charity Organisation Society during late nineteenth century, to introduce higher level of medical and nursing supervision in convalescent homes.	Late nineteenth century, lectures from MOH, James Burn Russell encouraging removal of poor children from the city for short periods.
Increase in the number of trained nurses in hospitals during the late nineteenth and twentieth century, and many were introduced into convalescent homes.	From around 1890 onwards, overall concern for health and welfare of children also encouraged numerous established children's homes and fresh air fortnight societies that took ailing and convalescent children needing country breaks or holidays. Also the Bannatyne Home established 1892, for 'tired workers', not necessarily recovering from specific illness.
New techniques and methods developed during the First World War. Higher standards of care expected of wartime convalescent homes.	Rise in numbers taking annual holidays for working classes with similar recreational activities as those found in convalescent homes.
Establishment of rehabilitative type convalescent hospitals such as AAI and the use of rehabilitation and scientific convalescence.	Co-operative homes also identified convalescent homes with hydropathics
Production of numerous government initiated reports that attempted to divide convalescent homes into those offering recuperative holidays and others providing rehabilitation.	Co-operative Homes and friendly society homes encouraged their use as a rest home. Admission was therefore not necessarily for those recovering from illness.

The first of the two columns summarises reasons underlying the pull towards the medicalisation of the convalescent homes whereas the second explains their increasing push towards identification with recuperative holidays.

The first issue described in column one, was the attempt by the Charity Organisation Society, during the latter part of the nineteenth century, to pressurise convalescent homes into introducing higher levels of nursing and medical supervision. Although the results of this pressure were limited, it coincides with a second issue. This was the higher standard of nurse training introduced in hospitals during the latter part of the nineteenth century and early twentieth century.¹⁷⁷ At around the same time, the convalescent homes also began employing trained nurses. A third issue was the new

¹⁷⁷ See p. 245-6 of this thesis.

rehabilitative techniques developed during the First World War. These new techniques accelerated and encouraged a scientific approach towards convalescence. The fourth issue was that several infirmaries established auxiliary hospitals offering rehabilitation or longer periods of convalescence. The fifth issue was the numerous reports issued by the Department of Health. These reports suggested various ways of reclassifying convalescent homes but mainly towards either a recuperative holiday home or a medical convalescent home. The great acclaim given to the new rehabilitative methods developed after the First World War led to the marginalisation of traditional convalescent homes despite little evaluation on their methods.

The second column in table 3.4 summarises the factors involved in the push towards the identification of convalescent homes with holidays. The first of these variables occurred at the end of the nineteenth century when James Burn Russell gave lectures appealing for philanthropists to provide country or seaside breaks for children. This was despite concern from some members of Charity Organisation Society that people seeking a free holiday might be misusing the convalescent homes. The MOH for Glasgow, James Burn Russell supported this concern. The response to this prepared the ground for the second influential factor: some children's convalescent homes began combining the role of convalescent home with the provision of holidays for ailing children. The establishment of the Bannatyne Home of Rest for tired female workers in Dundee suggests the development of a similar trend amongst adults.

A third issue that encouraged a stronger association of convalescent homes with holidays was the increase in the numbers of working classes taking holidays during the twentieth century. Although holidays were still no more than a day trip or a few days staying with relatives for much of the working class population, they were increasingly accepted as a normal activity. Most convalescent homes provided many of the recreational activities found on an annual holiday, such as bowls and putting greens.¹⁷⁸ In addition, friends and relatives of patients sometimes used the

¹⁷⁸ See Chapter Five, pp. 201-4 of this thesis.

convalescent homes as a recreational day trip. Corstorphine House, for example, eventually banned Sunday visits to patients because they could not cope with the crowds of day-tripping visitors.¹⁷⁹ A fourth issue was that members of the co-operative societies also began to identify their convalescent homes with the hydropathics. By the twentieth century hydropathics had evolved from medical institutions to a type of hotel. Finally, a fifth point was that the Co-operative and at least one friendly society convalescent home encouraged their use as a rest home, not necessarily for recovery from illness although this trend was resisted in other homes.

Conclusion

In summary, most of the convalescent homes established in the nineteenth century not only survived into the twentieth but often expanded in size, particularly amongst the independent and religious homes in the West of Scotland. However, during the twentieth century there were several new areas of influence. Firstly, there was the escalation of concern for maternal and child health that occurred during the twentieth century. This led to growth of convalescent facilities specifically for children and mothers with young children. Sponsorship of the new children's convalescent homes emerged from a wide spectrum of interest and financial support, ranging from schools, charities, trusts, fresh-air fortnight societies and local authorities. A significant change occurred amongst the children's convalescent homes; this was the admission of ailing or malnourished children for a country or fresh air break. This pluralistic approach initiated an identification process of convalescent homes with holidays.

The second major influence within the sponsorship group that emerged during the twentieth century was the growth of interest in convalescent homes from mutual assurance societies. There were three types of mutual assurance societies: co-operative societies, friendly societies and occupational groups. The major difference between the sponsorship of these homes and the groups was that they were

¹⁷⁹ LHB 1/2/9, Minutes of Corstorphine Convalescent House Committee, 26 January 1898.

established as a benefit for their members, not as a charity. The convalescent homes established by the Co-operative societies also associated their homes with hydrotherapies. By the twentieth century, these were also associated with holidays and mostly regarded as middle-class hotels. This identification with a middle-class type of institution also suggests an upgrading in their social standing. Thus by 1939, many convalescent homes had a wider definition and higher social status than in the nineteenth century.

Following the First World War, there was considerable enthusiasm exhibited towards the new rehabilitative methods such as physical and occupational therapy. Numerous reports emerged from the Scottish Department of Health reflecting interest in new methods of rehabilitation and concerns over its perceived absence in the traditional convalescent homes. Particularly relevant were the *Mackenzie, MacAlister and Cathcart Reports*, published during the inter-war years and the *Scottish Hospital Survey* after the Second World War. Their authors attempted to classify convalescent homes into 'medical' and 'non-medical' suggesting that 'medical' convalescent homes were those offering modern rehabilitation methods. They believed that convalescent homes that provided rest, diet and recreation were 'non-medical' and should be regarded as recuperative holiday homes. However, there is little evidence of any systematic research to indicate the extent of any differences between various convalescent homes, such as the illnesses of patients, regime or staffing or the effectiveness of their treatment. Chapter Four will examine the first of these issues, illnesses.

Chapter Four

Illnesses

The previous chapter revealed that reports emerging from the Scottish Department of Health after the First World War raised serious doubts over the credibility of convalescent homes as medical institutions. This contrasted with the situation in the nineteenth century when their status was relatively unchallenged by medical authorities. An illustration of the earlier recognition of convalescent homes as medical institutions was the inclusion of the GCH, Mission Coast Home, Kilmun, Dunoon Homes and the Cottage Homes for Children at Helensburgh in a popular nineteenth century handbook entitled, *Medical Institutions of Glasgow*.¹ This handbook was significant because it was specifically prepared for one of the most prominent medical societies, the British Medical Association [BMA]. Numerous references to convalescent homes in the medical press between 1860 and 1914 provided further evidence of their acceptance as medical institutions. A survey of the *Lancet*, *BMJ* and *GMJ* during this period identified sixty references to Scottish convalescent homes.² The following extract from the *Lancet* in 1883 is typical of the acclaim given to convalescent homes in the medical journals during the nineteenth century.

Every effort seems to be made to make these institutions useful adjuncts to the infirmaries for those recovering from severe illnesses or suffering from overwork, so that an opportunity may be afforded them of completely re-establishing their health by change of air, with rest and good diet.³

¹ J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888). A handbook prepared for the Annual Meeting of the British Medical Association held in Glasgow, August 1888. This was compiled and edited at the request of the local committee by J. Christie (Professor of Physiology and Lecturer on Hygiene and Public Health in Anderson's College Medical School, Glasgow). In addition to the hospitals, other institutions listed in this handbook included, lunatic asylums, dispensaries, homes for incurables and institutions for the blind, deaf and dumb.

² As part of the analysis of the research for this thesis I compiled a database recording references to convalescent homes in the *GMJ*, *BMJ* and *Lancet* between 1860 and 1939.

³ *Lancet*, 6 October 1883, p. 173.

Even after the First World War, when the medical and nursing journals were reporting enthusiastically on new methods of rehabilitation, they still commented favourably upon the convalescent homes with their more traditional, empirical approach towards treating patients. For example, an article in the *BMJ* describing an investigation into the extent of convalescent facilities in Britain reported:

To a considerable extent the anxieties of hospital authorities with regard to the aftercare of patients have been relieved by the establishment and indeed the general extension of convalescent facilities working in close connection with the hospitals themselves.⁴

In addition, the infirmaries continued to imply recognition of their convalescent homes as medical institutions by consistently including them within their own annual reports throughout the nineteenth century and well into the twentieth century.⁵ This was despite the establishment of the AAI and other auxiliary hospitals during the inter-war period that used new rehabilitative methods of treatment and offered longer periods of convalescence. This evidence from the journals and infirmaries therefore suggests that the relegation of traditional convalescent homes into non-medical institutions was not present within the entire medical framework during the inter-war period.

Nevertheless, the loss of status of convalescent homes identified in the government reports was a critical issue since their authors were amongst the medical elite and therefore influential within the medical profession and central government. The explanation provided in Chapter Three for the downgrading of convalescent homes focussed mainly upon two areas of concern. Firstly, the majority of the beds for

⁴ 'Convalescent Provision in Great Britain', *BMJ*, 23 February 1929, p. 365.

⁵ For example see: LHB1/4/69-139, *Annual Reports of the Royal Infirmary of Edinburgh*, 1869-1939; GRHB 1/7/3-8, *Annual Reports of the Aberdeen Royal Infirmary*, 1873-1939; GGHB HB 14/2/10-14, *Annual Reports of the Glasgow Royal Infirmary*, 1895-1939; THB 1/2/5-11, *Annual Reports of the Dundee Royal Infirmary*, 1873-1939.

convalescent patients were organised outside the hospital system where the medical profession exerted far less control. Secondly, the association of convalescent homes with holidays and recreation, plus their reluctance to adopt the new rehabilitative techniques, encouraged the perception of them as non-medical establishments. By contrast, many of the tuberculosis sanatoria, that often followed a similar type of recreational regime to the convalescent homes, did practice new methods of treatment.⁶ Consequently, the adoption of new methods and techniques by the sanatoria furthered their links with medical professionals whereas the lack of take-up of rehabilitative techniques in convalescent homes distanced their association with medicine and the medical profession.⁷

The failure of convalescent homes to adopt the new rehabilitative techniques is therefore important, and the reasons why they were mostly ignored required clarification. There were a number of possible explanations. Firstly, the cost might have deterred some convalescent home managers since the equipment and additional staff necessary was more expensive. Yet, this cannot be the only explanation since, as shown in chapters two and three, sponsors and managers of convalescent homes had previously raised considerable sums of money either to establish new convalescent homes or provide extensions to existing premises.⁸ The convalescent homes were therefore familiar with raising funds for new projects. Secondly, since the authors of the government reports appeared to have carried out little or no systematic research on the therapeutic aspects of the traditional convalescent homes, it is possible that they were mistaken and the homes did use rehabilitative methods consistent with the highly acclaimed AAI. This is an issue examined further in Chapter Five. A third possibility is that the type and stage of the illnesses of patients

⁶ F. B. Smith, *The Retreat of Tuberculosis 1850-1950* (Beckenham, 1988), p. 101. F. B. Smith, for instance, observed that tuberculosis sanatoria in Switzerland were often more like hotels than hospitals; L. Bryder, *Below the Magic Mountain* (Oxford, 1988), p. 47. Linda Bryder also remarks that Dartmoor Sanatorium, Devon 'sounded more like a holiday resort than a hospital in its advertisement'.

⁷ Smith, *Tuberculosis*, pp. 139-165. Smith describes numerous therapeutic remedies that were introduced in sanatoria following the First World War, including artificial pneumothorax, exposure to X-rays, courses of injections of gold salts and intratracheal injections of methol, olive oil and guiacol.

⁸ The regularity of new and quite costly extensions are described in Chapter Three, particularly at the Dunoon Homes.

admitted to the convalescent homes simply did not merit the use of the new rehabilitative methods. In order to establish whether this third suggestion is conceivable, it was first necessary to assess the illnesses of patients before their admission to a convalescent home. The purpose of this chapter is therefore to consider a number of issues relating to the variety and extent of illness of the convalescent home patients, particularly its interpretation within convalescent homes together. Understanding the nature and patterns of illnesses in the convalescent homes is also important because without such awareness it is not possible to fully appreciate their development and function.

Interpreting Convalescence

The word 'convalescence' is derived from the Latin term 'valescere' meaning 'to grow strong'. During the nineteenth and early twentieth century, this definition was too narrow and there were numerous attempts to define convalescence more broadly. For example, the influential hospital administrator, Henry Burdett, described convalescence as 'a stage in the history of an illness which does not terminate fatally, where disease has ceased and health has to be restored. This is known as the period of convalescence'.⁹ P. G. Lewis, author of a popular nursing manual, defined convalescence as 'the period of a disease which is marked by the cessation of the more prominent characteristic symptoms, and is the period intermediate between them and full restoration to health.'¹⁰ Both these definitions refer to convalescence as a 'stage' or 'period' in an illness. Alexander Miles and John Cunningham, prominent doctors involved with the AAI, also describe convalescence as a stage in the course of an illness. Their definition stated that 'convalescence is to be looked upon as a definite stage in the course of an illness, comparable to the recognised stages of "incubation", "onset", "course" and "crisis".'¹¹ Although these definitions illustrate a common acceptance that illness has various stages, few attempts have been made to

⁹ H. C. Burdett, *Hospitals and Asylums of the World, Vol. III* (London, 1893), p. 849.

¹⁰ P. G. Lewis, *Nursing. It's Theory and Practice* (London, 1910), quoted in: C. Heckman, *Convalescence*, Unpublished MA Dissertation (Kings College, London, 1995).

¹¹ A. Miles and J. Cunningham, *The Convalescent-Rehabilitation Hospital as an Integral Part of the National Health Service* (Edinburgh, 1951), pp. 3-4.

analyse convalescence in this context. An exception is the work of E. Suchman, who divided illness into five stages, 'the symptom experience stage', 'the assumption of the sick role stage', 'the medical care contact stage', the dependent-patient role stage and finally, 'the recovery or rehabilitation stage'. Suchman identified this final stage as the 'convalescent' or 'recovery phase', 'a period of readjustment' and 'return to the well status'.¹²

Although Miles/Cunningham and Suchman used a different set of criteria to determine the stages of illness, they both described convalescence as the final phase. However, the point at which a patient enters the convalescent phase depends mainly upon the perception of the patient, nurse, and medical advisor or in the case of the convalescent home, their managers or medical officers rather than a definite set of physical signs. The flexibility of the definition of convalescence therefore allowed the convalescent homes to decide upon their own interpretation of a convalescent patient. Most convalescent homes established their definition of a convalescent patient through a published list of rules. These rules defined their ideal patient by clearly stating the type or stage of illness of patients admitted, or more commonly, not admitted to the convalescent homes. The next section used eight sets of surviving lists of rules to determine the physical condition and types of illness the convalescent homes expected of their patients on admission.

Patients or Type of Illness Excluded from Convalescent Homes

Although expressed in a variety of ways, all the convalescent home rules examined rejected the incurable, chronically ill or those with visible signs of active illness. For instance in 1870 at the Dundee Convalescent House, the rules declared that 'the Convalescent House is designed for those convalescent from illness and not for patients labouring under incurable and active disease'.¹³ Similarly, the Dunoon Homes excluded 'persons who are helpless and requiring active medicament. Those

¹² E. Suchman, 'Stages of Illness and Medical Care', *Journal of Health and Human Behaviour*, 6 (1965), pp. 114-128.

¹³ THB 13/1, 'Rules of the Convalescent House', *Seventeenth Annual Report of the Dundee Convalescent House*, 1877, p. 9.

afflicted with advanced pulmonary consumption and who are deemed with that or any other disease to be incurable'.¹⁴ Likewise, the GCH also excluded 'persons labouring under any acute disease which requires active medical treatment; persons labouring under any incurable disease; in a helpless condition; who are not really in a convalescent state'.¹⁵ Ravenscraig CH, a convalescent home for children, excluded chronic or acutely ill patients by introducing rules that rejected children who required extensive nursing:

Children shall not be sent to the Home unless they comply with the following further conditions:- are between 2 and 12 years of age and do not require regular night attendance or nursing; are convalescent and able to be out of bed practically all day; do not require active medical or surgical treatment saving such treatment as simply dry dressings, treating superficial wounds with woodwool, wadding etc.¹⁶

In 1900, Newhills, an independent home in Aberdeen, also denied access to 'persons confined to bed or requiring medical treatment or nursing to any material extent'.¹⁷ The Mission Coast Home implied they only wanted non-chronic and active patients by stating that the convalescent home was for 'those whose health is likely to be restored by residence for a week or two in the fresh air, with nourishing diet'.¹⁸ Similar rules existed in the convalescent homes attached to hospitals. At Corstorphine House, inadmissible patients were, 'persons labouring under severe chronic diseases of an incurable nature, affecting the lungs, heart or other important

¹⁴ ML G.362.160941435, *Sixteenth Annual Report of the West of Scotland Convalescent Seaside Homes*, [hereafter *WSCSH*], Dunoon, 1885, p. 35. [Dunoon Homes]. This convalescent home was also commonly known as the Dunoon Homes. See Appendix C.

¹⁵ ML G.362.160941435, 'Rules for the Admission of Patients into the Glasgow Convalescent Home', *Seventh Annual Report of the Managers of the Glasgow Convalescent Home to the Subscribers*, [hereafter *GCH*], 1871, p. 27.

¹⁶ GGHB 2/3/5, 'Rules and Constitution', Memorandum of Agreement between the Directors of the Royal Hospital for Sick Children, Glasgow and the Committee of Management of Trinity Church Convalescent Home for Children, at Ravenscraig, Renfrewshire, 1911-13.

¹⁷ GRHB 9/3/8, 'Rules at the Cottage Home for Convalescents and Sanatorium for Consumptives at Newhills', c.1908.

¹⁸ GCA T.Par 1.7, 'Rules for inmates', *Forty-Second Annual Report, Mission Coast Home, Saltcoats, 1906-1907*, pp. 30-31.

organs and persons requiring continuous medical or surgical treatment' and 'persons requiring continuous medical or surgical treatment'.¹⁹ Rules at the Schaw Home, (the convalescent home of the GRI) were not quite so specific but still deemed that 'persons labouring under an incurable disease' were inadmissible.²⁰

Other groups of patients not accepted by most convalescent homes were those recovering from infectious diseases. Their exclusion was surprising since typhoid, typhus, enteric fever, smallpox and scarlet fever were amongst the dominant illnesses during the nineteenth century. It is more understandable when considered in the light of the fear present amongst the urban population over the transmission of infectious diseases during the nineteenth century.²¹ These focussed mainly upon the anxiety concerning the possible introduction of infectious diseases by patients that often occurred when planning a convalescent home. One example was the conflict between Jean Colville and some neighbours in Helensburgh when she decided to establish a small home for convalescent children in 1884.²² This illustrates the prejudice that sponsors of convalescent homes could encounter if they allowed the admission of those recovering from infectious diseases.

Most of the rules in convalescent homes were therefore specific on the question of the admission of patients recovering from infectious diseases. The GCH for example, excluded 'persons labouring under or recovering from any contagious or infectious disease'.²³ Newhills also clearly stated that they did not admit patients 'labouring under infectious diseases'.²⁴ Similarly, the rules at Mission Coast Home stated that patients suffering from contagious or infectious diseases 'cannot be admitted'.²⁵

Ravenscraig CH expected those sending children to the convalescent home to ensure

¹⁹ LHB 1/194/25, 'Rules and Regulations', *Description and Plans of the Convalescent House, Corstorphine* (Edinburgh, 1894), pp. 11-12.

²⁰ GGHB HB 52/1/7, 'Rules of the Schaw Convalescent Home'.

²¹ A. G. Carmichael, in Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease* (Cambridge, 1993), pp. 720-721.

²² *Helensburgh and Gareloch Times*, 30 April 1885, p. 3. See Chapter Two for a further description of this conflict, pp. 52-53.

²³ ML G.362.160941435, 'Rules', *Seventh AR, GCH*, 1871, p. 27.

²⁴ GRHB 9/3/8, 'Rules, Newhills'.

²⁵ GCA T.Par 1.7, *Forty Second AR, Mission Coast Home*, 1906-07, p. 30.

that they 'are not suffering from any infectious illness'.²⁶ Although the rules of most convalescent homes excluded patients recovering from infectious diseases, there were some exceptions. During the early years of the Dundee Convalescent House (opened in 1860) many patients were recovering from infectious diseases. Nevertheless, comments in their annual report of 1865 indicated that they were not entirely happy with this situation:

It is not however desired to make the Institution so exclusively a fever convalescent home and it is intended to have the patients, as formerly, of a more mixed class, as it is much to be hoped that there may not continue to be the same necessity for receiving fever patients.²⁷

The Managers of Broughty Ferry CH, the convalescent home of the Dundee Royal Infirmary, also reluctantly accepted patients recovering from infectious diseases but only because it was a condition of the bequest from the principle benefactor, David Baxter.²⁸ Although the first Paisley Convalescent Home also admitted fever patients, they kept this category of patient in separate accommodation away from the medical and surgical patients.²⁹

A few homes accepted patients recovering from infectious diseases but with a time lapse between the onset of the disease and admission to the home, often as long as three months. They also required a medical certificate certifying that the patient was free from infection. The Dunoon Homes excluded patients recovering 'from eruptive or other fevers of an infectious nature as long as they are deemed capable of communicating infection'.³⁰ Yet in practice there were no patients recovering from common infectious diseases admitted to the Dunoon Homes until the 1930s. By then,

²⁶ GGHB 2/3/5, 'Rules, Ravenscraig', 1910-1911.

²⁷ THB 13/1, *Fifth Annual Report of the Dundee Convalescent House*, 1865, p. 6.

²⁸ THB 1/7, Minutes of the Dundee Convalescent Home Committee, 8 February 1872. [Broughty Ferry CH].

²⁹ GGHB HH 70/2/4, *Annual Reports of the Paisley Convalescent Home*, 1869-1873.

³⁰ ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, p. 35. [Dunoon Homes]. These rules remained throughout the period.

the infectious diseases no longer held the same fear amongst the general population.³¹ Although their rules governing the exclusion of patients suffering from infectious diseases remained,³² in 1934 the Dunoon Homes admitted a small percentage of children recovering from chicken pox, measles, scarlet fever, diphtheria and whooping cough.³³

The rules at Corstorphine House also stated that patients were not admitted 'until certified by the physicians under whose care they may have been, that there is no risk of infection'. Likewise, the Co-operative Society also specified that, 'all convalescents (children included) must forward a medical certificate stating that they are free from infectious disease'. They also specified a specific period of time, dependent upon the type of illness.

Whooping Cough	-	6 weeks
Scarlet Fever	-	6 weeks
Typhoid Fever	-	4 weeks
Measles	-	4 weeks
Diphtheria	-	3 weeks. ³⁴

In addition to the rules excluding patients recovering from infectious diseases, incurables, the chronic or acutely ill, many convalescent homes also refused admission to patients suffering from conditions likely to be difficult for staff to

³¹ Sir Alexander MacGregor, *Public Health in Glasgow 1905-1946* (Edinburgh and London 1967), pp. 32-34.

³² NLS GD.409/25/1, *Annual Report for the Gilmerton Convalescent Homes*, 1940, p. 29. Their Annual Report for this year still stated 'no infectious cases admitted'.

³³ See: A. J. Bollet, *Plagues and Poxes. The Rise and Fall of Epidemic Disease* (New York, 1987), pp. 25-27, 56, for descriptions of the conquest of diphtheria and smallpox. Also, P. Weindling, 'From Medical Research to Clinical Practice: Serum Therapy for Diphtheria in the 1880s', in John V Pickstone, ed., *Medical Innovations in Historical Perspective* (New York, 1992), pp. 72-84; R. McGrew, ed., 'Diphtheria' in *Encyclopaedia of Medical History*, (London and Basingstoke, 1985), pp. 93-98. For information on whooping cough and scarlet fever, see: A. Hardy 'Whooping Cough' and 'Scarlet Fever', in Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease* (Cambridge, 1993), pp. 990-992, 1094-6; For information on measles see: R. J. Kim-Farley, 'Measles', in Kiple, *Cambridge World History*, pp. 871-875.

³⁴ GGHB HB 6/4/55, 'Bye-laws to be Observed', *Eighth Annual Report of the Scottish Co-operative Convalescent Seaside Homes Association Limited, Seamill*, 1901, p. 37.

handle or that might cause problems with other patients. Two of the most prominently excluded conditions were epilepsy and mental illness. For example, the Mission Coast Home stated that patients with 'epileptic or other fits or in any degree mentally unsound' were not admitted.³⁵ The GCH and the Dunoon Homes both refused admissions to 'persons subject to epileptic fits or other fits or who are of unsound mind'.³⁶ The Schaw Home also denied access to 'persons suffering from epileptic or other fits' but there was no exclusion on mental illness.³⁷ At Corstorphine House, 'persons subject to epilepsy or other fits' were also on the inadmissible list, but not those with mental illness.³⁸ Nevertheless, in practice mentally ill patients were not admitted to Corstorphine House. The Dunoon Homes also rejected 'persons having ulcers attended with offensive discharges'.³⁹ A similar exclusion existed at Newhills, described in the rules as patients 'having sores with considerable discharges'.⁴⁰

Annual reports from the convalescent homes indicate that rules regarding infectious diseases were enforced. For example, in 1902, the examining medical officer of the Dunoon Homes, Robert Perry, reported that he refused admission to patients recovering from infectious diseases (unspecified).⁴¹ However, it was far more difficult to control the admission of a few extremely ill patients and also those with chronic illnesses. There were regular complaints from medical officers that subscribers and general practitioners were sending very sick patients. For example, Drs Stewart and Whitelaw, medical officers at the GCH remarked in 1874 that patients sent to the convalescent home were sometimes 'beyond recovery when they came to the Home'. They also commented that:

³⁵ GCA T.Par 1.7, *Forty-Second AR, Mission Coast Home*, 1906-1907, p. 30.

³⁶ ML G.362.160941435, 'Rules', *Seventh AR, GCH*, 1871, p. 27; ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, p. 35. [Dunoon Homes].

³⁷ GGHB HB 52/1/7, 'Rules, Schaw CH'.

³⁸ LHB 1/194/25, 'Rules, Corstorphine House'.

³⁹ ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, p. 35. [Dunoon Homes].

⁴⁰ GRHB 9/3/8, 'Rules, Newhills CH'.

⁴¹ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, pp. 10-11. [Dunoon Homes]

We desire respectfully to impress on all concerned the propriety of sending to the Home only such persons as are truly convalescent. During the last year not a few patients were so ill as to remain much in bed and require active medical treatment.⁴²

Similarly, in 1900, Dr MacArthur, Medical Officer at the Co-operative Society Home at Seamill also remarked that 'some patients came to the home too early in their convalescence'.⁴³

In 1893, Drs Stewart and Whitelaw complained about the inadvertent admission of chronically ill patients, such as a patient suffering with chronic kidney disease who later died of peritonitis.⁴⁴ Dr John Perry, Medical Officer at the Dunoon Homes, demonstrated efforts to deter admission by the chronically ill. In 1894, his report stated that,

a considerable number of rejected applicants were chronic invalids, who having already experienced the advantages of the Home – were again anxious to be admitted. These I am obliged to refuse, in order to retain room for suitable convalescents –the class of persons for whom the Institution is specially intended.⁴⁵

Deaths in Convalescent Homes

Until the beginning of the First World War a few deaths occurred annually in most convalescent homes. Although the number of patients that died was very small, usually between one and seven annually, they should not have occurred because patients admitted to the homes were supposed to be in a convalescent state. It supports the complaints by medical officers of convalescent homes during the nineteenth century that very sick patients were slipping through the net. It also

⁴² ML G.362.160941435, *Ninth AR, GCH*, 1873, p. 6.

⁴³ GGHB HB 6/4/55, *Tenth AR, Co-operative Seaside Homes*, 1901, p. 8.

⁴⁴ ML G.362.160941435, *Twenty-Ninth AR, GCH*, 1893, p. 6.

⁴⁵ ML G.362.160941435, *Twenty-Fifth AR, WSCSH*, 1894, p. 10. [Dunoon Homes]

illustrates that some patients were in very poor physical condition since some died shortly after arrival. For example, in 1867 Dr Goff, the medical officer of the GCH, reported that one female patient died of ‘complication of diseases, the most prominent of which was phthisis. Very shortly after admission she became bed-ridden and from that time gradually sank’.⁴⁶ In 1873, Drs Stewart and Whitelaw reported ‘one male patient died of heart disease and bronchitis and died on the third day of admission to the home.’⁴⁷ In 1881, they reported the deaths of three patients. The first was a male patient, aged 32 who died of diabetes and heart disease. The second male patient aged 34, died of aneurysm and general debility and the third patient, a female, aged 27 years, died of feeble heart and congestion of lungs.⁴⁸ In 1881 Kilmun reported four sudden deaths, three occurring within 24 hours of admission. Their comments in the annual report that ‘it is a pity that friends should send people to the Home so far gone that the fatigue of travelling hastens their death’ also indicates the advanced stage of illness of these patients.⁴⁹

In 1889, Drs Whitelaw and Stewart again reported three deaths at the GCH as follows,

a male patient aged fifty died of bronchitis and debility, while another male aged 32 succumbed to asthma and congestion of the lungs; and a third, aged 77 died of apoplexy. A female patient, aged 43, died suddenly – the cause of death being the rupture of an aneurysm.⁵⁰

In 1894, Medical Officer, Dr John Ritchie, reported that three patients died at the Dunoon Homes, ‘one occurred very suddenly, and due to heart disease, another was due to acute phthisis and a third to pneumonia’.⁵¹ In 1902, there were still four deaths

⁴⁶ ML G.362.160941435, *Fourth AR*, , 1869, p. 6.

⁴⁷ ML G.362.160941435, *Eighth AR, GCH*, 1873, p. 6.

⁴⁸ ML G.362.160941435, *Seventeenth AR, GCH*, 1882, p. 7.

⁴⁹ GCA TD.432/13, *Seventeenth Annual Report of the Kilmun Seaside Home for Convalescent Poor*, [hereafter *KSHCP*] 1883-1884, p. 4. [Kilmun]. See Appendix C for other titles given to this convalescent home.

⁵⁰ ML G.362.160941435, *Twenty-Fifth AR, GCH*, 1889, p. 8.

⁵¹ ML G.362.160941435, *Twenty-Fifth AR, WSCSH*, 1894, p. 11. [Dunoon Homes]

at Dunoon described in the annual reports as follows:

The first was that of an old man, who was really in a dying condition when admitted and who only lived with us for a few days. The second death was caused by an attack of hemiplegia. The third was due to heart disease and death came with tragic suddenness, while the man was out walking on the public street. The fourth death was caused by a severe attack of haemoptysis, and was also very sudden and distressing.⁵²

After the First World War, the annual number of deaths in convalescent homes declined. This was particularly evident at the Dunoon Homes. Between 1880 and 1914 mortality averaged 3.5 patients per annum whereas the average number of patients admitted each year was 3262. During the years 1915-1933, the death rate fell to 1.5 patients per annum but the average annual number of patients admitted had risen to 4985.⁵³ There was also little variation in the amount of time spent at Dunoon by each convalescent that might have affected the figures. This remained constant at around two weeks for each patient between 1869 and 1933.

Similar but rather more spasmodic statistics on death rates than those given at the Dunoon Homes occurred in other convalescent homes, suggesting a similar situation. At the GCH, most of the available annual reports recorded at least one death until the post-First World War period.⁵⁴ Yet in the annual reports of 1922 and 1936 (these were the only reports available), no deaths were reported.⁵⁵ Similarly, managers of the ERI regularly recorded one or two deaths per annum at Corstorphine House until 1908. After this time reports of deaths at Corstorphine House ceased. An increase in the return of some patients from the convalescent home to the Infirmary from around

⁵² ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, p. 11. [Dunoon Homes].

⁵³ Extracted from table published in *Sixty-Fourth Annual Report of the Glasgow and West of Scotland Convalescent Seaside Homes*, [hereafter *GWSCSH*, formerly *WSCSH*]. Dunoon, 1933, p. 5. [Dunoon Homes]. In previous years, the title of this convalescent home was *West of Scotland Convalescent Seaside Homes*. In years following 1933 it was known as the Glasgow and West of Scotland Convalescent Seaside Homes. See Appendix C for further details.

⁵⁴ ML G.362.160941435, *ARs, GCH*, 1869, 1870, 1882, 1889, 1893.

⁵⁵ ML G.362.160941435, *ARs, GCH*, 1922, 1936.

the turn of the century could explain the fall in death rates at Corstorphine House. At the non-hospital convalescent homes with no such facilities, the decline in deaths did not occur until after the First World War. Although many poor people still suffered serious social and nutritional deprivation during the twentieth century there was an overall improvement in the health of the population. This is one possible explanation for the fall in deaths in convalescent homes.⁵⁶ Another possible explanation was the development of medical institutions that siphoned off seriously ill patients previously sent to a convalescent home. These included homes for incurables, sanatoria for tuberculosis patients, auxiliary and cottage hospitals.

Non-Convalescent Patients

Despite these various complaints from medical officers over the admission of the incurable, chronically or acutely ill patients during the nineteenth century, the convalescent homes willingly accepted some categories of patients who were clearly not convalescent. The first of these were patients with pulmonary tuberculosis (phthisis).⁵⁷ This topic is dealt with later in this chapter. A second category of non-convalescent patient admitted to convalescent homes were pre-operative patients sent for 'building up' before undergoing surgery. Kilmun first mentioned this class of patient their annual report of 1910.⁵⁸ In 1939 they continued to comment that 'many patients come to have their strength built up preparatory to undergoing operations, with good results'.⁵⁹ There is also evidence that other convalescent homes occasionally admitted pre-operative patients. A ward journal of the Glasgow Royal Infirmary recorded that a nine-year-old girl, Christina Law, with strumous disease of the foot, was admitted to the infirmary on 17 April 1871 and later sent to the GCH on the 28 April 1871. The journal also recorded that she was instructed to return one month later. Later, on 17 June 1871, the ward journal stated that 'she having returned

⁵⁶ See: H. Jones, *Health and Society in Twentieth Century Britain* (London, 1994), pp. 58-78.

⁵⁷ The admission of pulmonary tuberculosis patients to convalescent homes only occurred during the nineteenth and early twentieth century and is dealt with later in the Chapter.

⁵⁸ GCA TD.432/13, *Forty-Fourth Annual Report of the Kilmun Seaside Home for Convalescents*, [hereafter *KSHC*, formerly *KSHCP*] 1910-1911, p. 6. [Kilmun].

⁵⁹ GCA TD.432/13, *Seventy-Second Annual Report of the Glasgow-Kilmun Convalescent Home*, [hereafter *GKCH*, formerly *KSHC*], 1938-39, p. 4. [Kilmun].

from Bothwell (another name for the GCH) with her foot no better Dr Watson performed 'Lymes' operation'.⁶⁰ The home background of Christina Law illustrates the difficulties experienced by the sick poor living in cramped accommodation during the nineteenth century. The 1871 census recorded that she lived with her mother, stepfather and three stepsisters aged 5 years, 3 years and 8 months in two rooms, in a poor area of Glasgow.⁶¹ Although the GCH annual reports do not mention this category of patient, it is unlikely that Christina was an isolated case, particularly as the admission of this type of patient is mentioned in the annual reports of other convalescent homes.

Overall Patterns of Illness

A comparison of types of illness during the years, 1883/1883 and 1938 provided an indication of the overall patterns in convalescent homes. In order to reduce the possibility of bias from either their location or sponsorship, the two convalescent homes selected were the Dunoon Homes, an example of an independent home on the West Coast of Scotland and Corstorphine House, an example of a hospital convalescent home situated near Edinburgh. The documentary source material used to examine illnesses at the Dunoon Homes was a statistical table on the annual breakdown of illness contained in their annual reports. This set of statistics on patients for the Dunoon Homes was unique amongst the convalescent home annual reports. Although similar source material did not exist for Corstorphine House, their admission books were available and contained information on the previous illness of each individual patient. These are the only convalescent home admission books known to have survived from the nineteenth and early twentieth century in Scotland.

A sample of 345 patient illnesses for 1883/5 and 1938 was extracted from the admission books of Corstorphine House. The months of January and July were used to reduce the possibility of seasonal bias. The illnesses of patients recorded in the admission books at Corstorphine House were then compared with those at the

⁶⁰ HH. 67/26/3, Ward Journal of Dr Ebenezer Watson, Glasgow Royal Infirmary, 1871, p. 171.

⁶¹ Census enumerator returns for 1871.

Dunoon Homes. Compatibility of the two sources was achieved by using a similar classification of the illnesses of the patients contained in the two sources. Following classification of patients' illnesses, the problem of numerical inconsistency remained. Using a percentage figure for both sets of figures overcame this problem. Table 4.1 describes the results of the analysis and contains four columns. Columns 1 and 2 compares and contrasts the patient illnesses at Corstorphine House in 1883 and 1938, whereas columns 3 and 4 compares and contrasts illness at Dunoon Homes in similar years.

Although there were similarities between the types of illnesses that patients were recovering from at both Corstorphine House and the Dunoon Homes, there were also variations. Table 4.1 indicates that pulmonary diseases represented the highest percentage of all patient illness at both homes in 1883 and 1885 (13.4% of all patients at Corstorphine House and 19.5% at the Dunoon Homes). This is consistent with the incidence of pulmonary illnesses within the general population, particularly bronchitis, a disease that flourished amongst the urban poor in the polluted nineteenth century industrial cities of Britain.⁶² Although by the 1930s there was a general decline in pulmonary disease it was still one of the highest causes of morbidity in urban Britain.⁶³ It is therefore not surprising that there was also a reduction in the number of convalescent patients recovering from pulmonary illness at both homes in the 1930s. By 1938, at Corstorphine House patients recovering from pulmonary illness had dropped to 4.6% and at the Dunoon Homes 12.0%. Phthisis followed a similar pattern of decline at both convalescent homes but for different reasons.⁶⁴ The number of patients with phthisis at Corstorphine House was 5.5% in 1883 and the Dunoon Homes 6.7% in 1885 but by 1938 was zero. The reasons for the absence of phthisis patients during 1938 neither accepted this category of patient after 1906.⁶⁵

⁶² G. M. Howe, *People, Environment, Disease and Death* (Cardiff, 1997), p. 173.

⁶³ A. Mercer, *Disease, Mortality and Population in Transition* (Leicester, 1990), pp. 108-113; A. Hardy, *Medicine in Britain since 1860* (Basingstoke, 2001), p. 13.

⁶⁴ Although phthisis was also a pulmonary disease, because of its highly infectious nature it was dealt with separately to other pulmonary diseases. See pp. 166-174 for further discussion on tuberculosis in convalescent homes.

⁶⁵ After 1906 few convalescent homes accepted patients with pulmonary tuberculosis.

Table 4.1 Main types of illnesses/disorders at Corstorphine House and the Dunoon Homes in 1883/5 and 1938

	1883 Corstorphine House	1938 Corstorphine House	1885 Dunoon Homes	1885 Dunoon Homes
	%	%	%	%
Debility	2.7	1.3	7.9	25.0
Accident ⁶⁶	13.1	6.2	3.2	2.8
Pulmonary diseases ⁶⁷	13.4	4.6	19.5	12.0
Anaemia	0	2.7	3.4	9.9
Influenza	0	1.3	0.1	7.3
Rheumatics ⁶⁸	3.4	1.3	6.6	5.2
Heart diseases ⁶⁹	10.3	0.6	2	3.1
Infectious diseases.	0	0	0	2.8
Gynaecological ⁷⁰	4.1	9.6	3.1	2.8
Gastritis ⁷¹	2.7	0.6	6.8	2.7
Tonsillitis ⁷²	0	0	0.7	2.6
Hyperplasia	0	0	0	2
Neuritis/neuralgia	0.6	0	3.1	1.2
Neurasthenia	0	0	0	1.1
Ulcers	2	7.5	0.5	1.1
Operations ⁷³	7.5	14.4	1	2.6
Abscess	0.6	4.8	1.2	0.6
Erysipelas	3.4	0	0.4	0.1
Phthisis	5.5	0	6.7	0
Other diseases	30.7	44.9	33.8	15.03

Source: Admission Books from Corstorphine House, 1883 and 1938 and *annual reports for the Dunoon Homes*, 1885 and 1938

Table 4.1 also indicates that accidents were the second highest reason for admission to Corstorphine House.⁷⁴ In 1883 it was 13.1% of all patients but this had declined by 1938 to 6.2%. Improvements in safety at work could account for fewer admissions of accident victims to the Infirmary.⁷⁵ Referring to the interaction between work and health McIvor notes that ‘improvements in occupational health and safety standards

⁶⁶ Included any complaint likely to have arisen from an accident including burns, injuries, concussion and fractures.

⁶⁷ Refers to pulmonary disorders including pneumonia, bronchitis, asthma and pleurisy.

⁶⁸ Includes disease referred to as rheumatism, sciatica and lumbago.

⁶⁹ Included any disease recognizable as a heart disease or condition such as myocarditis, endocarditis and cardiac disease.

⁷⁰ Any female disease.

⁷¹ Included any stomach disorder but mainly dyspepsia.

⁷² Includes quinsy, a condition common before the use antibiotics, but now rare.

⁷³ Operations. The higher proportion of patients recovering from operations at Corstorphine House in 1939 was taken up by the number of patients recovering from appendectomies.

⁷⁴ Emergency accident cases were a common as a cause of admission to the RIE.

⁷⁵ A. J. McIvor, *A History of Work in Britain* (Basingstoke, 2001), p. 132.

were uneven, subject to reversal (in depression and war) and inequalities in experience based on occupation, gender and class persisted'.⁷⁶ In other words the downward trend in accident related admissions at Corstorphine was possibly subject to periodic fluctuations. Although the percentage of patients recovering from accidents at the Dunoon Homes was far smaller than in Corstorphine House there was a similar pattern of decline from 3.2% of patients in 1885 to 2.8% in 1938. The numbers of patients recovering from rheumatic, gastric and neuralgic conditions also fell in both homes between 1883/5 and 1938. Although the reasons are not clear, it is possible that some improvements in nutrition and housing conditions amongst the working classes during the twentieth century affected the incidence of these conditions. It is also more difficult to explain the dramatic decline in patients described as recovering from heart disease at Corstorphine House, from 10.3% in 1883 to 0.6% in 1938, particularly with the continuing high incidence within the general population. The slight rise amongst this type of patient in the Dunoon Homes from 2.0% to 3.1% suggests a possibility that RIE transferred patients with heart conditions to other institutions rather than Corstorphine House.

There were some illnesses and conditions where the number of patients in convalescent homes increased. For example, in 1883 at Corstorphine House those in recovery from operations represented 7.5% but by 1938, these patients had doubled to 14.4%. This illustrates the expansion in operations performed in hospitals during the twentieth century. At Corstorphine House this was mainly due to the rise in the number of appendectomies performed.⁷⁷ The number of patients recovering from operations at the Dunoon Homes also doubled, but as only one sixth of patients originated from the hospitals, the percentage was far less. At Corstorphine House, there was also a rise in the number of patients recovering from gynaecological conditions from 4.1% in 1883 to 9.6% in 1938. This reflects a rise in the number of women patients admitted to the Infirmary with this type of disorder. At the Dunoon Homes there was a slight decrease in the percentage of patients recovering from

⁷⁶ Ibid., p. 112.

⁷⁷ K. Haeger, *History of Surgery* (London, 1988), pp. 254-255.

gynaecological conditions from 3.1% to 2.8%. There was also a growth in the number of patients with ulcers at both Corstorphine House and the Dunoon Homes. Although the types of ulcers were not specified, the rise was possibly due to the increase in the number of trained nurses able to undertake dressings for this condition.⁷⁸ There was also an increase in the number of patients with anaemia at both homes, although the incidence was higher at the Dunoon Homes. At Corstorphine House this rose from 0 to 2.7% between 1883 and 1938 whereas during a similar period at the Dunoon Homes it rose from 2.4 to 9%. Patients recovering from influenza also increased in both homes but more so at the Dunoon Homes to a surprisingly high 7.3%. Again the rise is not entirely clear but may have been due to the lessening of concern over infectious diseases.

The most conspicuous variation in illnesses of patients between the two homes was debility. At Corstorphine House in 1883 only 2.7% were described with debility, falling to 1.3% in 1938. At the Dunoon Homes it was far higher at 7.9% in 1885 but by 1938 this had risen to 25%. The explanation for the fewer patients with debility at Corstorphine House was that it was less likely to lead to hospitalisation if the cause was poor nutrition or social conditions. Although there were almost certainly debilitated patients at Corstorphine House, their condition was most probably caused by surgery or serious illness. The convalescent home authorities were therefore more likely to record the patients' primary illness or surgery in the admission books. Overall, the main differences between the illnesses of patients at these two homes was anaemia and debility resulting from non-specific illnesses at the Dunoon Homes whereas at Corstorphine House there were higher numbers of patients recovering from operations and accidents. However, there were similarities in the large numbers of patients with pulmonary illnesses.

Annual reports provided information on the patterns of illness in other convalescent homes. However, the style of the reports was often inconsistent and the quantity of

⁷⁸ See Chapter Six, pp. 245-246.

information varied, making comparison difficult. For instance, the annual reports issued by the Miners' Welfare Fund made no comment on the specific type of illnesses of the miners and their families who stayed in miners' convalescent homes during the 1920s and 1930s. It is though very likely that the illnesses of miners in convalescent homes were slightly different from those in the more general homes since mining has always been a notoriously dangerous occupation. The history of miners' diseases is well documented in George Rosen's book on this subject.⁷⁹ In addition to a high level of accidents the most common miners' diseases include: miners nystagmus⁸⁰ (an eye disease), various rheumatic illnesses and a whole range of lung diseases. These are mostly conditions where partial or even complete recovery could be facilitated through the type of rest and dietetic treatment offered by the convalescent homes.

Other annual reports, such as those for the Ashgrove CH, made general rather than specific observations about the type of illnesses of their convalescent children. In 1930, they merely noted that '893 children were treated during the year, 200 were recovering after serious illness.'⁸¹ Although most of the annual reports took a narrative rather than quantitative format, the style sometimes varied over time, even within the same convalescent home. For example, during the nineteenth century, the medical officers at the GCH produced informative narrative reports on the illnesses of patients but during the twentieth century, they only reported statistics on their condition before dismissal from the home. Nevertheless, in general, the content of the annual report was sufficient to obtain a general indication of the most common types of illness in convalescent homes.

During the nineteenth century, the most frequently mentioned illnesses in the annual reports were similar to those at both the Corstorphine House and the Dunoon Homes. These included pulmonary diseases, phthisis, heart disease, operations and accidents.

⁷⁹ G. Rosen, *The History of Miners' Diseases; a Medical and Social Interpretation* (New York, 1943).

⁸⁰ A. J. McIvor, *A History of Work in Britain 1880-1950* (Basingstoke, 2001), pp. 144.

⁸¹ ML G.362.7809411435, *Forty-Sixth Annual Report of the Glasgow Poor Children's Fresh Air Fortnight, and Crippled Children's League*, 1930, p. 7. [Ashgrove CH].

Debility and anaemia were more frequently noted at the non-hospital convalescent homes than homes attached to the infirmaries. For example, in common with Corstorphine House during the nineteenth century, Broughty Ferry CH had only a few cases of debility but there were high numbers of pulmonary diseases, rheumatism, fractures, operations, stomach disorders, heart disease and phthisis.⁸² By contrast, during a similar period, Drs Stewart and Whitelaw, medical officers at the GCH, reported the admission of many cases of general debility together with the others recovering from accidents, scrofulous sores, phthisis, operations and chest diseases.⁸³ Similarly, in 1883 the annual report of Dundee Convalescent House commented that, although the majority of their patients were recovering from general debility, there was also a high proportion recovering from pulmonary illnesses.⁸⁴ In 1893, the GCH continued to report high numbers of patients recovering from accidents, sores, operations, phthisis and debility.⁸⁵ In 1884 at Kilmun, the Matron's report described an interesting 'snapshot' of the various ailments and conditions of twenty sample patients representative of others admitted to the Home during the year.

We have one man who has had his right leg amputated, a young lad has got his left leg cut off, another man has bronchitis, and one heart disease. One poor woman wants the use of both hands – one arm has been broken and one of the fingers of the other had had to be amputated, another woman has only the use of both hands – one arm has been broken and one of the fingers of the other hand had to be amputated, another woman has only the use of one arm, two have bronchitis, and one is in consumption, while others suffer from nervousness, and others from general debility.⁸⁶

⁸² THB 1/2/5, AR, *Dundee Royal Infirmary*, 1881. Broughty Ferry, the convalescent home belonging to the Dundee Royal Infirmary was one of the few homes that accepted patients recovering from infectious diseases.

⁸³ ML G.362.160941435, *Eighth AR, GCH*, 1873, p. 6.

⁸⁴ THB 13/1, *Twenty-Third AR, Dundee Convalescent House*, 1883, p. 7.

⁸⁵ ML G.362.160941435, *Twenty-Eighth AR, GCH*, 1893, p. 6.

⁸⁶ GCA TD.432/13, AR, *KSHCP*, 1883-84, p. 3. [Kilmun].

Although this summary of patients' illnesses at Kilmun was consistent with those in other convalescent homes, there was one exception. None of the other convalescent homes during the nineteenth century mentioned the term 'nervousness'. A modern interpretation of the term might be stress or depression. It is possible that because of the association with mental illness, conditions described as 'nervousness' at Kilmun, were described in other homes as some other disorder such as debility. Kilmun though demonstrated no such inhibitions. By 1939, their Matron remarked that 'debility covers a good many varieties and degrees of suffering, physical and mental – in these days of anxiety and strain – and perhaps this class of sufferer benefits as much as any from the change of air and scene.'⁸⁷

An example of a patient admitted for this type of condition was the writer, broadcaster and actress, Molly Weir, who, as a twelve year old, was admitted to Kilmun suffering from the effects of bereavement, following the death of her much loved grandmother.⁸⁸ The symptoms that caused concern amongst her family, teachers and doctor, were loss of weight, fatigue and unhappiness. After an extended stay of four weeks at Kilmun, Molly Weir both gained weight and returned to health. She recalled, 'I was quite transformed from the wee white-faced ghost who had arrived a short few weeks ago.'⁸⁹

References to debility and anaemia increased at most non-hospital convalescent homes during the twentieth century. For example, in 1903, Dr MacArthur the Medical Officer at Seamill reported that 'as in former years the majority of patients were suffering from anaemia. Pulmonary and rheumatic complaints, next in frequency, while a goodly number do not suffer from any well-defined disease but simply complain of debility and being run down.'⁹⁰ At Kilmun in 1910, the matron also reported anaemia as one of the most common conditions amongst the patients.

⁸⁷ GCA TD.432/13, AR, GKCH, 1938-39, p. 4. [Kilmun].

⁸⁸ M. Weir, *Best Foot Forward* (London, 1970), pp. 145-163.

⁸⁹ Weir, *Best Foot*, p. 162.

⁹⁰ GGHB HB 6/4/55, *Tenth Annual Report of the Scottish Co-operative Convalescent Seaside Homes Association Limited*, Seamill, 1901, p. 13.

This was still the case at Kilmun in 1934 when the annual report noted that ‘anaemic patients, mostly young women, come in large numbers and almost invariably improve.’⁹¹ Anaemic patients may have been a symptom of poor general health or an inadequate diet. It is therefore not surprising that they all benefited from a few weeks in a convalescent home. Although Gilmerton did not specifically mention anaemia, they commented that many of the children admitted were suffering from malnutrition. Similarly they reported the fact that the children made a ‘great improvement in their health results from good food, fresh air, regular hours and the wise and kindly rule of Miss Fraser (Matron) and her staff’.⁹² In 1912, Linn Moor reported on the rising number of ailing children with, ‘malnutrition, anaemia and other forms of debility’.⁹³ By 1939, Dr Harry Rae, the Medical Officer at Linn Moor, reported the admission of delicate children, non-thrivers, anaemic, ‘pre-tuberculous’, nervy and convalescent children; conditions that he claimed were exceptional not to improve.⁹⁴ These reports from the convalescent homes therefore provide insight into the typical illnesses found in the convalescent homes. It is evident that although there were patients recovering from a variety of diseases and accidents, others, particularly in the non-hospital convalescent homes, were not recovering from specific illnesses but from debility caused by poor diet, social conditions or fatigue.

Tuberculosis Patients

The most prominent group of non-convalescent patients admitted to the convalescent homes during the nineteenth century were those suffering from tuberculosis.

Although their number gradually diminished during the early twentieth century, for most of the nineteenth century they were a relatively conspicuous group of patients.⁹⁵

⁹¹ GCA TD.432/13, AR, GKCH, 1938-39, p. 4. [Kilmun].

⁹² NLS GD.409/25/1, *Gilmerton Convalescent Home, Report for the Year, 1940*, p. 4.

⁹³ ACL 362/78/L64, *Twenty-Fourth Children's Fresh-Air Fortnight and Ailing Home, 1912*, p. 4.

[Linn Moor]

⁹⁴ ACL 362/78/L64, *Fifty-First Annual Report of the Home for Ailing Children and Fresh-Air Fortnight, Linn Moor, Culter, 1939*, p. 8. [Linn Moor].

⁹⁵ Bryder, *Magic Mountain*, p. 3. Tuberculosis can affect various parts of the body, although pulmonary tuberculosis had the highest mortality within the adult population. There are a variety of names given to tuberculosis, often depending on the part of the body affected. Phthisis or consumption was the term normally used for pulmonary tuberculosis. Tuberculosis of the lymph nodes was known as scrofula and skin, lupus vulgaris.

The convalescent homes admitted patients suffering from all forms of tuberculosis but pulmonary tuberculosis (phthisis) was the most common type. In 1885, the annual number of patients admitted with pulmonary tuberculosis at the Dunoon Homes was 6.7% of their total annual number of patients. At Corstorphine House in 1883 there was a similar percentage of 5.5%. Taking these percentages as representative figures, it is therefore estimated that in the 1880s, the total number of phthisis patients in the West of Scotland averaged around 6% of the patient population. By calculating 6% of the patients (9000), in the sixteen convalescent homes in the West of Scotland area in 1885, it was further estimated that approximately 540 phthisis patients were admitted annually to the convalescent homes. Although this is only a small percentage of all patients suffering from phthisis in the West of Scotland, Neil MacFarlane estimated that between 1880-4, together, the GRI and Western infirmary of Glasgow treated a similar number of patients, estimated at an average of 604 per annum.⁹⁶ At that time there were few institutions other than the GRI and Western Infirmary of Glasgow and the convalescent homes treating phthisis patients.⁹⁷ Within this perspective, therefore, the convalescent homes did make a significant contribution towards the care of phthisis patients during the nineteenth century. An exploration of this topic is therefore an important aspect of our understanding of the care given to pulmonary tuberculosis patients in the nineteenth century.

Since phthisis was considered mostly incurable during the nineteenth century and the infectious nature of the disease was suspected even before Robert Koch's confirmed this in 1882, the convalescent home should not have admitted these patients.⁹⁸ The

⁹⁶ Neil Munro, MacFarlane, *Tuberculosis in Scotland, 1870-1960*, unpublished PhD thesis, (University of Glasgow, 1990), p. 34.

⁹⁷ The first sanatoria in the West of Scotland did not open until 1896. This was at the Quarrier Homes at Bridge of Weir. During the twentieth century, the Poor Law hospitals also took over their treatment. MacFarlane argues that unlike England, in Scotland the poorhouses admitted only a minority of cases and therefore could not have made a significant impact upon the care of tuberculosis patients. In 1899, he said that in that year phthisis patients in Scottish Poorhouses represented only 6% of patients.

⁹⁸ See pages 150-152 for discussion on the rules that excluded incurable, chronic and infectious patients. Bryder, *Magic Mountain*, pp. 16-18; MacFarlane, 'Tuberculosis in Scotland'; Smith, *Tuberculosis*, p. 237. Smith estimated that in the 1880s survival beyond the initial diagnosis was as low as 10 per cent.

acceptance of incurable and infectious tuberculosis patients during the nineteenth and early twentieth century by the convalescent homes therefore requires an explanation, particularly as managers and medical officers were not ignorant of the very poor prognosis of phthisis patients during the nineteenth century. This was illustrated in 1872 when Bruce Goff, the Medical Officer for the GCH excused a reduction in the number of patients dismissed as 'completely recovered' because of the large number of consumptives admitted.⁹⁹ Convalescent homes, in common with voluntary hospitals, published annual statistics on patients dismissed as 'cured', 'relieved', 'no improvement' or 'died'. These published statistics on the number of 'cures' were important to the convalescent home since, in common with the hospitals, subscribers and other financial sponsors often looked more favourably on homes with a high rate of 'cures'. In 1894, remarks in the Glasgow Abstinence Union report on Kilmun also revealed awareness that consumptive patients were not usually curable. This stated that, 'we knew the improvement was not of a permanent character.'¹⁰⁰

The acceptance of tuberculosis patients in convalescent homes illustrates the difference in perception of the disease to other types of sickness, within the population as a whole, particularly during the nineteenth century. Smith summarises the resignation toward tuberculosis within the community thus: 'Until about 1890 sufferers' kin, philanthropists and legislators were resigned to it as a morally neutral, ubiquitous affliction beyond official intervention.'¹⁰¹ Unlike other illnesses, such as typhoid or pneumonia, sufferers were not obviously infectious or necessarily completely incapacitated and often experienced periodic remissions. Recognition of the infectious nature of the disease took time to filter through to the medical profession, general public and the convalescent home authorities. Many influential doctors remained sceptical throughout the later part of the nineteenth century.¹⁰² Even

⁹⁹ ML G.362.160941435, *Eighth AR, GCH*, 1871, p. 6.

¹⁰⁰ GCA. TD.432/13, *Annual Report of the Glasgow Abstinence Union*, 1894, p. 6.

¹⁰¹ Smith, *Tuberculosis*, p. 1.

¹⁰² M. Warboys, 'The Sanatorium Treatment for Consumption in Britain, 1890-1914', in John V Pickstone, ed., *Medical Innovations in Historical Perspective* (New York, 1992), p. 49. Following an investigation by the BMA they found that only a quarter of doctors believed tuberculosis to be truly contagious disease

when the infectious nature of pulmonary tuberculosis was accepted, not everyone thought that segregation was necessary. For example, the Medical Officer of Health for Glasgow, James Burn Russell, was reluctant to support legislation making tuberculosis a notifiable disease because of the social burden it placed upon sufferers by segregating them from the community.¹⁰³ This opinion from such an influential figure as Russell could have retarded the exclusion of tuberculosis patients from convalescent homes, particularly as Russell was on the management committee of the Hozier Home (attached to the Western Infirmary of Glasgow).¹⁰⁴ Most homes therefore admitted patients with pulmonary tuberculosis throughout the nineteenth century but they usually made it a condition that the patient should be (or at least appear to be) in the early or incipient stage of the illness. For example, at a meeting of the Convalescent Home Committee at Bona, (attached to the Royal Northern Infirmary) the members decided that patients suffering from phthisis could be admitted if they were 'in the incipient stage of illness or so far recovered to be up and about all day'. The committee also believed that 'such cases would benefit by a stay in the Home' and that 'they would not be injurious to other patients'.¹⁰⁵

Although many medical officers in convalescent homes believed that the tuberculosis patients they admitted were only in the early stages of illness, during the nineteenth century diagnostic techniques were neither accurate or in common use. Dr Ritchie, Medical Officer at the Dunoon Homes, remarked that their 'constant and distressing night cough had a disturbing and injurious effect on the progress of recovery on the part of others', suggesting that their condition was often quite advanced.¹⁰⁶ The frequent deaths that occurred amongst phthisis patients provide a further indication that their illness was often in an advanced stage. Sometimes these were unexpected but on other occasions the medical officers were aware of the gravity of the patient's condition before death. In 1885, James Denniston, the Medical Officer at the Dunoon

¹⁰³ E. Robertson, *Glasgow's Doctor, James Burn Russell, MOH, 1837-1904* (East Lothian, 1998), p. 176.

¹⁰⁴ GGHB HB 7/1/1, *Annual Report of the Lady Hozier Convalescent Home*, 1895, p. 1.

¹⁰⁵ HHB 2/1/1, Minute book of Managing Committee of Convalescent Home of the Royal Northern Infirmary, 7 March 1895.

¹⁰⁶ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, pp. 10-11. [Dunoon Homes].

Homes stated, 'the patient was in the last stage of consumption on admission and was sent at once to bed and died in a few days. The case was manifestly unsuitable for the Institution, but it was impossible to send the sufferer home'.¹⁰⁷

Another reason for the acceptance of phthisis patients in convalescent homes during the nineteenth century was the lack of other institutions available for tuberculosis sufferers. There was also evidence of compassion extended by medical officers towards the phthisis patients. A statement from Dr John Ritchie, explained the admission of phthisis patients was, 'so that they could obtain relief from their distressing symptoms'. Yet, their admission clearly contravened the normal policies of the convalescent homes.¹⁰⁸ Authorities at Kilmun also demonstrated a similar sympathetic attitude towards the tuberculosis patients, stating that 'we do not think there is cause to regret giving these poor afflicted ones a few weeks of bright sunshine and fresh air, it was such a change from their own homes, and they enjoyed it to the full.'¹⁰⁹ A further indication of the consideration towards tuberculosis patients occurred in 1900, when the annual report at Kilmun reported the death of two patients both suffering from phthisis:

Neither of these young men had homes, both were in lodgings, the people they lived with evidently did not wish them to die when with them. We often think it is a pity that there is no place where cases like these would be taken to and cared for till the end came; none of them liked the idea of going to the poorhouse hospital.¹¹⁰

A number of initiatives eventually led to the acceptance of tuberculosis as an infectious disease and the exclusion of known phthisis patients from all convalescent homes. They included the presentation of a memorial to the Glasgow Town Council by a Committee of the Medico-Chirurgical Society of Glasgow in 1891. Committee

¹⁰⁷ ML G.362.160941435, *Sixteenth AR, WSCSH*, 1885, p. 11. [Dunoon Homes].

¹⁰⁸ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, pp. 10-11. [Dunoon Homes].

¹⁰⁹ GCA TD.432/13, *AR, Glasgow Abstainers*, 1894, p. 6.

¹¹⁰ GCA TD.432/13, *Thirty-Third AR, KSHCP*, 1900-01, p. 5. [Kilmun]

members included influential doctors such as Professor Gairdner and Joseph Coats who supported the idea of segregating patients with consumption from the rest of the community.¹¹¹ Remaining doubts amongst doctors over the contagious nature of tuberculosis were eventually overtaken by national concern emanating from movements such as the 'the National Association for the Prevention of Consumption and other forms of Tuberculosis'. In 1906, a Local Government Board circular advised local authorities in Scotland that they should deal with tuberculosis in the same way as any other infectious disease because it was within the meaning of Public Health (Scotland) Act of 1887.¹¹²

By 1906, apart from Newhills, few convalescent homes admitted phthisis patients. Although Newhills accepted tuberculosis patients, they were housed in a completely separate building to the convalescent patients. Matthew Hay, Medical Officer of Health for Aberdeen, took an active interest in this Home and the development of its sanatorium section. He encouraged this pluralistic approach to convalescence and tuberculosis treatment at Newhills.¹¹³ Michael Warboys observes that the doubling-up of convalescent home and sanatorium was common in privately run institutions in England before 1900.¹¹⁴ However, Newhills is the only example of a combined sanatorium and general convalescent home in Scotland. There is also some evidence that Ravenscraig CH still accepted tuberculosis patients in 1911, since their rules published in that year still stated that children were excluded only if they had 'consumption of the lung with spitting'.¹¹⁵ In other homes, a new attitude towards excluding consumptive patients in convalescent homes was evident from around 1905. For example, in that year the *Lancet* reported that the Dunoon Homes were refusing phthisis patients.¹¹⁶ In the following year, at their Annual General Meeting,

¹¹¹ C. Pennington, 'Tuberculosis', in O. Checkland and M. Lamb, eds., *Health Care as Social History* (Aberdeen, 1982), pp. 89-90.

¹¹² S. Wilson, 'The Public Health Services, in Gordon McLachlane, ed., *Improving the Common Weal, Aspects of Scottish Health Services, 1900-1984* (Edinburgh, 1987), p. 295.

¹¹³ E. Oliphant, 'Newhills Convalescent Home and Sanatorium' in David Rorie, ed., *The Book of Aberdeen* (Aberdeen, 1939), p. 95.

¹¹⁴ Warboys, 'Sanatorium Treatment', p. 53.

¹¹⁵ GGHB 2/3/5, 'Rules, Ravenscraig, 1910-1911'

¹¹⁶ *Lancet*, 30 September 1905, p. 1003.

the directors of the Arbroath Infirmary questioned the wisdom of admitting a patient suffering from pulmonary tuberculosis to the convalescent home. The subscribers and managers finally agreed that, before granting certificates for admission to the Home, all medical practitioners should satisfy themselves that the patients were not suffering from pulmonary tuberculosis.¹¹⁷

Although the care of tuberculosis patients in convalescent homes accounted for only a small proportion of sufferers, the wider picture is even more interesting. It is possible that convalescent homes could have played a significant role in preventing more serious illness, particularly tuberculosis. Evidence from a number of sources indicates that during the nineteenth and first half of the twentieth century tuberculosis had infected most people at some stage in their lives.¹¹⁸ However, only a small proportion went on to develop the disease. Although, it is still not clear why only some of those exposed developed the disease, it is widely accepted the most vulnerable patients were those living in overcrowded accommodation, receiving poor nutrition and in poor health.¹¹⁹ Given the overcrowding in Glasgow during the nineteenth century, together with the poverty and poor nutrition, there should have been far more deaths from tuberculosis in Glasgow than any other area in Scotland. Yet, as Neil MacFarlane observed, mortality from tuberculosis in Scotland declined from 1870 onwards.¹²⁰ This decline occurred five years after the first convalescent home opened in Scotland. In England, a similar decline in deaths from tuberculosis also began five years after the opening of the first English convalescent home. It is therefore possible that there is a relationship between the higher number of convalescent home beds in the Glasgow area and the decline in mortality from tuberculosis.

¹¹⁷ *Lancet*, 28 July 1906, p. 262.

¹¹⁸ Bryder, *Magic Mountain*, p. 4.

¹¹⁹ Smith, *Tuberculosis*, p. 1.

¹²⁰ Neil Munro McFarlane, *Tuberculosis in Scotland, 1870-1960*, unpublished PhD thesis, (University of Glasgow, 1990), p. 11.

Another significant point was that between 1860 and 1914, estimated figures of between 4000 (1870) and 24,600 (1912) patients passed annually through a Scottish convalescent home.¹²¹ Since the convalescent homes did not accept chronically ill patients, for the vast majority the two or three weeks spent in a convalescent home was a solitary occasion. The regime of a convalescent home, with fresh air, an adequate diet, rest and recreation may have been sufficient to boost the immune system of many vulnerable patients.¹²² It therefore seems entirely possible that, given the large volume of people admitted to a convalescent home at a precarious stage in their lives, many recovering from operations or accidents, these institutions prevented the development of tuberculosis or other serious illness. After the First World War, as convalescent home provision in the rest of Scotland began to equalise with Glasgow, coincidentally, so did mortality from tuberculosis. Although there were other reasons for decline in mortality from pulmonary tuberculosis such as improved nutrition, greater immunity and better housing, the contribution made by the convalescent homes towards the health of Glasgow may still have been far more than the provision of a recuperative holiday.

During the later nineteenth century, the managers of at least one Home, Kilmun, publicly claimed that they had contributed to the falling death rate in Glasgow.

The death rate in the city is said to have been reduced and much credit is given for this to the city improvement operations and improved sanitary regulations and while no doubt credit is justly due to such, still with the knowledge of the results of this home before one, it is not too much to assume that the combined results of the various convalescent homes have some appreciable influence in reducing the total of the early register of deaths in the city.¹²³

¹²¹ These figures were obtained from the database described in Appendix A.

¹²² These aspects of regime and described in greater detail in Chapter Five.

¹²³ GCA TD.432/20, AR, *Glasgow Abstainers*, 1894, p. 6.

In 1915, Kilmun continued to mention the contribution they believed they made towards saving lives.

Quite a number of the patients only require the rest and relaxation such as the Home affords. They have no special or organic disease. They merely suffer from weakness and languor often brought on by protracted labour beyond their strength, insufficient nourishment and other hardships. What proportion of this class has been spared a long illness or whose lives have been saved it is impossible to say, but an intimate knowledge of the work convinces one they are by no means a small percentage.¹²⁴

Linn Moor Home also believed that the regime of the home prevented children from developing tuberculosis. In 1924, their annual report stated, 'it must be borne in mind that a Home such as this is essentially a "preventorium". Children suffering from the stigma of tuberculosis are admitted with a view to the warding off of definite tuberculosis in later life.'¹²⁵

Conclusion

In summary, this chapter has determined that convalescent homes did not accept patients recovering from all manner of illness. Most convalescent homes excluded patients with conditions such as epilepsy or mental illness. They also banned patients recovering from infectious diseases or only accepted them with certain conditions. In addition, the majority of homes excluded patients with incurable, chronic or acute illnesses. In practice, although it was relatively easy to identify the patients recovering from infectious diseases, it was more difficult to exclude those with incurable or chronic illnesses.¹²⁶ During the nineteenth and early twentieth century, medical officers in convalescent homes often complained that many patients were sent too early in their convalescence. Their concern was confirmed by numerous

¹²⁴ GCA TD.432/13, *Forty-Seventh AR, KSHC 1914-1915*, p. 7. [Kilmun].

¹²⁵ ACL 362/78/L64, *Thirty-Sixth Annual Report of the Home for Ailing Children and Fresh-Air Fortnight, Linn Moor, Culter, 1924*, p. 5. [Linn Moor].

¹²⁶ Most convalescent homes required a medical certificate stating the reason for application for admission.

deaths that occurred amongst patients in most convalescent homes every year, particularly until the First World War.

Paradoxically, despite their restrictive policies and complaints from medical officers, the convalescent homes admitted some non-convalescent patients quite willingly. These included pre-operative patients and during the nineteenth century, those suffering from pulmonary tuberculosis. Although the numbers of pulmonary tuberculosis patients were relatively small, they still accounted for around 550 patients per annum at homes in the Glasgow area during the nineteenth century. During the nineteenth century, this was a significant number because there were so few institutions offering care to tuberculosis patients. There is also some evidence to suggest that convalescent homes also might have contributed to the prevention of tuberculosis by providing patients with a healthy recovery environment at a time when they were vulnerable to developing the disease.

Overall, the reduction in deaths in the convalescent homes during the inter-war period and fewer complaints from convalescent home medical officers over the physical condition of patients suggests they were less sick than in the nineteenth century. One explanation was the rise in alternative medical institutions, such as sanatoria for tuberculosis patients and auxiliary hospitals that accepted patients at an earlier stage of convalescence. There was therefore less likelihood of the inadvertent admission of seriously or chronically ill patients. Some differences in types of illnesses of convalescent home patients were detected between the nineteenth and twentieth century. The most significant was a reduction in the number of patients recovering from pulmonary diseases in all convalescent homes. There was also a rise in the number of patients recovering from operations in the hospital convalescent homes. This corresponded to the increased number of operations performed in hospitals. As admission policies became less rigid during the twentieth century there was a rise in the number of patients with anaemia and debility. These were conditions that responded well to the regime of convalescent homes of fresh air, recreation and an adequate diet.

By the inter-war period, convalescent homes mostly admitted patients in the latter stages of convalescence, the debilitated and malnourished together with those needing building up before operations. Despite this, the convalescent homes retained the key feature of medical institutions, with admission mostly on recommendation of a medical referee together with supervision by medical and nursing staff. However, as the next chapter will demonstrate, although the concept of convalescence as a recognised phase within an illness remained unchallenged, other changes such as advances in rehabilitative therapy affected the perception of convalescent homes, particularly amongst doctors.

Chapter Five

Regime

Chapter Three raised the question of whether medical elites were mistaken in their assumption that traditional convalescent homes did not offer treatment and often resembled holidays rather than medical institutions.¹ This chapter argues that therapy and rehabilitation of patients was not absent from convalescent homes but on the contrary formed an integral part of their regime. However, during the mid-nineteenth century, treatment of the sick by doctors was emerging from a long period when interventionist procedures such as bleeding, purging and cupping were preferred.² This is reflected in the comments made by Dr Frederick Roberts, author of *A Dictionary of Medicine*. Dr Roberts suggests that, at the end of the nineteenth century, doctors were still using some interventionist methods in convalescence. He noted that, 'much injury is not uncommonly inflicted by the injudicious administration of medicines and the employment of other means which are supposed to hasten convalescence.'³ Nevertheless, evidence provided in this chapter illustrates that this was not the case in the convalescent homes and they used only natural methods of treating their patients, based on fresh air, exercise and diet. Although this was widely accepted during the nineteenth century, it became less so during the twentieth.

During the nineteenth century, although scientific discoveries influenced the introduction of new therapeutic practice, they often took time to become accepted. As John Harley Warner has pointed out, in the first half of the nineteenth century 'medical science was progressing at an unprecedented rapid rate, yet therapeutics –

¹ See Chapter Three, pp. 130-40.

² W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994), pp. 17-20; G. B. Risse, *Hospital Life in Enlightenment Scotland* (Cambridge, 1986), pp. 177-239.

³ Frederick T. Roberts, 'Convalescence', in Richard Quain, ed., *A Dictionary of Medicine* (London, 1890), p. 295.

what the physician actually did to the patient – was in a troubling state of confusion.’⁴ Anne Digby also remarks that, although there were important scientific developments in the nineteenth and twentieth centuries, ‘therapeutics (i.e. the treatments of disease) changed much less dramatically than epistemology (i.e. the theory of the grounds of knowledge).’⁵ The conflict between scientific inquiry and therapy within convalescence became particularly apparent during the Inter-War period. During this time, new rehabilitative methods of treating convalescent patients, partly developed during the First World War, became more widely used in hospitals. Yet, apart from the AAI, none of the convalescent homes attempted to change their therapeutic regime and most continued to use natural methods. The chapter considers the extent to which this contributed towards the belief amongst professionals that convalescent homes resembled recuperative holiday homes, not medical institutions.

The chapter begins by firstly examining the nature of orthodox convalescent treatment during the nineteenth century and early twentieth century. Because convalescence was an area that aroused little interest amongst doctors, contemporary medical textbooks rarely, if ever, described or discussed the treatment of convalescent patients. Nevertheless, there was information about accepted methods of treating convalescent patients in medical journals, nursing textbooks, medical dictionaries and various works of domestic medicine. These sources were therefore used to assess methods used to treat convalescent patients. Secondly, this chapter explores the therapeutic regime found in the convalescent homes and its relationship to the general treatment of convalescence. Finally, the chapter examines other aspects of the regime, such as how the regime in a convalescent home compared with the experience of a holiday, and the amount of control convalescent home authorities exercised over the patients.

⁴ J. H. Warner, ‘Therapeutic Explanation and the Edinburgh Bloodletting Controversy’, *Medical History*, 24 (1980), p. 241: See also: A. J. Youngson, *The Scientific Revolution in Victorian Medicine* (London, 1979), pp. 9-41.

⁵ A. Digby, *Making a Medical Living* (Cambridge, 1994), p. 69.

Orthodox Treatment of Convalescence

One of the most influential writers on the topic of convalescence, Florence Nightingale, advised that ‘some convalescents will want entire rest and this, with fresh air and good food, will be the main element of their recovery’.⁶ She also believed in using occupation as therapy, but only for some convalescents. Similar recommendations emerged from other authoritative sources, although the importance of different variables changed from time to time. For instance, in 1867, the *Lancet*, noted, ‘when meat and wine and quinine are scarcely seen to further the patient’s progress – then there will remain the best tonic of the list, a change from brick walls and narrow streets and city air to open country and green fields’.⁷ Although the *Lancet* continued to stress the importance of rest, relief from anxiety and a healthy diet, six months later it placed fresh air and a change of scene as the most essential components of convalescence:

The things wanted by all who were just raised up from a bed of sickness, namely, repose of mind and body, freedom from anxiety, a sufficiency of wholesome food, but above all, a fresh supply of air, and even a change of scene and of association.⁸

By 1890, the *Lancet* included ‘kindly nursing’ alongside fresh air and diet as the essential requirements for convalescence, arguing that ‘the essential adjuncts of permanent recovery are [were] the enjoyment of pure country air, good food, and kindly nursing’.⁹

Many doctors during the nineteenth century recommended a cautious approach to exercise and renewal of occupation. In 1866, Dr Spencer Thomson, an Edinburgh doctor and author of a *Dictionary of Domestic Medicine and Household Surgery*,

⁶ F. Nightingale, *Notes on Hospitals* (third edn. London, 1863), p. 108.

⁷ ‘Convalescent Hospitals’, *Lancet*, 30 March 1867, p. 399.

⁸ *Lancet*, 30 November 1867, p. 679.

⁹ ‘The New Hospital Convalescent Home’, *Lancet*, 4 January 1890, p. 58.

stressed that 'over-exertion, both of body and mind, is to be strictly avoided'.¹⁰ The *Lancet* similarly advised,

a still weakly brain, or lung, or heart or liver or intestine, should no more be exposed to the wear and tear of ordinary life than a newly united fracture should be deprived of the support furnished by bandage and crutch, before it is strong enough to sustain the weight of the body and fulfil its accustomed task.¹¹

In 1890, Dr Roberts proposed careful observation rather than active administration of medicines for convalescent patients:

Patients frequently require careful watching and judicious treatment while becoming convalescent as they are apt to retard or even prevent their recovery, and to lay the foundation for permanent disease by neglect of due precautions, especially as regards their diet.¹²

Treatment of convalescence during the nineteenth century was therefore based mainly upon holistic but conservative methods with attention to diet, fresh air, gentle exercise and rest. Elaine Thomson describes this as a favoured method of treating patients during their illnesses in the Edinburgh Infirmary during the nineteenth century and also at the Edinburgh Womens' hospitals.¹³ Although conservatism in methods of treating convalescence remained, new methods developed during the twentieth century, particularly during the inter-war period.

¹⁰ S. Thomson, *A Dictionary of Domestic Medicine and Household Surgery* (London, 1866), p. 133. Although medical textbooks rarely comment on treatment of the treatment of convalescence, it was detected in other sources, particularly in medical or nursing journals and medical dictionaries.

¹¹ 'Convalescent Homes', *Lancet*, 20 August 1881, p. 347.

¹² Roberts, 'Convalescence', p. 295. See also comments from Roberts in footnote 3 of this chapter.

¹³ E. Thomson, *Women in Medicine in the Late Nineteenth and Early Twentieth-Century Edinburgh: a Case Study*, unpublished PhD thesis, (University of Edinburgh, 1998), pp. 126-129.

For example, in 1916, Major R. Tait McKenzie of the Royal Army Medical Corps (RAMC), wrote a lengthy article describing various forms of physiotherapy for soldiers.¹⁴ In the same year, Frank Radcliffe, an Edinburgh graduate in Medicine, and assistant to Major Tait Mackenzie, wrote another article on the treatment of convalescents with hydrotherapy.¹⁵ In 1919, Dr Basil Parson-Smith, a Captain in the RAMC, published his research into the 'fit and the unfit soldier'. Although the article mainly focused on the condition of 'soldiers heart', it also acknowledged the importance of convalescence in the recovery of illness.¹⁶

From the Army point of view two main classes only are recognised – viz., the fit and the unfit. During convalescence, an opportunity arises for the study of the indications and signs that characterise the merging of these two great classes.

The following year the *Lancet* published an article by T. E. Sandell, a Colonel in the RAMC, who was responsible for organising a convalescent depot for soldiers in France. This article, based on his observations of the methods used at the convalescent depot, described the beneficial effects of physical training upon soldiers.

Physical training is the watchword of the present method of convalescent treatment; its importance cannot be overestimated; combined with a judicious amount of amusement, moral training and discipline with good feeding, healthy surroundings, ample rest and freedom from exposure and strain, it

¹⁴ R. Tait McKenzie, 'The Treatment of Convalescent Soldiers by Physical Means', *BMJ*, 12 April 1916, pp. 215-218.

¹⁵ Robert Tait Mackenzie (1867-1938) was the son of a minister, William McKenzie, from Kelso, Scotland who emigrated to Canada in 1858. Mackenzie studied medicine at McGill University and from 1894 -1904 was their first Medical Director of Physical Training. In 1904, he was appointed head of Physical Education at Penn and a full professor in the Medical Faculty. When he joined the army in 1915 his knowledge as a physical educator gave him the opportunity to influence changes in the medical treatment of convalescent soldiers.

¹⁵ F. Radcliffe, 'Hydrotherapy as an Agent of the Treatment of Convalescents', *BMJ*, 21 October 1916, p. 554.

¹⁶ 'A Comparative Note on Fitness and Unfitness in Convalescence', *Lancet*, 29 March 1919, pp. 509-510.

reduces the period of convalescence within the shortest possible limit of time.¹⁷

Following the First World War, James K McConnell, a lieutenant colonel in the RAMC, with an attachment to St Thomas's, wrote a book entitled *Shorter Convalescence*. The publication of this book provides an example of the link between military and civilian convalescence.¹⁸

The medical press singled out the AAI as the model institution for convalescence, applauding their use of modern or scientific methods. In 1923, the *BMJ* reported that the AAI 'is to be equipped with modern facilities for scientific treatment and research so that patients may be followed up by their physicians and surgeons whom they were under at the Infirmary'.¹⁹ In 1930, the *BMJ*, commenting on the scientific study of convalescence at the AAI, stressed that 'the work of the institution would be to include scientific investigation of the process involved in the gradual restoration of health which constituted convalescence.'²⁰ An editorial in the *Lancet* in 1933, lamenting the overall lack of facilities for convalescent treatment combined with occupational therapy, referring to the AAI, commented that 'Edinburgh has an example of what can be done in systematising an institution for efficient convalescence.'²¹

Regular enthusiastic reporting by the *Lancet* and *BMJ*, of the similar methods of convalescent treatment using extended occupational, physical and recreational processes at the Burke Institute at White Plains, New York, may also have raised the interest of the medical profession in the new methods of treating convalescence.²²

¹⁷ T. E. Sandell, 'Treatment of the Convalescent Soldier', *Lancet*, 26 June 1920, pp. 1352-56.

¹⁸ Lieut-Colonel J. K. McConnell, 'Shorter Convalescence', *Lancet*, 12 July 1930, p. 86. (Review article).

¹⁹ *BMJ*, 8 November 1923, p. 838.

²⁰ *BMJ*, 31 May 1939, p. 1021.

²¹ 'The Problem of Convalescence', *Lancet*, 21 January 1933, pp. 145-146.

²² 'Institutional Convalescence', *Lancet*, 26 November 1921, p. 1140; 'The Work of the Burke Foundation, New York State', *Lancet*, 1 September 1923, pp. 491-492; 'The Care of the

John Bryant devotes much of his book on *Convalescence, Historical and Practical* to discussing the active methods of treating convalescence at the Burke Institute.²³ In 1932, a leading article in the *Lancet*, suggested the introduction of residential convalescent centres with therapy similar to the tuberculosis sanatoria, 'providing and enforcing graduated recreation and work, both mental and physical ... It entails, the organisation of games and physical exercise, garden work, farm work and a variety of indoor trades and occupations'.²⁴

However, the medical dictionaries did not always reflect these new methods of treating convalescence. For example, in the 1920s, Dr W. B. Drummond still stressed the cautious approach to convalescence by remarking that, 'the chief point in the management of convalescence is to avoid being in a hurry. Recovery of health after a weakening illness is a slow process and any attempt to hurry the process may be disastrous.'²⁵ Dr Drummond also advised taking a cautious approach to dietary changes, suggesting that 'change in diet should be brought about very gradually'. He also emphasised the advantages of a change of air, and that 'it is often of the greatest advantage in convalescence'. Similarly, in 1928, Dr John Comrie, writing in *Black's Medical Dictionary* warned that convalescence should involve 'working the body at low pressure for a time, exposing it to no strain, partaking of a moderate diet, and taking an ample allowance of rest and sleep till all the functions have regained their usual activity and vigour'.²⁶

Finally, in 1938, the *Lancet*, an article entitled 'A Century of Convalescence', reviewed the treatment of convalescence during the previous one hundred years. This article generally upheld the traditional recommendations on treating convalescence, such as the advice given by Florence Nightingale on the importance of occupation in

Convalescent', *Lancet*, 24 October 1925, p. 876; 'An American Convalescent Home', *Lancet*, 19 September 1925, p. 613; 'Recreation in Convalescence', *Lancet*, 29 September 1928, p. 686.

²³ J. Bryant, *Convalescence, Historical and Practical* (New York, 1927).

²⁴ 'The Problem of Convalescence', *Lancet*, 26 March 1932, p. 681.

²⁵ W. B. Drummond, *A Medical Dictionary* (London, Toronto and New York, 1920), p. 130. During the 1920s Drummond was medical superintendent of the Baldovan Institute in Dundee, a Home for mentally handicapped children.

²⁶ J. D. Comrie, *Black's Medical Dictionary*, (eighth edn, London, 1928), p. 221.

convalescence. Nightingale advised that, 'a little needlework, a little writing, a little cleaning, would be the greatest relief to the sick if they could do it.' The author of the *Lancet* article concluded that 'it remains as true as ever that restoration of health is greater aided by occupation as well by change of thought, change of scene and (as we still believe) change of air.' Yet, the writer also supported the more scientific study on the effect of the environment upon convalescents.²⁷ The next section demonstrates how the convalescent homes exercised an integrated therapeutic regime was consistent with their interpretation of convalescence and the orthodox recommendations from recognised authorities.

Therapy

Location

A major consideration for any convalescent home was that it should provide the patients with a healthy environment. Convalescent homes were therefore usually situated in areas generally considered as 'healthy'. For instance, the GCH was initially established at Bothwell in 1865, a locality that at the time was enjoying an enviable reputation as a health resort. R. Thompson notes that 'in 1840, doctors in Glasgow were advising patients in a delicate state of health to seek convalescence in Bothwell Village on account of the healthy climate.'²⁸ The *BMJ* also remarked upon the 'healthy locality' of the location of Ailsa CH.²⁹ Similarly, according to Ward and Lock's *Popular History and Illustrated Guide to Glasgow, Dunoon and Rothesay*, the area was chosen as a site for the West of Scotland Seaside Homes, (Dunoon Homes), because of its 'salubrious climate and accessible position'.³⁰ A warm and sheltered location was also preferred for the situation of a convalescent home, because, as Dr Drummond advised, 'the convalescent patient must be carefully protected from cold.'³¹ Consequently, Andrew Cunningham, author of a report on the opening of the

²⁷ 'A Century of Convalescence', *Lancet*, 2 July 1938, p. 27.

²⁸ R. Thompson, 'Bothwell', in D. Burns, A. Reid and I. Walker, eds., *Hamilton and District. A History* (Hamilton, 1995), p. 95.

²⁹ 'The Marchioness of Ailsa and the Maidens Convalescent Home', *BMJ*, 4 August 1888, p. 224.

³⁰ GUL. MU26 – f.44 Sp.Coll. *Ward and Lock's Popular History and Illustrated Guide to Glasgow, Dunoon and Rothesay* (London, 1880).

³¹ W. B. Drummond, *A Medical Dictionary* (London, Toronto and New York, 1920), p. 130.

Miners' Convalescent Home at Culross, was pleased to inform his readers, saying: 'No parish in the Kingdom has a finer sunny exposure than of Culross. The verdant braes slope down to the Firth of Forth and being crested with woods they are nicely sheltered from the north and east winds.'³²

Although the siting of a convalescent home sometimes resulted from the gift of a building, which restricted the choice of location, when they had a choice, promoters went to great lengths to secure a healthy, warm location. For example, when the directors of the GCH were seeking a new site for the Home, they informed their supporters of their considerable efforts over the selection of a suitable site:

The directors had been exceedingly careful in all their inquiries and had put themselves to a great amount of trouble to ascertain where they could best go and thought that all things considered they would be fully justified in the ultimate resolution they had come to, to erect a home at Lenzie Junction.³³

Robert Duncanson, president of the Co-operative Seaside Homes Association at the opening ceremony of Seamill, also claimed that their Committee had explored a number of possibilities before selecting the site for Seamill. The Committee eventually chose the Seamill site because of the sheltered position away from cold winds. In a speech at the opening ceremony of the Seamill home, Duncanson stated:

We visited a number of sites in the locality and agreed upon the present one as in every way adapted for the purpose being beautifully situated and well sheltered from cold winds and having a fine exposure to the south and west and a commanding view of the Firth of Clyde.³⁴

³² NLS CB3/136. Andrew Cunningham, *Report of the Opening Ceremony of the Charles Carlow Convalescent Home* (1927), p. 1.

³³ ML G.362 160941435, *Sixth Annual Report of the Managers' of the Glasgow Convalescent Home [GCH] to the Subscribers*, 1870, p. 14.

³⁴ 'Opening of Seaside Homes', *Scottish Co-operator*, July 1896, p. 523-25.

Likewise, the Committee from the Scottish Foresters' Friendly Society responsible for organising the establishment of their convalescent home also reported on an extensive search for a suitable house. Orwell House was eventually chosen at Kinbuck, Perthshire and described as 'well-wooded and sheltered in grounds of three acres'.³⁵ There were similar considerations made when choosing a location for the AAI. Charles Smith noted, 'such an environment was considered most beneficial in promoting convalescence.'³⁶

'Air'

In addition to a sheltered and warm location, the other attribute that constituted a healthy environment was the presence of 'fresh air'. The gospel of 'fresh air' grew in popularity during Victorian and Edwardian Society, and it was used therapeutically in other institutional regimes such as children's hospitals,³⁷ open-air schools³⁸ and tuberculosis sanatoria.³⁹ James Walvin argues that the Victorian obsession for air 'was in a large measure a result of the Victorian concern with pulmonary complaints, particularly tuberculosis'.⁴⁰ While this is true, the pollution in most British cities was so bad that even the most inattentive city dweller could not fail to notice the benefits of fresh air to their health and well-being. For example, the change in air quality was observed in the diary of convalescent home patient, Margaret Matthewson.

Describing her journey from the Royal Infirmary of Edinburgh to the convalescent home she wrote, 'I enjoyed the drive very much but felt the change of air as we

³⁵ 'Scottish Foresters' Home. Proposed Foresters' Convalescent Home for Scotland', *Lancet*, 15 June 1907, p. 1677.

³⁶ C. Smith, *Between the Streamlet and the Town* (Edinburgh, 1988), p. 30.

³⁷ R. Cooter, *Surgery and Society in Peace and War* (London, 1993), pp. 72-73.

³⁸ L. Bryder, 'Buttercups, Clover and Daisies', in R. Cooter, ed., *The Name of the Child* (London, 1992), pp. 72-93; 'The Barnard Street Open-Air School in Glasgow', *School Hygiene*, Vol. III, (June 1917).

³⁹ F. B. Smith, *The Retreat of Tuberculosis 1850-1959* (Beckenham, 1988), pp. 97-99. George Bodington was one of the first physicians to create a modern tuberculosis sanatorium with a therapy based on fresh air and exercise. His sanatorium was at Sutton Coldfield in the Midlands. According to Smith, although Bodington's ideas were at first scorned, they were later accepted and adopted by physicians in Europe.

⁴⁰ J. Walvin, *Leisure and Society 1850-1950* (London, 1978), pp. 79-80.

passed through the town into the country...the scenery there was very beautiful with strong bracing air.’⁴¹

Although some authorities expressed a preference for either sea or country air, the most important aspect was that the surrounding ‘air’ was not obviously polluted and thereby entitled to be called ‘fresh’. In 1906, the *Lancet* placed convalescence in the country alongside diet as an important recommendation for recovery, declaring that ‘a convalescence in the country is to the man recovering from disease, second only in importance to suitable and adequate food.’⁴² The *Nursing Record and Hospital World* reported that it was impossible ‘to exaggerate the benefit and service to men who had passed through the Hospital, of a week or a fortnight in the fresh air, where the cure might be completed and the strength absolutely restored’.⁴³ In 1885, the annual report of the Dunoon Homes advocated the therapeutic aspects of sea air:

The sea air at the homes possesses certain peculiarities that do not exist in an inland atmosphere and it has assisted in a marked degree towards the recovery from illness of the numerous convalescents brought under its genial influence.⁴⁴

The Dunoon Homes were also specific on the benefits of sea air for rheumatic patients. The annual report observed that, ‘the convalescents from acute rheumatism have improved rapidly even in winter and this fact alone shews the inestimable value of the air at Dunoon, and of the Institution as a health resort.’⁴⁵ A resident of the village of Edzell, a small convalescent home belonging to the Montrose Royal Infirmary, recalls Edzell Convalescent Home in the 1930s and the reasons for its situation as ‘recuperation in the splendid clean air to be found in this Angus village’.⁴⁶

⁴¹ M. Goldman, *Lister Ward* (Bristol, 1987), p. 124.

⁴² ‘The Need for Convalescent Homes’, *Lancet*, 18 November 1906, p. 1486.

⁴³ *Nursing Record and Hospital World*, 1 August 1896, p. 94.

⁴⁴ ML G.362.160941435, *Sixteenth Annual Report of the West of Scotland Convalescent Seaside Homes*, [hereafter *WSCSH*], Dunoon, 1885, p. 5. [Dunoon Homes].

⁴⁵ *Ibid.*

⁴⁶ Personal correspondence from resident of Edzell, PM/JC.

The title of an organisation providing country breaks for children, 'Fresh Air Fortnight' societies, also illustrates the importance attached to the concept of fresh air. During the 1930s, the Glasgow Children's Fortnight and Crippled Children's League made constant references to the benefits of fresh air for children. For example its annual report observed 'There are many lonely and friendless children in this city of Glasgow who need just such an opportunity as is offered by the Fresh Air Fortnight of escaping for a brief space from surroundings that are drab and sordid, into sunlight and pure air.'⁴⁷ Similarly, it reported that, 'even when the rain comes on, many of the Homes have playing sheds, so that all day long the children may be in the fresh air.'⁴⁸ The enthusiasm for fresh air was also apparent in the various verandas and shelters built for patients in convalescent homes. For instance, in 1904, the Dunoon Homes built a shelter in the grounds, and in 1914, a pavilion.⁴⁹ Similarly, in 1911 a pavilion containing a rest room was opened at Seamill.⁵⁰

In common with hospital buildings, fresh air was also a highly valued feature within the structure of a convalescent home.⁵¹ When the representative from the Committee for the Aberdeen Convalescent Hospital inspected Corstorphine House, he reported approvingly that, 'the ventilation of the day rooms and dormitories is excellent, for being in the form of wings to the building the air passes freely from window to window while there are also openings in the roofs for the same purpose.'⁵² In 1884, the directors of the Dunoon Homes noted, 'the new accommodation which is being

⁴⁷ ML G362 7809411435, *Forty-Sixth Annual Report of the Glasgow Poor Children's Fresh-Air Fortnight and Crippled Children's League*, 1930, p. 2. [Ashgrove CH].

⁴⁸ ML G362 7809411435, *Forty-Sixth AR, Glasgow Poor Children's Fresh-Air Fortnight*, 1930, p. 6. [Ashgrove CH].

⁴⁹ Argyle and Bute District Archives, Dean of Guild Series. Glasgow and West of Scotland Convalescent Homes.

⁵⁰ A. Buchan, *History of the Scottish Women's Co-operative Guild* (Glasgow, 1913), pp. 7, 60.

⁵¹ See: J. Taylor, *The Architect and the Pavilion Hospital* (London, 1997), pp. 47-60; B. Duncan 'The Development of Hospital Design and Planning', in F.N.L. Poynter, ed., *The Evolution of Hospitals in Britain* (London, 1964), pp. 207-222. Barbara Duncan notes the presence of design in ventilation in purpose built hospitals from the eighteenth century onwards.

⁵² GHHB 10/1/1, Minute Book of the Aberdeen Convalescent Hospital. Memorandum of Visit to the Edinburgh Convalescent Home, the Convalescent Home at Dunoon and the Glasgow Convalescent Home.

provided in the new wing, (now in the course of construction) there will henceforth be comfortable and airy sleeping rooms for 250 people.’⁵³ In 1894, the *Dumfries and Galloway Standard* at the opening ceremony of Glencaple also reported that, not only was it pleasantly situated, but it also, ‘has large and airy rooms’.⁵⁴ In 1933, the Directors at the Dunoon Homes reminded their supporters that, ‘the homes at Dunoon are constructed in such a manner that the convalescents enjoy the advantages of abundant light, sea air, efficient ventilation, good drainage, and as far as possible a regulated temperature.’⁵⁵

Despite the appreciation of fresh air, warmth was also regarded as essential and many convalescent homes paid considerable attention to maintaining heating systems and keeping a regulated temperature. By providing a warm, healthy and sheltered environment for the convalescent homes, with plenty of fresh air, the promoters of convalescent homes therefore fulfilled a major requirement of accepted convalescent therapy. The AAI took the concept of fresh air a stage further than the traditional convalescent homes by introducing the type of extreme fresh air conditions found in tuberculosis sanatoria. Charles Smith notes that maximum fresh air was included in the principle treatment at the AAI and some of the patients even slept outside on the veranda, open on three sides.⁵⁶

Another aspect of ‘air’ mentioned regularly as a part of the convalescent regime was a ‘change of air’. Although not easily definable, this generally seemed to imply a change of scenery rather than specifically just ‘air’. The benefits of ‘change’ or ‘change of air’ were regularly noted by the convalescent homes. For instance, at Kilmun in 1925, a reflective remark in the annual report reminded subscribers that the original purpose for establishing the convalescent home was, ‘to enable the struggling poor, broken in health and without the necessary means to obtain a change of air and

⁵³ ML G.362 160941435, *Twenty-Fifth AR, WSCSH*, 1894, p. 5. [Dunoon Homes].

⁵⁴ *Dumfries and Galloway Standard*, 6 June 1894, p. 5.

⁵⁵ ML G.362 160941435, *Sixty-Fourth Annual Report of the Glasgow and West of Scotland Convalescent Seaside Homes*, [hereafter *GWSCSH*, formerly *WSCSH*]. Dunoon, 1933, p. 5. [Dunoon Homes]. The Dunoon Homes added Glasgow to their title in the 1930s.

⁵⁶ Smith, *Streamlet and the Town*, p. 32.

to regain strength to resume their labours'.⁵⁷ The Newport Children's Home also referred to 'change' when they explained the aims of the home as 'opened two years ago to provide free of expense, rest and change for the poor and convalescent children of Dundee and neighbourhood'.⁵⁸ In 1902, a leading article in the *Hospital* (edited by Henry Burdett), referred to the 'influence of change' amongst recommendations on the benefits of the seaside.

Nothing can demonstrate more conclusively the reflex influence of change and the good effect of stirring up the dull monotony of illness by the introduction of new stimuli, than the wonderful restoration of appetite which in some cases occurs almost immediately on arrival at the seaside. We are referring here not to cases of organic disease but to convalescence in persons of sound constitution who have been knocked down by illness and have failed to find their feet again under ordinary home treatment. Under the new conditions appetite returns, exercise is taken, hours a day spent in the open air. In a curiously short space of time life is looked at from quite a new point of view.⁵⁹

Diet – Robust or Refined?

Recommendations on treatment in convalescence stressed that nutrition was equally important as fresh air. This was reflected in the range of popular publications on the topic of diet that appeared during the nineteenth and early twentieth century. Two examples were *Food for the Invalid, the Convalescent, the Dyspeptic, the Gouty* by Dr J.M. Fothergill and *Convalescent Cookery*, by Catherine Ryan, but there were many similar publications.⁶⁰ Advice on diet in convalescence was also contained in a

⁵⁷ GCA TD.432/13, *Forty-Eighth Annual Report of the Kilmun Seaside Home for Convalescents*, [hereafter, *KSHC*], 1915-1916, p. 5. [Kilmun].

⁵⁸ Dundee Central Library, 43 (28), Annie S. Swan, *The Child-Angel, An appeal on behalf of Children's Summer Trips and Children's Country Homes* (c.d. 1895), p. 9.

⁵⁹ 'Convalescence at the Seaside', *The Hospital*, 29 March 1902, p. 1.

⁶⁰ J. M. Fothergill, *Food for the Invalid, the Convalescent and the Dyspeptic and the Gouty* (London, 1880). J. Milner Fothergill was an MD from Edinburgh. He was also a member of the Royal College of Physicians of London. His appointments included Senior Assistant Physician to the City of London Hospital diseases of the chest; Catherine Ryan, *Convalescent Cookery. A Family Handbook* (London,

variety of books on domestic medicine. For example, Dr Roberts, writing on diet for convalescents in *A Dictionary of Medicine*, concluded that diet was an essential part of the overall treatment of the patient:

Patients frequently require careful watching and judicious treatment while becoming convalescent as they are apt to retard or even prevent their recovery, and to lay the foundation for permanent disease by neglect of due precautions, especially as regards their diet.⁶¹

Other remarks on diet in convalescence tended to be more specific. In the 1920s, Dr Drummond recommended, 'proceeding from milk to such things as arrowroot and semolina; next to chicken or mutton broth with rice; then to milk puddings with eggs, custards, white fish, and lastly well-cooked and tender meat and vegetables.'⁶² In 1928, C. Herman Senn, Examiner in Sickroom Cookery to several London hospitals, including St Thomas's, advised that 'as convalescence progresses, the milk diet may be supplemented by light beef tea, or clear soup free from fat, broths and jellies in moderation.'⁶³

Diet was a topic constantly mentioned in the annual reports and other documentary material relating to convalescent homes. Although this suggests their awareness of the therapeutic value of nutrition, expenditure on food formed a major part of the convalescent home budget. In order to avoid accusations of extravagance, the managers or directors of convalescent homes perhaps felt it necessary to emphasise the importance of a nutritious diet to convalescent patients. At the Dunoon Homes,

1881); Edmund S. Delemare, *Wholesome fare: or the Doctor and the Cook. A manual of the laws of food and the practice of cookery, embodying the best recipes in British and Continental cookery, with hints and recipes for the sedentary, the sick, and the convalescent*, (London, 1886); Barbara Thomson, *Cookery for the Sick Cookery for the Sick and Convalescent with Directions for the Preparation of Poultrices, Fomentation's* (London, 1886); Anon, *Dainty Dishes for the Sick and Invalid* (Glasgow, 1893); J. Williams, *Art of Feeding the Invalid and Convalescent* (London, 1923); Charles Herman Senn, *Cookery for Invalids and the Convalescent* (London & Melbourne, 1928); Alys Lowth, *The Invalid and Convalescent Cookery Book* (New York, 1914).

⁶¹ F. T. Roberts, 'Convalescence', in Richard Quain, ed., *A Dictionary of Medicine* (London, 1890), p. 295.

⁶² Drummond, *Medical Dictionary*, p. 130.

⁶³ C. Herman Senn, *Cookery for Invalids and the Convalescent* (London and Melbourne, 1928), p. 10.

where the provisions bill was constantly higher than at many other homes, Beatrice Clugston justified this with the remark that, 'as to the matter of food, the directors and myself have always thought that as the best means to recovery a generous diet should be allowed.'⁶⁴ In 1885, Sir Peter Coats, Chairman of the Management Committee of the Dunoon Homes, informed the assembled supporters at the annual general meeting that 'a generous and health giving diet must be afforded, for that in the experience of Miss Clugston and the directors is where half the battle for convalescence lies'.⁶⁵ In 1939, the Dunoon Homes still promoted their diet amongst the other benefits, as 'the directors, being aware that good food properly cooked is essential for the building up of the body after illness, are constantly giving attention to the diet provided for the patients.'⁶⁶

The food offered to patients at most convalescent homes contained an abundance of protein, fat and carbohydrate, thought by the Victorians and Edwardians to be the perfect diet.⁶⁷ The significance of vitamins and minerals in food did not emerge until early in the twentieth century. Consequently, at Corstorphine House there was an emphasis on meat and starch rather than fresh vegetables despite the production of their own fruit and vegetables.⁶⁸ Even if meat and starch dominated the diet, the meals in convalescent homes varied each day. For example, dinners at Corstorphine House consisted of:

Mondays: barley soup, thickened with cabbage and cold beef and bread,

Tuesdays: rice soup and cabbage, boiled beef and bread,

Wednesdays: potatoes and Irish stew, rice and milk,

Thursdays: boiled meat and bread, also barley broth,

⁶⁴ B. Clugston, *West of Scotland Convalescent Seaside Homes, Dunoon: A short account of their present position and capabilities of extension and use* (Glasgow, 1871), p. 13.

⁶⁵ ML G.362.160941435, Sixteenth AR, *WSCSH*, 1885, p. 4. [Dunoon Homes].

⁶⁶ ML G.362.160941435, Seventieth AR, *GWSCSH*, 1939, p. 6. [Dunoon Homes].

⁶⁷ M. Stevens, *The Good Scots Diet, What Happened to it?* (Aberdeen, 1985), p. 103.

⁶⁸ Other homes known to produce their own fruit and vegetables included Ascog and the GCH. See: J. Salmon, *Proud Heritage* (London, 1954), p. 84. My thanks to Emily Sime at Lenzie Hospital for supplying a brief historical note written by an ex-gardener at the GCH from 1928-1973, describing the production of fruit and vegetables at the Home.

Fridays: potatoes and hash, also rice and milk,
Saturdays: rice soup thickened with leeks, cold meat and bread,
Sundays: roast meat (cold) and bread, also barley broth.⁶⁹

This diet also met with apparent approval by the Aberdeen Convalescent Hospital Committee because, following the visit from their representative to Corstorphine House in 1871, they adopted the same diet for their patients.⁷⁰ Beatrice Clugston also provided a detailed account of the typical daily diet at the Dunoon Homes:

Breakfast

Porridge and milk, followed by tea, bread and butter, an egg, potted ham or herring (Of these latter addition, of course only one is offered each day, as variety of diet and economy of outlay are always included in our arrangements)

12 o'clock

Beef tea or stimulant

2.00 pm Plain Dinner

Butcher's meat, bread and cereal

Roast beef on Sunday and seven different dinners in the course of the week.

Half a pound of butcher's meat is allowed daily per patient.

6.00 pm Tea

8.30 pm Light Supper

Sago and milk, rice or cornflour, and if prescribed stimulants are given in case of great weakness.

The diets detailed at the Dunoon Homes and Corstorphine House suggest that the typical convalescent home diet was rather more robust than general recommendations of delicate offerings to convalescent patients. Yet, during the nineteenth century, any sort of food offered to the poor was likely to be an improvement on that available to

⁶⁹ M. Goldman, *Lister Ward* (Bristol, 1987), p. 124.

⁷⁰ GRHB 10/1/1, Minute Book of the Aberdeen Convalescent Hospital, 15 October 1873.

them in their own homes. M. Stevens, in her book on the *Old Scots Diet*, comments on the inferior food consumed by the urban poor of the nineteenth century, when bread, margarine and tea replaced previous rural diet of oats and potatoes.⁷¹ Although the old Scots diet, based on oats and potatoes, was nutritionally superior to the new urban diet, it was more expensive, required cooking facilities and took time to prepare. Sufficient funds, time and cooking facilities were not always available to the urban poor. The more affluent amongst the urban working classes who had the means to keep to the old Scots diet therefore fared better nutritionally. Richard Rodger notes that, during the period 1841 to 1914, wages in most Scottish cities were comparatively lower than in England, but the cost of food was 10-15 per cent higher.⁷² Providing food for any kind of convalescent diet, whether robust or refined, was therefore often difficult or even impossible for many families in Scotland, and probably more so than in England. This was perhaps one reason why many convalescent homes, given the short period of residence of around three weeks, thought that providing their patients with an abundance of food was more appropriate than the conventional advice of a refined diet. In 1868, the GCH stated that, 'the object of the institution is to feed up patients who are in that state of convalescence which requires not only substantial food, but an abundant supply of it.'⁷³

The following remarks by Beatrice Clugston suggest her awareness of the difference between the convalescent diet of the middle-classes, and that found in convalescent homes. Referring to the details of the diet at the Dunoon Homes she remarked that:

These details are offered for the approval of all who can with a generous eye consider the poor man's case, and if any should criticise with a grudging mind, I can only direct them to the future of their own experience when,

⁷¹ Stevens, *Scots Diet*, pp. 90-99.

⁷² R. Rodger, 'Employment, Wages and Poverty in the Scottish Cities, 1841-1914', in George Gordon, ed., *Perspective of the Scottish City* (Aberdeen, 1885), p. 43.

⁷³ ML G.362 160941435, *Fourth AR, GCH*, 1869. p. 4

'desire failing' they will need much more pampering than has ever been given in the 'working man's seaside homes'.⁷⁴

During the nineteenth century the trend towards 'feeding up' as an accepted therapy for tuberculosis patients might also have influenced their belief in the benefits of providing a substantial diet for their convalescent patients.⁷⁵ The annual recording of average weight gains of patients at Corstorphine House suggests the importance they also attached to 'feeding up' patients. Weight gains of patients during the two or three weeks spent at Corstorphine House varied between four and five pounds.⁷⁶

Despite the efforts made by the convalescent home authorities to ensure that their patients were well fed, during the later nineteenth and early twentieth century there were complaints, particularly from the COS, over the inflexibility of the diet. The *Lancet* echoed this concern over rigid dietary rules with the statement:

In most convalescent institutions the diet, though good in quality and sufficient in amount is not exactly that which is best suited for many patients just recovering from severe diseases especially of the digestive organs.... there is clearly a need for a little less adherence to a definite uniform diet, a greater power of adaptation to individual needs.⁷⁷

Interestingly, the progressive Burke Foundation in New York took a different view. They believed that special diets retarded return to normality for most convalescent patients. The *Lancet* reported that that 'at White Plains special dieting is not favoured; a carefully considered standard dietary is given, which results in the correction of many digestive and physical faults'.⁷⁸

⁷⁴ Clugston, *West of Scotland Convalescent Seaside Homes*, pp. 10-11.

⁷⁵ Smith, *Retreat of Tuberculosis*, pp. 98-99. Smith describes the Sanatorium of Dr Otto Walther at Nordrach in the Black Forest which opened about 1889. Walther believed in building bodily resistance by 'overfeeding'. Many sanatoria published annually the average weight gain of their patients.

⁷⁶ LHB 1/4/7103-139, *Annual Reports of the Royal Infirmary of Edinburgh*, 1903-1939. .

⁷⁷ *Lancet*, 22 April 1905, p. 1077.

⁷⁸ 'The Work of the Burke Foundation, New York State', *Lancet*, 1 September 1923, p. 492.

Food at the convalescent homes was also an important issue for the patients. Some convalescent homes promoted the value of their diet by publishing letters from grateful patients. For instance, the following extract from a rivet boy was published in the annual report of 1901 of the Dunoon Homes. It recorded: 'What I like here is that the meat is splendid, and you get as much as you can eat. The Superintendent seems to be better pleased when you eat a lot.'⁷⁹ However, because the annual reports were anxious to present a positive picture of the convalescent homes, negative comments about food were rare. Nevertheless, the Co-operative Convalescent Home at Seamill did record some letters of complaint in their minute books. The first occurred in October 1898, only a short while after the Home opened. The complaint was regarding a patient who, following discharge, had complained to the secretary at the Dreghorn Branch over 'the inferior quality and quantity of the food at the Seamill Home'.⁸⁰ The Convalescent Home Committee responded by requesting that the ex-patient return to the Seamill Home for an interview but remarked that the patient should have first complained to the matron. The ex-patient from Dreghorn consented, but after the interview withdrew his complaint saying he would modify his statements to the Dreghorn Society and 'expressed his regret that he had not taken the proper course of action to have his complaint rectified'.⁸¹ This retraction immediately following the interview suggests that he might have undergone some pressure to modify his previous objections.

This did not prevent six male residents making further complaints to the directors over the food at Seamill in March 1899 (apparently on behalf of the other eighty residents). Their specific grievances were over 'the poor quality and quantity of food and the strict discipline imposed in the dining room'. They were particularly concerned about the following items in the diet:

⁷⁹ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, p. 3. [Dunoon Homes].

⁸⁰ GCA CWS 33/3/1, Minutes of the House Committee of the Scottish Co-operative Seaside Homes Association, 29 October 1898. The Dreghorn Branch of the Co-operative Society had recommended the admission of the patient to Seamill.

⁸¹ GCA CWS 33/3/1, Minutes, Scottish Co-operative Homes, 20 November 1898.

‘the quality of the Hoch soup’
‘salmon being served cold for breakfast’
‘the quantity of tripe and mince for dinner’
‘a badly cooked dessert (roly-poly)’
‘tinned meat of any kind being served’
‘a badly cooked fish for breakfast’⁸²

The spokesman acting for the patients was also indignant because Seamill included tinned meat in the diet. He said that he would also have refused the salmon had he known it was tinned. He also mentioned staying at Kilmun and Dunoon, which he claimed, ‘had never served tinned meat’.⁸³ Patients continued to make numerous objections to their branch secretaries over the food until 1908. From that year, the Convalescent Home Committee refused to deal with complaints unless patients approached the Matron beforehand. This may explain why the minutes recorded fewer complaints from patients after this date.

The grievances of the patients at Seamill signal several further developments. Firstly, they indicate expectations of a far higher standard regarding food from patients at the Co-operative Homes. Their concern over ‘tinned meat’, ‘cold salmon’ and ‘badly cooked fish’, reveals that the expectations of patients had risen beyond a breakfast of bread and margarine. Moreover, the patients were not the destitute poor previously found in homes such as Kilmun and the Mission Coast Home. Secondly, the non-charitable status of the Co-operative Society convalescent homes made it more appropriate for their patients to complain than for those in convalescent homes funded through charity. Thirdly, the recommendation of patients through Co-operative Society branches gave them an easier channel to direct their complaints through their branch secretaries. Nevertheless, the reluctance of the directors to deal with

⁸² Ibid., March 1899.

⁸³ Ibid.

complaints unless the matron had first been approached indicates they found this kind of conflict difficult to handle.

Whether or not the diet offered met with approval from the patients appeared to depend equally on the expectations of the patients and the quality of food. For example, a fourteen-year-old patient recovering from a long illness who went to Bandrum during the 1930s had pleasant memories of the food offered. She particularly remembered: 'My favourite pudding was rice and raisins which we were fed often and it was made from creamy milk straight from the farm nearby. Happy days indeed.'⁸⁴ By contrast, Molly Weir, aged thirteen years, who stayed at Kilmun, (also during the 1930s and used to high culinary standards at her own home) recalled that on one occasion when the cook burnt the scrambled eggs, it received furious condemnation from the patients. To quote: 'We came into the dining room holding our noses, but, burnt or not, the horrible mess was served up to us.'⁸⁵

Overall, diet was a big issue in convalescent homes amongst patients, doctors, nurses and managers. The homes were aware of the therapeutic value and made considerable effort to provide the patients with appropriate nutrition. However, it was not necessarily within the standard expectations of a convalescent diet.

Occupation as Therapy

In her *Notes on Hospitals*, Florence Nightingale set out some basic rules for using occupation as therapy for convalescent patients. These included helping in the kitchen (for women) and gardening (for men):

The indispensable hospital rule, that no patient should be sent to or admitted into the kitchen or ward scullery, is also reversed in a convalescent home, where the more the patients are occupied the better. The men who are able for it should be employed in the garden, which is better for them than their in-

⁸⁴ Personal correspondence from patient admitted to Bandrum in 1930. GS/JC.

⁸⁵ Molly Weir, *Best Foot Forward* (London, 1972), p. 159.

door trades. The women who are able for it should do nearly all the household work, at least on their own side; and a little sick cookery may well be taught them in the kitchen, but on a hot plate as convalescents should not be called upon to stand long at a hot kitchen fire.⁸⁶

Florence Nightingale also indicated some flexibility should remain 'in subordination to the necessity of giving the convalescents constant fresh air, and as much as possible of it out of doors'.⁸⁷ Beatrice Clugston also emphasised the therapeutic aspects of assisting with domestic work, although she suggested that there was some flexibility, and convalescents were excused if they were not strong enough.⁸⁸

Work therapy also probably benefited the convalescent homes by keeping down staffing costs. During the nineteenth century, it was common practice to enlist the assistance of patients in some of the domestic tasks on the wards in hospitals and asylums.⁸⁹ Many convalescent homes did not accept patients unless they were willing and able to assist with the chores. This was sufficiently important to the convalescent home regime for many to include it in their rules. For example, in 1906 at Saltcoats, the rules stated:

Inmates, according to ability, shall render every assistance to the Matron as she may direct, in cleaning, cooking at *etc.*, that the family nature of the Home may be maintained, and that the home may be kept scrupulously clean near and tidy.⁹⁰

A similar set of rules existed at Newhills:

⁸⁶ Nightingale, *Notes on Hospitals*, p. 108.

⁸⁷ *Ibid.*

⁸⁸ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 9.

⁸⁹ W. B. Howie and S. A. Black, 'Hospital Life a Century Ago', *BMJ*, 28 August, 1976, p. 516. Howie and Black describe patient occupation amongst the chores in the wards. In 1876 at the Royal Infirmary of Edinburgh, patients were expected to make themselves useful by helping to clean and tidy the ward. They also helped roll bandages.

⁹⁰ GCA T.Par 1.7, 'Rules for inmates', *Forty-Second Annual Report of the Mission Coast Home, Saltcoats, 1906-7*, p. 30.

All the inmates as they are able shall render every assistance to the housekeeper as she may direct in cleaning cooking etc., and persons refusing to give what help they can, or not working agreeably with others, or making themselves in any way offensive or disagreeable are liable to immediate expulsion.⁹¹

At Kilmun, the annual reports regularly made comments on the contribution made by patients at convalescent homes to the domestic chores, such as, ‘we still continue to employ the patients, who are able to assist in the work of the Home – making beds, washing dishes, sweeping and tidying their rooms, or any other light work.’⁹²

By the turn of the century, the rules at the Co-operative Homes indicated that participation in household activities was optional. These stated: ‘Male convalescents, if inclined, will have an opportunity of assisting in the gardens and grounds. A similar opportunity will be afforded female convalescents to assist the Matron within the house under her direction.’⁹³ Traditional convalescent homes were therefore providing their patients with occupation before it was medicalised at the AAI, although the motives were probably equally economic and therapeutic.

The AAI took a more scientific approach to their provision of convalescence. In her study of occupational therapy at the AAI, Irene Paterson notes that the Medical Superintendent at the AAI, John Cunningham, advocated ‘graded occupation and recreation, both mental and physical as a factor in bringing about an ultimate return to health.’⁹⁴ The medicalisation of occupation as therapy at the AAI subsequently led to the employment of a Canadian occupational therapist, Amy Normand de Brisay, in

⁹¹ GRHB 9/3/3, ‘Rules of Cottage home for Convalescents and Sanatorium for Consumptives at Newhills’.

⁹² GCA *Thirteenth AR of the Kilmun Seaside Home for Convalescent Poor*, [hereafter *KSHCP*], 1880, p. 4. [Kilmun].

⁹³ GCA CWS1/33/3/1, Co-operative Seaside Homes Association Rules, c.1903, p. 2.

⁹⁴ Paterson, ‘Occupational Therapy in Scotland’, p. 132.

1933.⁹⁵ The AAI also differed in that there were many more activities included under 'occupation'. These took place in two workshops. The first was a workshop for quiet occupations that included weaving, painting and basketry. A second workshop housed noisier crafts such as carpentry and metal work. It is interesting to note that occupations were segregated by gender: 'Men were engaged in rug making, basketry, painting, woodcarving, leatherwork and weaving with small looms, while needlework in its various forms and knitting are most popular in the women's pavilions.'⁹⁶

Knitting and sewing also featured in the traditional convalescent homes. For example, a patient at Troon during the 1930's remembers knitting socks but she thought this was regarded as a recreational activity.⁹⁷

Recreation

The managers of the convalescent homes, including the AAI, considered recreational activities as an important part of the therapeutic regime in a convalescent home. For example, during the early years of the GCH this was recognised in the following statement: 'During the critical weeks of convalescence, great care requires to be exercised and thought and consideration extended to the patient to dispel that lassitude and depression which illness brings in its train.'⁹⁸ At most convalescent homes, reading, music, and later on, listening to the radio, were high on the list of recreational activities, together with indoor games, such as billiards, drafts and dominoes. In 1885, reading material received by the GCH, in addition to unspecified magazines included, bound volumes of *Christian Leader*, *Sunday at Home*, *Chambers Journal*, *Girls Own Paper*, *Life and Work*, *Day of Rest*, 100 *Sankey's Hymn Books*, 24 *Bibles*, copies of *Hogg's Instructor* and *Good Words*. In 1902, patients at Kilmun received the *Sunday Magazine*, *Spurgeon's Sermons*, *the Peoples Friend*, *Glasgow Herald* and the *Scottish Temperance League Journal*, *League Journal*.⁹⁹ In 1901, the Dunoon Homes, in addition to numerous parcels of unnamed literature, received a

⁹⁵ Ibid.

⁹⁶ 'Astley Ainslie Institution', *BMJ*, 19 June 1937, p. 1278.

⁹⁷ Personal correspondence from patient in Miners' Convalescent Home at Troon in 1938, JL/JC.

⁹⁸ ML G.362 160941435, *Seventy-Second AR*, *GCH*, 1936, p. 7. [Dunoon Homes]

⁹⁹ ML G.362.160941435, *Thirty-Second AR*, *WSCSH*, 1901, p. 36. [Dunoon Homes].

box filled with *Illustrated Monthly Magazine*, plus six copies of *Horner's Pocket Library*, the Christmas numbers of *Black and White*, copies of *Cassells Magazine*, the *Gentlewoman*, *Good Words*, the *Graphic*, the *Illustrated London News*, *Pears Annual*, the *Sphere*, the *Sketch*, the *Queen and the Quiver*, two bound copies of *Co-operative Annual for 1901*, *Chambers Journal*, *Answers*, and *Spare Moments*.

Exposure to this wide range of magazines may have been a new experience for some patients since many of the working-class patients might not previously have had the means, inclination or time to acquire them. At Seamill, Dr MacArthur, the Medical Officer, commenting on the popularity of the indoor recreation rooms, reported: 'The library and recreation rooms are well patronised, their attractions sometimes proving stronger than the bracing air and sunshine out of doors.'¹⁰⁰

Musical instruments were another popular form of gift to convalescent homes. In 1897, the gifts to Seamill included a grand piano, an American Organ, and a Bagatelle Table. In 1902, the Dunoon Homes received a Broadwood and a grand piano.¹⁰¹ In addition to the musical instruments, local residents often gave concerts to the patients. However, the concerts did not please all the patients. When Margaret Matthewson was a patient at Corstorphine House in the 1870s, she described the concerts as 'repugnant'.¹⁰² Yet, the number of concerts presented to the patients suggests that they were popular, and Margaret Matthewson's objection was an exception. For example, at the GCH, during 1885, there were seven musical entertainments and five magic lantern shows.¹⁰³ In 1901, the annual reports at the Dunoon Homes recorded that 'through the kindness of several of the residents and visitors at Dunoon and of the choirs connected with the various churches, the inmates have been provided with frequent entertainment.'¹⁰⁴ The Inter-War period saw the emergence of the radio as an additional form of entertainment for patients. At Alderston CH, the convalescent home for male rural workers, the *BMJ* reported that

¹⁰⁰ GGHB HB 6/4/55, *Tenth Annual Report of the Scottish Co-operative Convalescent Seaside Homes Association Limited*, 1902, p. 13.

¹⁰¹ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, p. 36. [Dunoon Homes].

¹⁰² M. Goldman, *Lister Ward* (Bristol, 1987), p. 124.

¹⁰³ ML G.362.160941435, *Twentieth-First AR, GCH*, 1885, p. 19.

¹⁰⁴ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901, p. 7. [Dunoon Homes].

'recreation is provided in the form of billiards, musical instruments and wireless installation.'¹⁰⁵ Despite the introduction of the wireless, concert entertainment for convalescent home patients continued and in 1936, local people entertained the patients at the GCH on five occasions, including a show by the 'Kirkintilloch Players'.

Physical Exercise

Although physicians such as George Bodington had already used graduated exercise as therapy for tuberculosis during the nineteenth century, exercise therapy gained wider acceptance amongst doctors during the twentieth century.¹⁰⁶ Despite this acknowledgement of the therapeutic use of exercise, some doctors advised a cautious approach for convalescent patients. In 1866, Dr Thomson recommended that, 'general exercise is to be resumed cautiously and should never be carried to the extent of fatigue.'¹⁰⁷ Interest increased during the First World War when doctors treating large numbers of wartime casualties used exercise and other physical therapies to rehabilitate their convalescent patients. During the inter-war period, several infirmaries established departments that used physical therapy. In 1920, for example, the Western Infirmary of Glasgow opened the School of Massage, Medical Electricity and Remedial Exercise.¹⁰⁸ It is therefore not surprising that physical therapy formed an important part of the regime at the AAI. Outdoor games formed part of physiotherapy, but it also included remedial exercises and electrical treatment.¹⁰⁹

Exercise also played an important part of the regime at traditional convalescent homes, but in common with occupation and recreation, the methods were casual rather than scientific. Patients in many convalescent homes were expected to take at least one or sometimes two organised walks per day. Beatrice Clugston described the morning routine at the Dunoon Homes: 'Descending to the sitting room flat one finds

¹⁰⁵ *BMJ*, 31 October 1925, p. 814.

¹⁰⁶ F. B. Smith, *The Retreat of Tuberculosis 1850-1959* (Beckenham, 1988), pp. 97-99.

¹⁰⁷ S. Thomson, *A Dictionary of Domestic Medicine and Household Surgery* (London, 1866), p. 133.

¹⁰⁸ A. Kerr and L. McQueen, *The Western Infirmary in Glasgow, 1874-1974* (Glasgow, 1974), p. 71.

¹⁰⁹ A. Miles and J. Cunningham, *The Convalescent-Rehabilitation Hospital as an integral part of the National Health Service* (Edinburgh, 1951), p. 5.

the hall filled with men who from the cloakroom are getting mufflers and coats to prepare for their morning walk'.¹¹⁰ In 1884, the installation of a glass-covered promenade at the Dunoon Homes described by the directors as, 'for the use of patients when the weather outside makes open-air exercise impossible', further illustrates the therapeutic value the homes placed on exercise.¹¹¹ Daily walks were also mentioned in the rules at the Mission Coast Home¹¹² and Newhills.¹¹³ Although a rule at Newhills stating that, 'patients must have their shoes brushed before leaving the Cottage for the forenoon walk', seems to relate more to the appearance rather than the benefits of exercise, it also implies a mandatory expectation of a daily walk.¹¹⁴ The Mission Coast Home published an almost identical rule over brushing shoes 'before a forenoon walk'.¹¹⁵ At Kilmun, Molly Weir recalled that the walks were escorted and taken twice daily.¹¹⁶ The annual report in 1933 recorded that, at Ashgrove CH, the children were also taken on regular accompanied walks and excursions: 'On every day on which the weather permits, the children are taken for walks in the surrounding countryside and in summer special excursions are made to the shore. The afternoons are devoted to playing.'¹¹⁷

Some convalescent homes provided bowls and croquet as both recreation and exercise. At Corstorphine House, the grounds were 'laid out with trees and shrubs, and bowling and croquet greens provided in the upper part for use of patients'.¹¹⁸ At Kilmun there were croquet, bowling, putting greens and billiards for the patients.¹¹⁹

¹¹⁰ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 9.

¹¹¹ 'The Dunoon Convalescent Homes', *BMJ*, 31 May 1884, p. 1060.

¹¹² GCA T.Par 1.7, 'Rules for Inmates', *Forty-Second AR, Mission Coast Home*, 1906-7, p. 30.

¹¹³ GRHB 9/3/8, 'Rules, Newhills CH'.

¹¹⁴ *Ibid.*

¹¹⁵ GCA T.Par 1.7, *Forty-Second AR, Mission Coast Home*, 1906-7, p. 30. Much of the wording found in the rules Mission Coast Home at Saltcoats and Newhills CH, situated near Aberdeen, was very similar. This suggests that at some time there might have been collaboration between the two convalescent homes. The only link so far established between the two homes was that the founder of Newhills, Catherine Cruikshank originated from Stevenston, where her father was a minister. Stevenston is only a few miles from Saltcoats.

¹¹⁶ Weir, *Best Foot*, pp. 162-3.

¹¹⁷ ML G.362.7809411435, *Fiftieth AR, Glasgow Poor Children's Fresh-Air Fortnight*, 1932.

¹¹⁸ LHB 1/194/25, *Description and Plans of the Convalescent House* (Edinburgh, 1894), p. 7.

¹¹⁹ GCA TD.432/13, *Annual Report of the Glasgow-Kilmun Convalescent Home*, [hereafter *GKCH*, formerly *KCHSP*], 1933-4. [Kilmun].

They also provided competitive games such as cricket and football. In 1934, their annual report noted that, 'in this way patients enjoy congenial exercise in health giving surroundings'.¹²⁰ A more unusual form of exercise detected at Corstorphine House was an exercise horse.¹²¹ From around 1924, Linn Moor employed a remedial expert, with the intention of providing the children with twice-weekly treatment of exercise and massage. However, the following statement reveals that the value of the exercises was perceived as an adjunct to diet, fresh air and sunlight therapy rather than a replacement.

The value of these exercises cannot be exaggerated, as, from experience, they have led to an improvement in carriage, appetite and general health, and without exception, an increase in chest expansion and weight. The giving of remedial exercises forms an important adjunct to the routine treatment which consists of good food, fresh air and sunlight.¹²²

The inclusion of sunlight is indicative of the growing interest in treatment by heliotherapy.

Heliotherapy

Heliotherapy, or sunshine treatment, gained popularity amongst the medical profession from around the turn of the century.¹²³ Dr Niels Finseen (1860-1904) is reputed to be the first medical practitioner to study the effects of heliotherapy for treating tuberculosis. He also invented carbon-arc lamps known as 'Fisen lamps'.¹²⁴ Other practitioners using heliotherapy for treating tuberculosis patients included Dr Oskar Bernhard (1861-1939) and Dr August Rolliet (1874-1954). This type of therapy became more extensively used during the First World War following the

¹²⁰ GCA TD.432/13, *Sixty-Seventh AR, KHFC*, 1934-5, p. 4. [Kilmun].

¹²¹ LHB1/194/21, Inventory and Valuation of Furniture, Furnishing etc in the Convalescent House, Murryfield, Peter McNeill, 11 Lauriston Park, August 1905.

¹²² ACL 362/78/L64, *Thirty-Sixth Annual Report of Home for Ailing Children and Fresh Air Fortnight*, 1924, p. 5. [Linn Moor].

¹²³ H. Richardson, *English Hospitals* (Swindon, 1998), p. 52.

¹²⁴ R. A. Hobday, 'Sunlight Therapy and Solar Architecture', *Medical History*, 42 (1997), pp. 455-72.

successful treatment of war wounds.¹²⁵ After the First World War, ultra-violet lamps were used to treat children in some of the welfare clinics. The AAI also adopted sunlight as one of their therapies.

More recently, the appeal of sunbathing for health has declined due to the increased incidence of skin cancer resulting from excess exposure to sunshine. However, during the nineteenth and pre-Second World War period, there was no such concern and convalescent homes encouraged sunbathing. Although, the heliotherapy was informal, there is evidence that sunshine was valued therapeutically. For example, Beatrice Clugston described patients sunbathing on the roof of the Dunoon Homes:

‘On a summer day there is not a lovelier sight than to find this covered with poor sufferers basking in the sunshine, and sufficiently far from the sea to enjoy its exhilarating influence without the fear of its being too much for a weak frame.’¹²⁶

Likewise, an official visitor at Corstorphine House in May 1895 found that ‘the patients, most of them outside enjoying the sunshine, looked very happy.’¹²⁷

Similarly, another official visitor to Bona in 1914 noted that ‘all the patients [five] were out of doors enjoying the sunshine and fresh air’.¹²⁸ At the children’s convalescent home, Muirfield, the building was constructed so that the wards connected with a large glass room, with sliding doors allowing easy access to the garden. The doors were opened in good weather when ‘the children either play or lie in stretchers in the sun or under a shady tree’ but in bad weather they could remain in the glass room.¹²⁹ In 1925, the annual report at Linn Moor referred to their belief in the advantages of sunlight noting:

The greatly improved condition of the children even after only a short period of residence is the best evidence of the beneficial results obtained from good

¹²⁵ Ibid.

¹²⁶ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 7.

¹²⁷ LHB 1/194/1, Manager’s Book, Corstorphine House, 11 May 1895.

¹²⁸ Convalescent Home of the Royal Northern Infirmary at Bona, Visitors Book, 3 April 1914.

¹²⁹ ‘The Convalescent Home, Gullane’, *British Journal of Nursing*, 11 December 1909, p. 485. The *Scottish Hospital Report*, South East Region, p. 77. The *Scottish Hospital Report* also comments on the south-facing veranda at Muirfield CH that enabled staff to move the children easily into the open air. See illustration 7, p. 64 for photograph of Gullane that shows the veranda.

food, fresh air and sunlight, careful supervision by a trained and sympathetic staff and special treatment when medically subscribed.¹³⁰

In the same year, the value of light was also mentioned when reporting on a new extension that was reported as ‘well lighted from both sides, as well as from the roof, efficiently ventilated and heated, and has a veranda on the west side’.¹³¹

Hydrotherapy

Hydrotherapy, defined as bathing in water, or drinking water, as therapy, has a relatively long history in treating illnesses stretching back as far the ancient Greeks.¹³²

During the eighteenth and nineteenth centuries, various forms of spa treatment became fashionable for numerous conditions and ailments, including convalescence.¹³³ Although hydrotherapy is associated with spa treatment, James Bradley, Marguerite Dupree and A. Durie also point out that ‘hydrotherapy, as it initially appeared in the 1820s, was an entire medical system, exclusive of all other forms of treatment, based upon the internal and external application of water.’¹³⁴

Robin Price refers to the uneasy relationship between hydrotherapy and orthodox medicine in England during the twentieth century.¹³⁵ There was probably a similar situation in Scotland. Nevertheless, there was some support for the use of hydrotherapy for convalescents in hospitals. In 1916, Frank Radcliffe suggested that ‘it would greatly strengthen the equipment of the civil hospitals of this country if they installed a hydrotherapeutic establishment in connexion with their electrical departments as a means of the treatment of convalescents.’¹³⁶

¹³⁰ ACL 362/78/L64, *Thirty Seventh Annual Report of the Home for Ailing Children and Fresh-Air Fortnight*, 1925, p. 6. [Linn Moor].

¹³¹ *Ibid.*, p. 4.

¹³² R. Price, ‘Hydrotherapy in England 1840-70’, *Medical History*, 25 (1981) p. 269.

¹³³ B. Abel-Smith, *The Hospitals* (London, 1964), p. 133.

¹³⁴ J. Bradley, M. Dupree and A. Durie, ‘Taking the Water-cure: The Hydropathic Movement in Scotland, 1840-1940’, *Business and Economic History*, 26, 1997, pp. 426-437.

¹³⁵ Price, ‘Hydrotherapy in England’, p. 269; See also, D. Cantor, ‘The Contradictions of Specialism; Rheumatism and the Decline of the Spa in Inter-War Britain’, in R. Porter, ed., ‘The Medical History of Waters and Spas’, *Medical History, Supplement No 10* (London, 1990), pp.127-144.

¹³⁶ *The Spas of Britain, Official Handbook of the British Spa Federation*, (Bath, 1923), p. xiii.

¹³⁶ F. Radcliffe, ‘Hydrotherapy as an Agent of the Treatment of Convalescents’, *BMJ*, 21 October, 1916, p. 554.

Despite the association of hydrotherapy with the affluent sick, from the early days of their establishment there was a modest use of hydrotherapy in working-class convalescent homes. Baths were already installed when Beatrice Clugston purchased 'Arduvullin' from the trustees of the Robert Wylie estate for use as a convalescent home (Dunoon Homes). Wylie built 'Arduvullin' as a hydropathic but died before it opened. According to Robert Hillhouse, Secretary of the Dunoon Homes during the late nineteenth and early twentieth century, they inherited Turkish baths, vapour, spray and ordinary baths.¹³⁷ Although it is difficult to establish precisely the extent of hydrotherapeutic treatment at the Dunoon Homes, Beatrice Clugston comments that some baths were used for their convalescent patients:

The Baths are considered the first in the country and I have a contract made for getting in salt water so that feeble limbs of inmates and feeble children of the visitors to Dunoon may all derive more good from the Baths than now. Two baths are kept for inmates, four are reserved for hire. Of course the Turkish Baths are reserved for the public.¹³⁸

Burdett mentioned that acetic acid was used to treat patients at the Mission Coast Home.¹³⁹ This usually involved refreshing the patient by sponging with vinegar and water. However, annual reports at the Mission Coast Home suggest they also used other forms of hydrotherapy. In 1912, the annual report commented that 'the Committee are pleased to note that the simple remedies employed are being more widely appreciated and that many of those under treatment have been specially recommended by their medical advisors to take advantage of the Home bathrooms.'¹⁴⁰ Yet, the hydrotherapy offered by the Mission Coast Home must have been relatively unusual as they also commented that 'giving this form of help is peculiar to this

¹³⁷ R. Hillhouse, *Bygone Years of the West of Scotland Convalescent Seaside Homes*, Dunoon, (Glasgow, 1909), p. 4.

¹³⁸ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 15.

¹³⁹ *Burdetts' Hospitals and Charities*, (1899, 1911, 1930).

¹⁴⁰ GCA T.Par 1.18, *Forty-Seventh AR, Mission Coast Home*, 1911-12, p. 6.

institution amongst convalescent homes.’¹⁴¹ Nevertheless, it is likely that a demand existed for hydrotherapy as by 1920, the Mission Coast Home reported the addition of new baths, heating and equipment consistent with those used for hydrotherapy treatment. These were: ‘plunge, sitz, spray and shower, with an abundant supply of hot water’.¹⁴²

At Seamill, the patients were offered warm baths, although their rules do not suggest it was compulsory. Their rules stated that ‘if approved of by the Medical Officer or Matron, a warm bath is given to convalescents on the day of arrival.’¹⁴³ From a current perspective, ‘warm baths’ have a stronger relationship with cleanliness than therapy. However, Ian Smith and Alan Swan have shown that ‘warm baths’ were used therapeutically during the nineteenth century at Gartnavel Hospital in Glasgow.¹⁴⁴ They may therefore have also have been regarded as therapeutic in the convalescent homes in the sense that although bathing was a hygienic measure, it also made the patient more comfortable.

Bathing children on or before arrival was a common procedure in most children’s convalescent homes. At Linn Moor, the annual reports emphasise the importance of this procedure and how those responsible for despatching children to the countryside initially used washing facilities in a school beforehand. After 1912, they waited until the children arrived at the convalescent home.¹⁴⁵ At Ashgrove CH, the annual report described the bathing routine when the children arrived: ‘When they arrive at the Homes the children are bathed and given a change of clothes, while each establishment is provided with a chamber for fumigating the clothing thus

¹⁴¹ Ibid.

¹⁴² GCA T.Par 1.31, *Fifty-Sixth AR, Mission Coast Home, 1920-21*, pp. 3-4.

¹⁴³ GCA, CWS1/33/3/1, Rule 5, of ‘Bylaw’s to be observed at the Co-operative Convalescent Homes’ c.1900.

¹⁴⁴ I. Smith and A. Swan, ‘Medical Officers and Therapeutics, 1814-1921’, in I. Smith and J. Andrews, eds., *Let There Be Light* (1993), p. 55.

¹⁴⁵ ACL 362/78/L64, *Twenty-Fourth Annual Report Children’s Fresh-Air Fortnight and Ailing Home, 1912*, p. 5. [Linn Moor]

temporarily discarded.¹⁴⁶ A young convalescent of 1932 described her experience when she arrived:

I was showed into the bathroom and then I listened to my name being called. Answering my name I was given a bag to put my clothes in. I went over to the big bath and waited till I was told to go in. I must really say I enjoyed my bath. I went out after tea and played with girls.¹⁴⁷

However, a patient sent to Ashgrove CH during the 1930s, when she was only five years old, recalled a less pleasant experience of the nightly baths.

An older girl was in charge of the two of us, and it was just my luck that she did not like this girny-faced home sick kid. Every night she would put me at the drain end of this enormous bathtub telling me that if I didn't stop crying, beasties would come up the drain and drag me off to the Clyde. You can imagine the nightmare that accounted for, for a number of growing up years.¹⁴⁸

Comparison between Therapies at Astley Ainslie and Traditional Convalescent Homes

This description of treatment in traditional convalescent homes in many respects seemed to vary little from methods used at the AAI. These techniques included massage, exercises, electrical and dental treatment, heliotherapy (exposure to the direct rays of the sun) and gardening exercise.¹⁴⁹ The Medical Superintendent of the AAI, John Cunningham, summarised the regime as providing 'an ample supply of fresh air and sunlight, a generous and nutritious diet'. Nevertheless, a further statement from Cunningham describing their therapy as 'treatment for a sufficient time to permit recovery to the fullest extent; and a judicious allowance of occupation

¹⁴⁶ ML G.362 7809411435, *Forty-Sixth AR, Glasgow Children's Fresh Air Fortnight*, 1930, p. 5. [Ashgrove CH].

¹⁴⁷ *Ibid.*, 1932, p. 9.

¹⁴⁸ Personal correspondence from patient who went to Ashgrove CH in 1938, JD/JC.

¹⁴⁹ C. Smith, *Between the Streamlet and the Town* (Edinburgh, 1988), p. 30.

and recreation', illustrates a greater preoccupation with occupation and recreation and their willingness to take patients at an earlier stage of convalescence.¹⁵⁰ The medical profession took the AAI far more seriously because they employed and studied a wider range of physical and occupational methods of treating convalescent patients within an experimental environment. It was therefore necessary for patients to stay for longer periods than the two or three weeks. Unlike the traditional convalescent homes, patients who needed longer convalescence or treatment were therefore welcome at the AAI, and they stayed for periods of between eight weeks to a year. Yet, successive managers of traditional convalescent homes had made considerable effort during the sixty years before the establishment of the AAI to exclude patients requiring extensive treatment because they were not perceived as 'convalescent'. Also, demand for admission in the existing convalescent homes from patients within their interpretation of 'convalescent', remained high. It is therefore hardly surprising that the traditional convalescent homes were reluctant to adopt the new methods of convalescent therapy. Nevertheless, their reluctance to make changes within the therapy, combined with the greater willingness of many new convalescent homes to accept patients for a rest, inevitably increased the association with holidays. Yet, how different was the experience of time spent in a convalescent home to that of a holiday? The remainder of this chapter considers firstly the concept of a holiday and secondly how it compared with the convalescent homes.

Comparison between Holidays and Convalescent Homes

It is easy to understand why many people associated convalescent homes with a type of holiday since there were some similarities. Convalescent homes were often sited at resort locations, and both offered recuperation in some form or other. The convalescent homes also provided many of the activities anticipated on a holiday such as bowls, putting, tennis and croquet and various forms of entertainment. Despite these similarities, in other respects they were very different. Whereas holidaymakers

¹⁵⁰ C. F. Paterson, 'The Development of Occupational Therapy in Scotland 1900-1960', unpublished PhD thesis, (University of Aberdeen, 2002), p. 130.

were more often seeking various forms of amusement, patients in the convalescent homes focused upon restoration of their health.

There were also different types and expectations from the experience of a holiday. In Scotland during the nineteenth century, the middle-classes often spent holidays with relatives or friends, in good hotels or hydropathics, whereas others rented or built properties in resort areas. The more adventurous travelled or enjoyed sporting, painting or literature holidays. The working classes took day excursions on steamers or trains; others stayed with relatives in the country or rented rooms in boarding houses at the seaside. Although holidays for many poorer people were often no more than a day or two, the better-off amongst the working classes sometimes took weekly holidays, even in the nineteenth century.¹⁵¹ This increased during the twentieth century when paid holidays also became more common, mainly through pressure exerted by unions.¹⁵² The concept of the holidays away from home was therefore well established by the late nineteenth century.

A major difference between the convalescent home and any type of normal holiday accommodation was the admission procedure. Whereas residence in holiday accommodation normally depended upon an ability to pay, admission to a convalescent home was usually conditional upon a medical referral and medical examination.¹⁵³ Convalescent homes generally exercised far more control of the patient than the hotel or boarding house proprietors did over their guests. Unlike the accommodation provided for holidays, convalescent homes always had a matron in charge. She was usually assisted by at least one nurse, who during the later nineteenth and twentieth century, was hospital trained. Many also emphasised the medical tone of their institution by producing an annual medical report containing

¹⁵¹ J. Walvin, *Leisure and Society 1850-1950* (London, 1978), pp. 79-80.

¹⁵² C. G. Brown, 'Popular Culture', in T. M. Devine and R. J. Finlay, eds., *Scotland in the Twentieth Century* (Edinburgh, 1996), p. 223-4.

¹⁵³ The referral procedure was discussed in detail in Chapter One. There is evidence that a few convalescent homes, such as those sponsored by the Co-operative Society, took paying 'boarders' where medical referral was not required.

various statistics on the condition of the patients on discharge, weight gain of patients, types of illness.

Reference to the inmates as 'patients', not residents, tourists or holidaymakers is a further indication of the medical focus of the convalescent homes. Numerous examples found in the literature include *Medical Institutions of Glasgow*, whose author, Christie, commented that 'the GCH has accommodation for 67 patients'.¹⁵⁴ When Viscount Chelmsford discussed the miners' convalescent homes, in a pamphlet on the Miners' Fund, he remarked that 'most of the welfare convalescent homes are intended for use simply by male patients'.¹⁵⁵ In 1903, the *Annual Report of the Royal Northern Infirmary* commented that the official visitors, 'found the management of the House and care of the patients were quite satisfactory'. In 1906, the annual report of the Mission Coast Home commented that 'considering the great good vouchsafed to such large number of patients, the Committee desire gratefully acknowledge the guiding hand of God.'¹⁵⁶ Kilmun also consistently referred to their inmates as patients. For example, their annual report in 1938 observed that, 'it is only when the circumstances and condition of the respective patients are considered that a proper estimate can be formed of the work.'¹⁵⁷

Another difference between the convalescent homes and holidays was that they constantly stressed that their major purpose was the restoration of health. For instance, in 1874, the Glasgow Abstainers' Union contrasted the poor domestic environment of many of their patients with the health-giving influence of Kilmun:

Given that 445 poor persons in impaired health removed from such homes as theirs are known to be, with impure air, insufficient or unsuitable diet and all the other depressing influences by which they are surrounded, removed from

¹⁵⁴ J. Christie, *Medical Institutions of Glasgow* (Glasgow, 1888), p. 161.

¹⁵⁵ Scottish Mining Museum. EDO 338, Rt Hon Viscount Chelmsford, 'The Miners' Welfare Fund', p. 35.

¹⁵⁶ GCA T.Par 1.7, *Forty-Second AR, Mission Coast Home 1906-1907*, p. 9.

¹⁵⁷ GCA TD.432/13, *Seventy-Second AR, GKCH, 1938-39*, p. 4. [Kilmun]

these to the seaside, to a comfortable home, with nourishing and suitable diet, cheerful society, and other health giving influences, the results need not be recorded.¹⁵⁸

At the opening ceremony of the convalescent home of the Western Infirmary in Glasgow, the Hozier Home, a speech from one of the managers, Leonard Gow, focused attention upon the curative aspect of the home. He is reported to have said that 'it was only when an infirmary had a convalescent home as an organic part of its own curative system that its benefits could be seen and appreciated.'¹⁵⁹ Similarly, restoring health was emphasised at the opening procedures of the Co-operative Home at Abbotsview, when Mr J. M Lochhead, Chairman of the Co-operative Inland Homes Provisional Committee, said that he 'hoped that the Home would be the means of restoring health to any of them that required to come there in the future'.¹⁶⁰ Even convalescent homes associated with 'fresh air fortnights' stressed the health aspects of the homes rather than the holidays. In 1930, the *Annual Report of the Glasgow Poor Children's Fresh-Air Fortnight and Crippled Children's League* reported that at Ashgrove CH 'all returned to homes greatly benefited by the strong air, careful nursing and attention'.¹⁶¹ In 1939, the annual report at Linn Moor promoted the health aspects of the Home with the comments that 'few institutions could illustrate the great value of the simple things of life in promoting health and happiness – plain nourishing food with plenty of milk, open air recreation and abundant fresh air by day and night with long hours of sleep.'¹⁶² These examples indicate that the focus of the regime of convalescent homes was on health not holidays. Another major contrast between holidays and convalescent homes was the excessive control convalescent homes had over their patients. The next section

¹⁵⁸ GCA TD.432/13, AR, *Glasgow Abstainer's Union*, 1874, p. 7.

¹⁵⁹ 'Opening of the Lady Hozier Convalescent Home, Lanark', *Glasgow Herald*, 11 July 1893, p. 3.

¹⁶⁰ 'Opening of Abbotsview Homes', *Scottish Co-operator*, 6 April, 1906, p. 321. Speech by Mr J. M. Lochhead, Chairman of the Inland Homes Provisional Committee.

¹⁶¹ ML G.362 7809411435, *Forty-Sixth AR, Glasgow Poor Children's Fresh-Air Fortnight*, 1930, p. 7. [Ashgrove CH].

¹⁶² ACL 362/78/L64, *Fifty-First Annual Report for the Home for Ailing Children and Fresh Air Fortnight*, 1939, p. 8. [Linn Moor].

examines some of the numerous rules and restrictions encountered by patients in convalescent homes.

Control

House rules were, and still are, found in even the most exclusive holiday establishments. These might include anything from set mealtimes to a ban on smoking or drinking on the premises. However, the rules in convalescent homes resulted in far greater control and supervision of patients than would be expected on any holiday. Discipline was a constant issue at most convalescent homes, even on seemingly minor occasions. For example, in 1893, the managers at Corstorphine House expressed concern over problems amongst patients created by the close proximity of the bowling and tennis greens. In 1893 they reported:

Having seen Miss Ferguson and examined the place I am disposed to recommend the erection of two small fences separating the bowling green from the croquet and tennis greens on either side. This is to assist Miss Ferguson in the difficult task of pressing discipline.¹⁶³

Another more prominent example of imposed discipline was the common time of rising and going to bed. At the Dundee Convalescent House, the rules stated that ‘unless otherwise directed, they [patients] shall rise by half past seven in the summer and eight in the winter.’ There were similar expectations written into the rules at Seamill. According to the rules ‘the bell is rung each morning at eight o’clock and all are then expected to rise.’¹⁶⁴ Beatrice Clugston also described the common period of ‘getting up’ routine at the Dunoon Homes as, ‘at 8.00 am the great bell in the passage rings and all that are able may rise and prepare for the day’s duties.’¹⁶⁵ Convalescent home rules also often stated the precise time of retiring. At the Dundee Convalescent House this was fixed as, ‘quarter-past nine o’clock in the winter and at

¹⁶³ LHB 1/194/1, Managers Book for Corstorphine House, 11 April 1893.

¹⁶⁴ GCA CWS1/33/3/1, Bylaw’s to be observed at the Co-operative Homes’ c.1900, p. 2.

¹⁶⁵ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 9.

ten o'clock in the summer.'¹⁶⁶ The Co-operative Society convalescent homes expected patients to be in bed by ten o'clock when they turned off the gas lighting.¹⁶⁷ This was also the case at the Mission Coast Home but with some additional rules that stated 'no talking in bedrooms after that hour.'¹⁶⁸ The common times of rising and retiring might have assisted in rehabilitating patients into regular sleep patterns, but it also enabled the convalescent homes to supervise and control the patients more easily.

Patients encountered further constraints in the use of bedrooms during the day. Harriet Richardson, in her study of the architectural design of hospitals, notes that this was also common practice in England. She observed that: 'A fundamental factor governing the design of convalescent homes was the mobility of patients who were neither expected, nor encouraged, to remain in their beds during the day.'¹⁶⁹ This restriction was also important enough to be included in the rules of some convalescent homes. At the Co-operative Convalescent Homes, for example, the rules were that: 'convalescents shall not make use of their bedrooms during the day.'¹⁷⁰ Certainly, confining patients to the grounds and recreation rooms (usually situated on the ground floor) assisted the domestic routine of the convalescent homes such as cleaning and maintenance. However, it might also have benefited the patients by encouraging active participation in recreational activities.

Patients were also confronted with some stern discipline at mealtimes. However, Seamill patients were less inclined to accept this kind of control. For instance, in 1905, when the Matron publicly reprimanded a patient in the dining room at Seamill, the patient complained to her branch secretary.¹⁷¹ On this occasion, the Directors upheld the complaint but advised the Matron to caution patients privately in future.

¹⁶⁶ THB 13/1, *Twenty-Third AR, Dundee Convalescent House*, 1883, p. 11.

¹⁶⁷ GCA CWS1/33/3/1, 'Bylaw's , Co-operative Homes'.

¹⁶⁸ GCA T.Par 1.7, 'Rules for Inmates', *Forty Second AR, Mission Coast Homes, Saltcoats*, 1906-1907, p. 31.

¹⁶⁹ H. Richardson, *English Hospitals 1660-1948* (Swindon, 1998), p. 183.

¹⁷⁰ GCA, CWS1/33/3/1, Rule 14, 'Bylaw's , Co-operative Seaside Homes'.

¹⁷¹ GCA, CWS1/33/3/2, House Committee Minute Book, 1900-1906, 13 July 1905.

Nevertheless, a patient at the Co-operative Society convalescent home at Airdmhor, in 1938 noticed that the dining room discipline was still strict 'with scoldings if food was left on the plate'.¹⁷²

Convalescent homes often issued instructions about the items of clothing they expected patients to bring with them. The Mission Coast Home stipulated that patients must 'have with them a change of clean underclothing; if this is not attended to they cannot be allowed to remain'.¹⁷³ Even at the Co-operative Homes, there were still rules issued over clothing, stating:

It is absolutely necessary that each person, when going to the Homes, must take with them two changes of underclothing; each must have at least one clean change on entering the Homes. Male convalescents must have a nightshirt, a pair of house slippers and a hair comb. Females – a sleeping gown, a pair of slippers and a hair comb.¹⁷⁴

Lack of cleanliness amongst patients also caused concern amongst the convalescent home authorities. It was sometimes caused by the lack of appreciation from the middle-class volunteers and organisers of the convalescent homes that poorer patients lacked adequate washing and bathing facilities in their own homes. An annual report at Linn Moor described differences between the expectations of middle-class volunteers preparing children for their country break and standards of their families:

One great difficulty that has to be contended with is the dirty condition of the clothing and bodies of some of the children dealt with. Much is being done to get this condition of things amended, and the Committee are hopeful that in the near future the parents of these children will be induced to do their duty to their offspring. It may be said with truth in regard to this matter that many of

¹⁷² Personal correspondence from ex-patient at Airdmhor, JC/JC.

¹⁷³ GCA T.Par 1.7, 'Rules for inmates', *Forty Second AR, Mission Coast Home, 1906-1907*, p. 30.

¹⁷⁴ ML, Glasgow, C.104261, *Handbook of Glasgow Charitable and Beneficent Institutions* (Glasgow, 1888), p. 105.

¹⁷⁴ GCA CWS1/33/3/1, Rule 3, of 'Bylaw's , Co-operative Seaside Homes'.

the parents know no better, and are surprised when the real state of matters is pointed out to them.¹⁷⁵

There were also rules about washing and cleanliness in adult homes such as those at Newhills that quite bluntly stated 'dirty people will be dismissed instantly'.¹⁷⁶ At the Mission Coast Home, patients were told that 'inmates shall wash thoroughly in the morning'.¹⁷⁷

A further example of close supervision of patients was the set of restrictions often imposed on patients over visiting the locality outside the convalescent homes. Patients were therefore mostly unable to enjoy any of the facilities offered by local resorts such as shops, entertainment on the pier or beach and cinema. This represents a further difference between the convalescent homes and hotels or boarding houses. This type of restriction varied between homes. For instance, some homes, such as Newhills, did not allow patients out of the grounds.¹⁷⁸ Other homes, such as Corstorphine House and the Dundee Convalescent House, insisted upon issuing a pass to patients beforehand. Corstorphine House only considered issuing a pass after ten days in the Home.

The necessity of retaining good relations with the neighbourhood probably accounts for most of the restrictions since many convalescent homes were in middle-class areas and there were occasional problems when patients visited the localities. For example, in 1895, shortly after establishing the Schaw Home in the exclusive Glasgow suburb of Bearsden, there were numerous complaints from local residents about the patients' activities. The misdemeanours included 'blocking the footpath of a local railway bridge'. Because of the complaints, the Management Board at the Schaw Home

¹⁷⁵ ACL 362/78/L64, *Twenty-Second AR, Fresh Air Fortnight and Ailing Home*, 1910, p. 6. [Linn Moor].

¹⁷⁶ GRHB 9/3/8, 'Rules, Newhills CH'.

¹⁷⁷ GCA T.Par 1.7, 'Rules', *Forty-Second AR, Mission Coast Home*, 1906-1907, p. 30.

¹⁷⁸ GRHB 9/3/8, 'Rules, Newhills CH'.

eventually decided to confine patients to the grounds of the Home.¹⁷⁹ Although the Directors at Seamill also received several complaints about patients' behaviour from local residents, they declined to impose restrictions on movement. Instead, they threatened offenders with expulsion from the Home. The complaints included a local farmer who protested that patients were damaging his crops and neighbours who complained about patients 'loitering about the station platform interfering with the access of passengers to and from the station'.¹⁸⁰ Following these complaints, the Directors of Seamill decided to write a letter to the Matron with the intention that she read it to the patients 'expressing the directors regret at receiving these very serious complaints'. The Directors also pointed out 'that patients against whom a similar complaint was made could be dismissed under the terms of the bylaws'.¹⁸¹

Despite this type of restriction imposed by some convalescent homes, others imposed few restraints on their patients. For instance, there was no indication of restrictions on the patients at the Dunoon Homes. The Mission Coast Home also only requested that patients did not leave the vicinity of Saltcoats.¹⁸² A surprise visit made to Bona in 1913 also indicated the absence of restrictions when the official visitor reported that the patients were 'enjoying a sail on Loch Ness and in good spirits'.¹⁸³

The convalescent homes employed a variety of methods to encourage both religious observances and strict moral behaviour. For instance, during the nineteenth century, the walls of Corstorphine House were liberally clad with engravings, lithographs, scripture text and moral quotation cards.¹⁸⁴ During the nineteenth century most convalescent homes segregated male and female patients. Some of the larger convalescent homes incorporated gender segregation into the design of the building.

¹⁷⁹ J. Jenkinson, M. Moss and I. Russell, *The Royal* (Glasgow, 1994), p. 149.

¹⁸⁰ GCA CWS 33/3/1-8, Scottish Co-operative Convalescent Seaside Homes House Committee Minute Books, 16 May 1900.

¹⁸¹ *Ibid.*

¹⁸² GCA T.Par 1.7, 'Rules', *Forty-Second AR, Mission Coast Home*, 1906-7, p. 30.

¹⁸³ HHB 2/1/1, Visiting Book of Managers of Convalescent Home of Royal Northern Infirmary [Bona] 3 June 1913.

¹⁸⁴ GHHB 10/1/1, Minute Book of the Aberdeen Convalescent Hospital. Memorandum of Visit to the Edinburgh Convalescent Home, the Convalescent Home at Dunoon and the Glasgow Convalescent Home on 7, 9 and 10 August, 1871.

Typically, there was a central block, containing the administrative offices, matron and nursing accommodation with a male and female wing on either side. Separation of men and women at meal times was common at most convalescent homes. This was achieved by providing either two dining rooms, separate tables within the same dining room or two sittings. Corstorphine House had separate male and female sittings for mealtimes whereas the Dunoon Homes had two dining rooms. However, when Seamill was established at the turn of the century, they did not separate patients during meals. Such restrictions may have been less acceptable at non-charitable homes such as Seamill. Nevertheless, the practice persisted at other convalescent homes. Molly Weir describes the mealtimes at Kilmun, where male and female patients sat on separate tables during the 1930s:

At one long table the women were ranged down both sides. At the other table two rows of men faced one another. I noticed some of the women seemed very curious, and kept stealing little glances across the no-man's land between the tables. At the top of the room the matron and her assistants sat at a small separate table, keeping an eye on the proceedings.¹⁸⁵

Molly Weir recalls that Kilmun also kept patients well apart during their daily walks with the men escorted in one direction, the women in another. However, on Sundays, when the daily walk was towards church and total segregation was impractical, the women set off first, followed at a safe interval by men.¹⁸⁶

Most convalescent homes, in common with hospitals, employed a paid minister or chaplain who held prayers and religious services. This often went beyond providing for the spiritual needs of patients, and in many homes religious observance was either compulsory or actively encouraged. At Newhills, the managers made their expectations regarding the Sabbath observance quite clear, stating, 'family worship shall be maintained, and the Lord's Day duly observed. Sunday Strolling is strictly

¹⁸⁵ Weir, *Best Foot*, p. 159.

¹⁸⁶ *Ibid*, 162-3.

forbidden.’¹⁸⁷ Although Kilmun claimed there was no religious discrimination in their admission policies, a scandal arose during 1921 and 1929 when several newspapers received complaints over the dismissal of several Roman Catholic patients because they refused to attend their evening prayers.¹⁸⁸ Other homes, such as the Co-operative Homes used moral encouragement with ‘sanctity of the Sabbath is requested’, in the rules.¹⁸⁹ The YMCA also held a religious service each day at Seamill.¹⁹⁰ The Dunoon Homes encouraged rather than obliged patients’ attendance at the ‘social worship’ held twice daily.¹⁹¹ They also allowed a city missionary a one-week holiday at the Dunoon Homes in return for conducting services, thus providing a permanent spiritual advisor for the patients. This practice continued until the 1930s.

Although the convalescent homes sometimes used alcohol medicinally, there was usually a strict prohibition on the general consumption by patients. The exclusion of alcohol was therefore often included in the rules of convalescent homes with instant dismissal of patients who did not comply. For example, the rules at Newhills stated:

Intoxicating liquors are wholly disallowed, and any of the inmates tampering with such things outside or inside the institution shall be dismissed forthwith. Any stimulants used under medical advice are to be under the charge of the Matron or nurse’.¹⁹²

Despite the restrictions on alcohol, it still found its way into some convalescent homes. The annual matron’s report at Kilmun regularly reported the dismissal of convalescents found consuming alcohol. For instance, in 1900 eighteen men and three women were ‘sent away for taking drink’. This was presumably not on the

¹⁸⁷ GRHB 9/3/8, ‘Rules, Newhills CH’.

¹⁸⁸ GCA TD.432/20 bundle. Press cuttings and correspondence about the expulsion of Catholics admitted to the home who refused to attend Protestant worship including *Glasgow Observer*, 23 May 1921, *Sunday Observer*, 7 September 1929; Letters from Stewart and Lloyds Limited, 1 May 1929; John MacDonald, 15 April 1929; Rev. A. J. Layden, 18 April 1929.

¹⁸⁹ GCA CWS 1/33/3/1, Bylaw’s, Co-operative Seaside Homes’, p. 2.

¹⁹⁰ GGHB HB 6/4/55, *Tenth AR, Co-operative Seaside Homes*, 1902, p. 9.

¹⁹¹ ML G.362.160941435, *Thirty-Second AR, WSCSH*, 1901. [Dunoon Homes].

¹⁹² GRHB 9/3/8, ‘Rules, Newhills CH’.

same day but the total for the year.¹⁹³ In 1898, the minutes at the Co-operative Homes also recorded dismissing several patients because of offences relating alcohol.¹⁹⁴

Kilmun, Mission Coast Home and the Co-operative Homes probably took alcohol consumption more seriously because their management was either involved in or sympathetic to the temperance movement. Even the children were not free from the temperance influence in some homes. In 1910, the annual report at Linn Moor mentioned that the Young Abstiners' Union visited the home during the season and 'provided a treat for the children, with prizes for singing races and other games'.¹⁹⁵

It is easy to appreciate the reasons for the ban on alcohol in the light of the havoc an intoxicated patient might cause to the smooth running of an institution. Nevertheless, for many, alcohol consumption was still an important part of leisure and holidays and therefore represents yet another difference between holidays and the time spent in a convalescent home.¹⁹⁶ For example, excessive alcohol consumption was common on the Clyde steamers that were used extensively for leisure and holidays.¹⁹⁷ Yet there was also a counter movement to discourage alcohol amongst the working classes particularly amongst holidaymakers. Hamish Fraser notes that, during the later nineteenth century, under legislation such as the 1853 Forbes Mackenzie Act, the influence of temperance organisations and alternative recreational activities, alcohol consumption declined amongst many of the respectable working classes.

Temperance hotels became common, and Thomas Cook, one of the founders of modern popular tourism, established his tours of Scotland as part of a move to encourage temperance.¹⁹⁸ Although alcohol was not part of a holiday experience for everyone, the convalescent home patient did not have a choice. The restrictions placed upon alcohol by the convalescent homes therefore made further inroads into

¹⁹³ GCA TD.432/13, *Thirty-Third AR, KSHCP*, 1900, p. 5. [Kilmun].

¹⁹⁴ GCA CWS 33/3/1-8, *Scottish Co-operative Convalescent Seaside Homes House Committee Minutes*, 26 February 1898 and 30 July 1898.

¹⁹⁵ ACL 362/78/L64, *Twenty-Second, AR, Fresh Air Fortnight and Ailing Home*, 1910, p. 6. [Linn Moor].

¹⁹⁶ H. Fraser, 'Developments in Leisure, in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990), pp. 241-242.

¹⁹⁷ C. Smout, *A Century of the Scottish People 1830-1950* (London, 1986), p. 157; H. Cunningham, *Leisure in the Industrial Revolution* (London, 1980), p. 186.

¹⁹⁸ L. Withey, *Grand tours and Cook's Tours: A History of Leisure Travel, 1750 to 1915* (London, 1997), pp.135-146.

the distancing of convalescent homes from holidays.

The convalescent homes also attempted to take an educational role for their patients by encouraging higher standards of domesticity within their own homes. This might have been helpful to some patients, but perhaps frustrating for slum-dwellers with a large family, living in one or two rooms. For such poor people, imitating the domestic standards of a large well-equipped house, such as a convalescent home, with domestic servants would have been especially frustrating. Beatrice Clugston was usually understanding of the difficulties faced by the poor. Despite this, in 1871 she suggested that 'the cleanliness, order, and methodical arrangements of the Homes are considered, by those who visit them, profitable lessons for the inmates for the conducting of their own dwellings.'¹⁹⁹ This paternalistic role was also found in the annual report of 1871 at the GCH:

Many have left us improved in mind and heart as well as in body and many have felt much regret at leaving and made many promises to come and see us when able. One thing pleased me much and that was to hear some of the women say that they felt dissatisfied with the irregular and careless way in which they and their families had lived, and were determined when they got back to their homes to make them like ours.²⁰⁰

Nevertheless, in 1894, at the annual report of Dunoon Homes, they believed they had achieved some success in their instructive role:

The Directors have been much encouraged by learning from donors and subscribers that a number of those who have had their health and strength restored have returned to their own dwellings improved in other ways.

¹⁹⁹ Clugston, *West of Scotland Convalescent Seaside Homes*, p. 10.

²⁰⁰ ML G.362.160941435, *Seventh AR, GCH*, 1871, p. 9.

Several have tried to imitate the cleanliness and good order which prevail at the Homes.²⁰¹

Although the convalescent homes therefore believed that their moral stance benefited their patients, there were some complaints of over-strictness. In 1921, three male patients complained to the *Sunday Mail* over several issues at Kilmun. These included only being allowed cold baths, and the removal of chamber utensils from their bedrooms 'as a punishment for men having dropped cigarette ends in them'.²⁰² There were therefore two sides to the story but the annual reports generally only recalled one.

Conclusion

In conclusion, the evidence presented in this chapter indicates that traditional convalescent homes provided a therapeutic regime consistent with the accepted methods of treatment for convalescence. This included, siting the convalescent homes in a healthy environment, providing adequate nutrition, fresh air, warmth, exercise, sunshine, occupation and various recreational activities. One exception was the diet offered to patients. In most homes, their diet was not typical of the general advice of the time on nutrition for the convalescent patient. This was partly due to convenience and economy, but many patients were malnourished through poverty. It was therefore more appropriate, while the convalescent homes had the opportunity, to provide patients with a hearty diet. Nevertheless, the COS made complaints over the inflexibility of the convalescent home diet. By contrast, the Burke Foundation, an influential convalescent institution in the United States, whose methods were regularly reported in the medical press, later opposed special diets for convalescents because they believed it delayed the rehabilitative process. When considering the different aspects of the therapeutic regime at the traditional convalescent homes it became apparent that, despite their informality, the convalescent homes did offer a

²⁰¹ ML G.362.160941435, *Twenty-Fifth AR, WSCSH*, 1894, p. 7. [Dunoon Homes].

²⁰² GCA TD.421/20, Letter to Directors at Kilmun from reporter on *Sunday Mail*, 23 May 1921. There was no responding letter available.

treatment similar to that at the AAI. Yet there were considerable differences. At the AAI there was a greater range of activities that were supervised more closely by a far greater number of doctors, nurses and therapists. They also took patients at an earlier stage of convalescence that would have been rejected by the traditional convalescent homes.

There were also substantial differences between the experience of patients in a convalescent home and holidaymakers on holiday. Although a holiday was often a recuperative experience, the major focus was upon a variety of recreational activities. By contrast, although recreation formed a therapeutic part of the convalescent home regime, their main aim was the restoration of health. The highly controlled regime of a convalescent home represented a further major difference between these institutions and the various types of establishments used by holidaymakers. While resident, patients were expected to comply with common times of rising and going to bed, mealtimes were often heavily supervised and patients were not allowed to use their bedrooms during the day; they were even informed of the type of clothes they were expected to bring. Many homes segregated male and female patients and restricted or banned visits to the locality. Some convalescent homes exercised an educative role towards their patients by anticipating that the cleanliness and order they experienced within the convalescent home would influence their attitudes towards domesticity. They also exerted a moral influence by either expecting or insisting the participation of patients in their religious observances. Most convalescent homes also issued strict rules that excluded the consumption of alcohol, with expulsion of deviant patients. In summary, despite the attempts by convalescent homes authorities to exert moral control over the patients, the homes were dedicated to the return to health of their patients. Although there was also clear evidence of organised therapy, it was casual and lacked a scientific or medical focus. In addition, as the next chapter will illustrate, nurses and domestics mainly supervised the regime and the therapy in convalescent homes, not doctors.

Chapter Six

Doctors, Domestic and Nurses

The topic of convalescence as a phase of illness has traditionally held little appeal for most doctors.¹ Elizabeth Lomax noted this lack of interest with the comment that, during the nineteenth century, infirmary doctors were reluctant to visit convalescent patients following discharge from hospital, even though they were encouraged to do so.² Similarly, John Bryant, writing in 1927, remarked that the prime purpose for writing his book on *Convalescence, Historical and Practical* was to ‘lessen the medical neglect so often meted out to the convalescent patient, who, precisely because he grows less acutely ill, so often seems to grow progressively less interesting to the physician immersed in the subtleties of latter-day medical science.’³ In 1939, concern over the neglect of convalescence prompted the organisation of a conference at the New York Academy of Medicine, to discuss problems associated with the subject. Although the conference was held in the US and attended mostly by American doctors, topics presented were relevant to convalescence in Britain at that time. These included, ‘Basic Considerations of Convalescent Care’, ‘Convalescent Care for Various Types of Patients’, ‘Psychosomatic Aspects of Convalescent Care’ and ‘The Social Financial and Administrative Aspects of Convalescent Care’.⁴ The President, Dr Malcolm Goodridge, stressed the lack of management of the convalescent period. He also said that, ‘convalescent care should be considered as a continuing service in which the physician, the hospital, social service, and the convalescent home all have a share.’⁵ However, the evidence produced in this chapter suggests that interest from doctors in Scotland in convalescence and traditional convalescent homes declined during the twentieth century.

¹ J. Bryant, *Convalescence, Historical and Practical* (New York, 1927), p. 1.

² E. Lomax, ‘Small and Special: The Development of Hospitals for Children in Victorian Britain’, *Medical History*, Supplement 16 (1996), p. 85.

³ Bryant, *Convalescence, Historical and Practical*, p. ix.

⁴ ‘Convalescent Care. Proceedings of a Conference held under the Auspices of the Committee on Public Health Relations of the New York Academy of Medicine, November 9 and 10’ (New York, 1949), p. vii-ix.

⁵ *Ibid*, p. v.

Explanations for the lack of interest in convalescence from the medical profession mostly centre on the belief that patients need less medical attention during this stage of their illness. In 1899, Henry Burdett stated, 'after the doctors have done their part, whether in hospital or sick room there comes the stage of convalescence when nothing but a change of air and scene can give new life and vigour to the body and mind.'⁶ An editorial in the *Archives of Paediatrics* in 1911 also remarked that children in convalescence only needed 'rest and watching'.⁷ During the 1930s, R. Fortescue Fox and W. E. B. Lloyd, two doctors respected as authorities on the topic of the therapeutic effects of climate and bathing, commented on their belief in the lack of medical intervention necessary in convalescent homes:

Convalescent homes in large numbers, many of them attached to city hospitals, have been opened at the seaside. Those who have visited these often quite small and unpretentious places are well aware of the surprising change which is produced in a few weeks in the condition of their inmates especially children simply by the marine climate and systematic rest and without other medical treatment – very often amounting to a physical and mental transformation.⁸

The lack of acceptance of responsibility by the medical profession towards patients in convalescent homes conflicted with their perception by lay people, who believed that such institutions were their concern. This was noted by Elizabeth Gardiner in the 1930s, when she blamed a lack of interest in convalescent homes from doctors as, 'partly due to the fact that the medical profession as a whole has considered such institutions as part of the social field, and the socially minded lay person has thought

⁶ *Burdett's Hospitals and Charities* (London, 1899), p. 114.

⁷ 'Convalescent Hospitals for Children', *Archives of Paediatrics*, 28 (1911), pp. 241-43 in: J. Golden, ed., *Infant Asylums and Children's Hospitals* (New York and London, 1989).

⁸ R. Fortescue Fox and W. E. B. Lloyd, 'Convalescence on the Coast', *Lancet*, 2 July 1938, p. 38.

of convalescent homes as lying in the medical field'.⁹ However, she did not discuss the reasons for this.¹⁰

Despite the general indifference of doctors towards convalescence, the appointment of a medical officer in a convalescent home was a highly sought-after post during the nineteenth century. The explanation for this ambiguity lay partly in the overcrowding of the medical profession during the nineteenth century, resulting in a surplus of doctors.¹¹ In order to make a living at this time, most general practitioners therefore accumulated a variety of different appointments, including: factory medical inspectors; prison doctors; Medical Officers of Health; Poor Law Medical Officers; and vaccinators.¹² Hilary Marland suggests that in the nineteenth century, amongst the doctors in Huddersfield and Wakefield, these posts varied considerably in demand, with medical officer appointments to dispensaries or asylums being amongst the most popular. By contrast, the least popular were friendly society and Poor Law appointments and consequently often undertaken by young, new practitioners.¹³ Evidence produced in this chapter suggests that the appointment of medical officer to a convalescent home in Scotland ranked highly as a medical appointment. The posts were mostly given to doctors with an established practice and once secured they did

⁹ E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), p. 8.

¹⁰ *Ibid.* At this time, Elizabeth Gardiner was Assistant Professor and Supervisor of Medical Social Work at the University of Minnesota.

¹¹ This was partly due to the expanding numbers of middle-class families who regarded medicine as a respectable career for their sons. The relatively easy entry into medicine further exacerbated the number of surplus doctors but legislation, centring mainly upon the 1858 Medical Act, eventually restricted the number of qualified medical practitioners. The Act established a Medical Register, with admission dependent upon formal qualification acquired through examination set by one or more of nineteen recognised institutions. Although this narrowed entry into medicine, it was not until the end of the century that there was a significant reduction in the number of practising doctors. See: J. Moore, *A Zeal for Responsibility* (Athens and London, 1988), pp. 40-43.

¹¹ A. Digby, *Making a Medical Living* (Cambridge, 1994), pp. 107-127.

¹² C. Lawrence, *Medicine in the Making of Modern Britain 1700-1920* (London and New York, 1994), p. 55; W. F. Bynum, 'Medical Values in a Commercial Age', in *Victorian Values*, ed., T. C. Smout (Oxford, 1992), pp. 161-163; M. W. Dupree and M. A. Crowther, 'A Profile of the Medical Profession in Scotland in the early Twentieth Century: The Medical Directory as a Historical Source', *Bulletin of History of Medicine*, 65 (1991), pp. 223-231; M. Dupree, 'Other than Healing: Medical Practitioners and the Business of Life Assurance during the Nineteenth and Early Twentieth Centuries', *Social History of Medicine* (1997), p. 81.

¹³ H. Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987), pp. 274-280; Sir John Brotherston, 'Scottish Health Services in the Nineteenth Century', in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987), p. 27.

not easily relinquish it. This suggests that it was relatively high on the ranking list of sought after appointments amongst medical practitioners.

Despite the importance of the Medical Officer to the convalescent homes, he was not the key figure.¹⁴ This was reserved for the Matron. She was usually a mature woman of relatively high social status. During the nineteenth century, her housekeeping skills were valued above those of nursing but there was a gradual shift in this view. By the twentieth century, although housekeeping skills were still essential, most convalescent homes employed trained nurses as their matrons. However, apart from the matron, until the end of the century few convalescent homes employed additional nurses and it is likely that domestic staff undertook some nursing duties. In addition, when trained nurses and nurses in training were introduced, they took over some tasks previously undertaken by the medical officers. Consequently, the importance of doctors to the convalescent homes lessened and gave the medical elite even more reason to suggest that convalescent homes were not medical institutions.¹⁵

The chapter is divided into two sections: the first deals with the doctors; the second the nurses and domestic staff. The first section explores the role of the convalescent home Medical Officer and the reasons why the post was so popular in the nineteenth century. This is followed by two case studies that examine the involvement of doctors in two convalescent homes: the GCH and Corstorphine House. The practice of medical officers in other convalescent homes is then compared with those at Corstorphine House and CGH. Also discussed is the participation of doctors in the social and general management of convalescent homes. The second section considers the role of matrons and other nurses and changes in their role that occurred between 1860 and 1939, particularly their increasing professionalism. It also attempts to understand the nature of nursing in convalescent homes and the relationship with domestic work.

¹⁴ All the medical officers identified in traditional convalescent homes were male. The AAI was the first to employ a female medical officer.

¹⁵ See Chapter Three, pp. 130-40 for discussion on the medical elites that authored numerous influential government reports on Scottish Health Services and Hospitals.

Doctors

Appointment of Medical Officers

The difficulties doctors experienced in making a living during the nineteenth century arose because the supply exceeded demand for their services from paying patients or other medical appointments.¹⁶ Consequently, securing a medical appointment was often highly competitive. It allowed convalescent home managers to be very selective in their choice of a Medical Officer, and they often demanded high qualifications from applicants. For instance, when Kilmun advertised for a Medical Officer in 1886, they insisted that applicants should possess an MD.¹⁷ Many doctors in convalescent homes also had this higher qualification, which suggests that other convalescent homes were equally demanding. For example, in 1885, both the Medical Officers at the Dunoon Homes, Drs Robert Perry and James Denniston, possessed an MD. Similarly, other Medical Officers at the GCH, Bruce Goff, William Whitelaw and John Wilson held an MD. Likewise, Dr Archibald McArthur, the first Medical Officer at Seamill, had the MD qualification.¹⁸

Despite this demand for higher qualifications, doctors' fees were low. Kilmun offered only £20 per annum to their Medical Officer, plus another £30 from the superior of the estate.¹⁹ In 1906, at the Mission Coast Home, Saltcoats, the fees were even lower, at £11 per annum. This sum also included medicines given to the patients.²⁰ In 1936, medical fees and medicines had risen to only £27 18s 4d.²¹ In 1920, the salary offered to a new Medical Officer at the Co-operative Society Home at Seamill was far higher at £50 per annum. However, the Directors expected the Medical Officer at Seamill to attend patients while in the Home and examine them

¹⁶ See footnote 11 of this chapter.

¹⁷ 'General Advertiser', *Lancet*, 3 July 1875.

¹⁸ *Medical Register*, 1900, p. 1278.

¹⁹ 'General Advertiser', *Lancet*, 3 July 1875.

²⁰ GCA T.Par 1.7, 'Ordinary Revenue Account', *Forty-Second Annual Report of the Mission Coast Home*, Saltcoats, 1906-7, p. 16.

²¹ ML G.362.160941435, 'Ordinary Revenue Account', *Seventy-Second Annual Report of the Glasgow Mission Coast Home*, Saltcoats, 1936-37, p. 15. [During the 1930s the Mission Coast Home also included 'Glasgow' at the beginning of their title. See Appendix C]

beforehand.²² Considering the amount of work involved therefore, the salary was still poor. Nevertheless, his salary was far higher than the meagre £15 per annum paid to Dr John Ritchie, Medical Officer for Airdmhor at Dunoon in 1918.²³ At the time, Dr Ritchie was also Visiting Medical Officer for the Dunoon Homes where the remuneration was possibly more generous. In 1885, the combined salary of the visiting and examining doctors at the Dunoon Homes was £120,²⁴ although by 1933 this had risen to £210.²⁵ The latter was far higher than the GCH, where the combined salary of the visiting and examining doctors around the same time was only £135.²⁶

The post of Medical Officer in a convalescent home was usually part-time and his fees therefore constituted only part of a doctor's overall salary. Yet, it was often a welcome addition to what could be an uncertain income from private practice. This was particularly important to Scottish doctors. As Anne Digby points out, 'medical incomes in Scotland were notorious for their meagreness and for the hard work that was needed to win them.'²⁷ The meagreness towards doctors' salaries was also found in a suggestion made by the Managers of Corstorphine House to reduce the annual salary of their Resident Medical Officer in 1908.²⁸ The infirmary managers' reasons were the poor financial position of the convalescent home and the considerable competition for the post.²⁹ A further example of the managers' parsimony towards the resident Medical Officers was their recommendation that he should not take any holidays during his six-month appointment.

²² GCA CWS. 1/33/3/5, Scottish Co-operative Convalescent Seaside Homes Association, House Committee Minute Book, 16 April 1914.

²³ GCA CWS.1/33/3/5, Co-operative Convalescent Homes Minute Book, 29 June 1918.

²⁴ ML G.362.160941435, 'Abstract of Accounts for year ending 31 July 1885', *Sixteenth Annual Report of the West of Scotland Convalescent Seaside Homes*, [hereafter *WSCSH*], Dunoon, 1885, p. 14. [Dunoon Homes].

²⁵ ML G.362.160941435, 'Abstract of Accounts for year ending 31 July 1933', *Sixty-Fourth Annual Report of the Glasgow and West of Scotland Convalescent Seaside Homes*, [hereafter *GWSCSH*, formerly *WSCSH*], Dunoon, 1933, p. 12. [Dunoon Homes].

²⁶ 'Annual Revenue Account for year ending 1936', *Seventy-Second AR of the Managers of the Glasgow Convalescent Home to the Subscribers*, 1936, p. 12. It was only possible to elicit doctors salaries from 1936 as before this time they were included in 'wages and salaries' for other staff at the Home.

²⁷ Digby, *Making a Medical Living*, p. 165.

²⁸ The currently available sources do not reveal the salary of the Resident Medical Officer in 1908.

²⁹ LHB1/194/1, Managers Book, Corstorphine House, 27 October 1908.

Despite low fees, high expectations and poor conditions, there were some additional benefits arising from a post as a convalescent home Medical Officer. For example, it could provide access to additional fee-paying medical services to the wealthy visitors who often patronised the same health resorts.³⁰ Another advantage was that the annual reports sometimes displayed the name of the Medical Officer prominently on the front page of an annual report, alongside influential, affluent or titled patrons. This made him more visible to a potentially lucrative clientele. In 1885, for instance, there were forty-three wealthy or titled patrons listed in the *Annual Report of the Dunoon Homes*, including the daughter of Queen Victoria, Princess Louise.³¹ It also provided a valuable association for an ambitious doctor when there were eminent medical men on the Board of Management. For example, in 1867, Joseph Lister and George Buchanan were both on the Board of Management of the GCH.³² The professional association with a voluntary hospital was often even more important to a doctor than remuneration. An illustration of this point occurred when the managers at Corstorphine House offered payment to a local practitioner, Dr Matthew, who had previously been attending their patients without charge. Dr Matthew declined the payment but instead accepted an honorary position as, 'Extra Surgeon to the Convalescent House'. Thus the title, with its prestigious association to the Infirmary, seemed more important to Dr Matthew than the remuneration. It was not until several years later, in 1892, that Dr Matthew accepted an honorarium of fifty guineas a year.

The considerable length of time that local practitioners held an appointment as Medical Officer at a convalescent home is one indication of the popularity of the post. Table 6.1 illustrates that there were only four visiting Medical Officers and three examining Medical Officers during a period of over seventy years at the GCH.³³ Drs

³⁰ Digby, *Medical Living*, pp. 187-189.

³¹ ML G.362.160941435, *Twenty-First AR, WSCSH*, 1885, p. 4. [Dunoon Homes].

³² ML G.362.160941435, *Second Annual Report of the Managers of the Glasgow Convalescent Home [GCH] to the Subscribers*, 1867, p. 2.

³³ There were two types of doctors at the GCH, the Visiting Medical Officers attended patients while in the convalescent home and an Examining Medical Officer who assessed the suitability of a patient for admission.

Donald Stewart and William Whitelaw, jointly appointed in 1873,³⁴ were both still in office in 1893.³⁵ This amounted to at least twenty years for each doctor.

Table 6.1 Medical Officers at the GCH between 1865-1936

Visiting Medical Officer	Examining Medical Officers
Bruce Goff	No Examining Medical Officer, because until 1873, all patients were referred from the infirmary
Donald Patrick Stewart	John Wilson
William Whitelaw	Hugh Thomson
A. G. Macintyre	G. Scott Macgregor

Sources: *Annual Reports of the Glasgow Convalescent Home*, 1867, 1869, 1870, 1871, 1872, 1873, 1882, 1885, 1889, 1893, 1922, 1925, 1936.

The situation was similar in other convalescent homes. Dr MacArthur, the Medical Officer for Seamill, held his post for twenty years. Dr John Ritchie, Visiting Medical Officer for the Dunoon Homes, also held his appointment for over thirty years. At Corstorphine House, Dr Matthew remained as a medical officer for over thirty years. His successor, Dr Fleming also remained in the post for fifteen years.

Understanding patterns of employment of the Medical Officers and their backgrounds helps to appreciate any changes that occurred over time in the convalescent homes. Corstorphine House and the Dunoon Homes were selected as case studies because different types of organisations sponsored them. They were therefore likely to produce variations in their medical practice (Corstorphine House was attached to an infirmary and the GCH was an independent home). The medical practice in the two convalescent homes thus provides a basis for comparison with other convalescent homes.

Corstorphine House

Table 6.2 illustrates the changes occurred in Corstorphine House in four main phases between 1869 and 1939.

³⁴ ML G.362.160941435, *Ninth AR, GCH*, 1873, p. 2.

³⁵ ML G.362.160941435, *Twenty-Ninth AR, GCH* 1893, p. 2.

Table 6.2 Medical Officers at the Royal Infirmary of Edinburgh and Corstorphine House between 1869-1939

Year	Medical Officers at Corstorphine House Recruited from the RIE	Medical Officers at Corstorphine House recruited from local practitioners.
Phase 1		
1869-1870	Thomas Annandale	none
1870-1872	Joseph Bell	none
1872-1878	John Chiene	none
1878-1879	A. Gordon Miller	none
1879-1883	John Bishop	none
Phase 2		
1883-1898	J.M. Cotterill	Alexander Matthew
Phase 3		
1898-1899	W.W. Wood	Alexander Matthew
1899-1900	J. A. Thompson	"
1900-1901	George Mackie	"
1901-1902	W. H. Hill	"
1902-1903	D.G. Hall	"
1903-1904	Arthur J. Brock	"
1904-1905	W. Sibbald	"
1905-1906	A. N. Fell	"
1906-1907	T. S. McIntosh	"
1908-1909	H. B. Watson	"
1910-1911	A. Fergus Hewat	"
1911-1912	John Stevenson	"
1913-1914	Russell E. Walker	"
Phase 4		
1914-1922	none	Alexander Matthew
1922-1937	none	Dr A Fleming
1937-1939	none	Dr Ian Meikle

Sources: *Annual Reports of the Royal Infirmary of Edinburgh 1867-1939*

The first phase, between 1869 and 1883, was a time when the Corstorphine House was an innovative type of institution and it therefore received a high level of interest from the hospital managers and doctors. A junior doctor from the RIE, called the 'Acting Surgeon', was responsible for assessing the suitability of patients for Corstorphine House.³⁶ During this period, the post of 'Acting Surgeon' was non-resident and the holder was based at the Royal Infirmary of Edinburgh. Table 6.2 also indicates that during Phase 1, five infirmary surgeons held this post. However, because the holders were normally junior doctors who relinquished the post upon promotion, they remained in the post for a shorter time than most doctors associated with the convalescent homes. Most of the surgeons appointed to the post of 'Acting

³⁶ Most of the patients sent to Corstorphine House came from the RIE.

Surgeon' to the convalescent home later held prominent positions within the Infirmary. As noted in the introduction, Thomas Annandale, the first Acting Surgeon at Corstorphine House, later became Regis Professor of Clinical Surgery, 1877-1907.³⁷ Similarly, Joseph Bell, who replaced Annandale, also became distinguished within the Infirmary with the title of 'Consultant Surgeon'.³⁸ This was also the case with John Chiene who succeeded Bell as Acting Surgeon in 1873 and also became a Professor at the Infirmary.³⁹ The doctors who held the post were therefore already amongst the elite of the junior doctors. Although this does not necessarily confirm that the post of 'Acting Surgeon' for Corstorphine House was a stepping-stone to a higher post, it does suggest that during this phase the post held considerable prestige.

Although the Acting Surgeon for Corstorphine House visited the patients when they were at the Home, the carriage fares recorded in the accounts suggest that he did not make daily calls.⁴⁰ This was probably because Corstorphine House was about four miles from the Infirmary, and with no train station nearby, visits were time-consuming. It also explains why it was necessary to call out a local practitioner, Alexander Matthew, to visit patients. At first, this was only for emergency cases, but later it became a routine practice.⁴¹ In 1884, further changes occurred when the medical practice at Corstorphine House entered Phase 2. During this period, Dr Matthew engaged in a more formal arrangement with the RIE and agreed to attend the patients at Corstorphine House in return for the title, 'Extra Surgeon to the Convalescent House'.⁴² In 1892, Dr Matthew made a further agreement with the

³⁷ A. Logan Turner, *Story of a Great Hospital, The Royal Infirmary of Edinburgh* (Edinburgh, 1937), p. 373.

³⁸ LHB1/194/25, 'Medical and Surgical Officers', Description and Plans of the Convalescent House, Corstorphine (Edinburgh, 1894), p. 3. Joseph Bell retained his interest in Corstorphine House and when a senior doctor, became one of the managers at Corstorphine House. He was also Convenor of the convalescent house and visited the Home regularly.

³⁹ Turner, *Story of a Great Hospital*, pp. 174, 373.

⁴⁰ Goldman, *Lister Ward*, p. 124. During this period, the annual sum for the surgeon's carriage to Corstorphine House was 52 pounds, and the fare was ten shillings a trip. This indicates that the Infirmary doctors made visits perhaps once a week.

⁴¹ LHB 1/194/1. Minutes of the Convalescent Home Committee, Corstorphine House, 8 February 1886.

⁴² *Medical Register*, 1900, p. 1293. In 1900, the Medical Register recorded that Dr Matthew had several public appointments including Parochial Medical Officer and Vaccinator for Corstorphine. He was also previously a Physician for the Royal Hospital for Sick Children in Edinburgh, an appointment with a higher status.

Infirmery that included making a daily visit to the convalescent house, and at other times, when necessary.⁴³ However, Dr Matthew only saw patients while they were at the convalescent home, not in the Infirmery. A doctor at the Infirmery still selected the patients sent to Corstorphine House but no longer visited patients while they were there. Table 6.2 indicates that from 1883 to 1897, this was Joseph Montague Cotterill.⁴⁴ It is not clear how much Dr Matthew knew about the background to the patient's condition. Before 1900, patient records from the Infirmery were kept in ward books and not easily transferable to the convalescent home.⁴⁵ Nevertheless, the infirmery must have sent some information to the Convalescent Home, because there was an entering diagnosis given in their Admission Book.

In March 1897, Corstorphine House opened an extension that provided an extra forty beds, thus almost doubling the size of the Home.⁴⁶ Coincidentally, in the same year, the Infirmery managers commented on the unsatisfactory nature of the information that passed between the Infirmery and Convalescent Home. The additional patients in the new extension might have increased an awareness of communications problems between the two institutions. At a meeting of the Managers at Corstorphine House the minutes read that:

the suggestion of the staff was that the effects upon patients of a residence at the convalescent house were not so satisfactory as it could be and that this was chiefly due to want of connection between the medical services at the infirmery and at the convalescent house and that this might be remedied by the appointment of a resident medical officer for the latter.⁴⁷

⁴³ LHB 1/194/1, Minutes, Corstorphine House, 7 March 1892.

⁴⁴ Turner, *Story of a Great Hospital*, p. 373. Cotterill, later Sir Joseph Montague Cotterill, was an assistant surgeon from 1883-1897.

⁴⁵ The reason the records were not easily transferable was that the Ward Books containing hand written information about the patient belonged to individual physicians and surgeons. Thus, information for numerous patients was written in the same ward book.

⁴⁶ LBH 1/4/96, *Annual Report of the Royal Infirmery of Edinburgh*, 1896-7, p. 27.

⁴⁷ LHB 1/2/9, Minutes, Corstorphine House, 12 March 1897.

The managers therefore decided to make further improvements to the exchange of information between the convalescent home and the infirmary. However, these changes also highlighted deficiencies of the previous arrangements. The minutes recorded:

They consider it important that there should accompany each patient a short statement (not on the card which the patient sees) indicating not only the main disease but also the past treatment and present condition of the patient and any suggestion for the future that the surgeon or physician has to make. In this way, the selecting officer at the infirmary will be better able to judge of suitability and the medical officer at the convalescent house of the line of treatment to adopt.⁴⁸

Although the Committee still insisted that every care should be taken that the 'convalescent house be not transformed into an infirmary', they did make some changes. Corstorphine House thus entered Phase 3, when the managers created a new post at Corstorphine House of Resident Medical Officer. As the title suggests, this medical officer was resident at Corstorphine House, not the Infirmary, as had previously been the case. His duties were to 'take steps to ascertain in reference to the patients admitted, the diagnosis, the Infirmary history, and any suggestions for the treatment which it may be desirable to carry out'.⁴⁹ The Resident Medical Officer also assessed patients at the Infirmary on two days during the week regarding their suitability for the Home. This appointment of Resident Medical Officer was an innovative move by the Infirmary managers, because at that time none of the other convalescent homes in Scotland had a full-time resident doctor. Table 6.2 also indicates that the resident medical officers at Corstorphine House held the post for no more than one year. The Managers selected new applicants annually from junior doctors at the Infirmary. This was significant because the junior position and limited time in the post of Medical Officer provided few opportunities for the Resident

⁴⁸ Ibid.

⁴⁸ Ibid.

⁴⁹ Ibid, 24 May 1897.

Medical Officer to make any changes in the regime. During this period, the Infirmary retained Dr Matthew as the senior doctor. He visited the patients at Corstorphine House once a week and was given a new title of 'Consulting Medical Officer'.

A fourth phase occurred following the outbreak of the First World War (Table 6.2). In 1914, the Infirmary discontinued the post of Resident Medical Officer at Corstorphine House and Dr Matthew remained as the only Medical Officer. The shortage of doctors due to outbreak of war explains the suspension of the post in 1914. Yet it is not clear why the Infirmary failed to reinstate the post of Resident Medical Officer afterwards. Possible reasons were the introduction of individual patient records that were easier to transfer, faster transport links, and the greater use of the telephone. These were all factors that improved communication between the Infirmary and Convalescent Home, and which might have reduced the need for a Resident Medical Officer in the Home. However, the loss of the Resident Medical Officer severed valuable medical links between the Home and the Infirmary and suggests a decline of interest on the part of the Infirmary in the convalescent home. It is also likely that the interest of the infirmary doctors in convalescence was diverted towards the new AAI.

The Glasgow Convalescent Home

Although the working practice of doctors at the GCH was different to that at Corstorphine House, the amount of medical attendance given to patients followed a similar pattern. During the nineteenth century, there was an increase in medical attendance, followed by a decline after the First World War. For most of this period, the GCH employed two different types of doctors. Firstly, there was the Visiting Medical Officer, who attended patients while in the Home. Secondly, there was the Examining Medical Officer who assessed the suitability of patients for admission who had been ill at home. The infirmary doctors referred patients sent directly from the infirmaries.

The background to the Medical Officers at the GCH illustrates that established and

well-qualified local practitioners held this appointment. The first Visiting Medical Officer at the GCH was Dr Bruce Goff. He took up this post when he was thirty-three years old. At that time, he already had an established medical practice in Bothwell. In addition to his MD from Glasgow University, obtained in 1853, he became a Fellow of the Royal College of Physicians of Glasgow two years later. While at the GRI Goff was House Surgeon and later Private Assistant to Professor Lawrie.⁵⁰ Following a further period of medical training in Paris, Goff settled down in Bothwell. The various posts held by Goff included Parochial Medical Officer for Bothwell and medical referee for several assurance societies.⁵¹ His position as an established and well-qualified practitioner in Bothwell, previously connected to the GRI, made him a logical candidate for the post of convalescent home doctor. He probably welcomed the appointment since it enlarged his practice and enjoyed the association with distinguished names on the Board of Directors of the GCH. These included Joseph Lister, John Coats, George Macleod and George Buchanan. Goff resigned from his appointment in 1872 when the GCH moved from Bothwell to Lenzie. The association with the GRI may have benefited Goff, because following his appointment with the GCH he achieved prominence in medical politics. In 1880, Goff became President of the Glasgow and West of Scotland Branch of the BMA and in 1895, he was elected President of the Faculty of Physicians and Surgeons of Glasgow.⁵²

After 1873, when the GCH moved to Lenzie, and the number of beds doubled to sixty-two, the managers appointed an extra Visiting Medical Officer. Both of these medical officers, William Whitelaw⁵³ and Donald Stewart, held a number of other

⁵⁰ J. Jenkinson, M. Moss and I. Russell, *The Royal* (Glasgow, 1994), p. 281.

⁵¹ *Medical Directory*, 1881, p. 941.

⁵² *BMJ*, 17 July 1915, Obituary, p. 122.

⁵³ Appointments of William Whitelaw included, Medical Officer of Health for Kirkintilloch; Medical Officer for Kirkintilloch Trades Annual Society; and Solsgirth and Gartshore Collieries. He was also Medical Officer for the Broomhill Home for Incurables at Kirkintilloch. This was another type of Home, also sponsored by Beatrice Clugston, the founder of the GCH. He also had a number of publications.

appointments.⁵⁴ This suggests that, in common with Goff, they were also established and well-respected practitioners in the community. This was also the case with Dr A. Gray Macintyre who replaced Stewart as Visiting Medical Officer at the GCH.⁵⁵ Sometime between 1911 and 1921, perhaps because of the First World War, Whitelaw retired and was not replaced. Macintyre remained as the sole Visiting Medical Officer at least until 1936. He died in 1939.

From 1873, the GCH also engaged an Examining Medical Officer. He examined prospective patients for admission to the GCH in an office in Bath Street in the centre of Glasgow on two afternoons a week. There were only three examining medical officers between 1873 and 1936 (Table 6.1). This provides a further indication that this was a cherished post for a doctor. The three examining medical officers were also well qualified and both Dr John Wilson and Hugh Thomson had an MD.⁵⁶ Thomson also had numerous other public appointments and publications. He was the only employed doctor ever elected to the Board of Managers as a representative of the Faculty of Physicians.⁵⁷ His successor was another prominent and well-qualified doctor, G. Scott McGregor.⁵⁸

The post of Medical Officer was therefore a valued appointment during the nineteenth and early twentieth century. The amount of medical attendance increased in both convalescent homes until the First World War but thereafter declined. There are

⁵⁴ *Medical Directory*, 1881, p. 987. Donald Stewart's appointments included Medical Officer of the Board of Health and Surgeon to the County Prison, Kirkintilloch, Assistant Surgeon Highland Borderer's Light Infantry, and Medical Referee to several friendly societies. He was President of the Hunterian Society and member of the Archaeological Society of Glasgow

⁵⁵ 'Obituary', *BMJ*, 25 February, 1939, p. 421. At the time of his appointment, Dr Macintyre was also a general practitioner at Lenzie although he had previously held an appointment as an Assistant Physician at the Crichton Royal Institution. In 1938, he was Chairman of the Dumbartonshire Division of the BMA

⁵⁶ *Medical Directory*, 1881, p. 989. The Directory for 1881, only mentioned his honorary membership of the university Medical Society and his appointment as Examining Medical Officer to the GCH.

⁵⁷ *Medical Directory*, 1880, p. 967.

⁵⁸ Scott McGregor trained initially at Edinburgh, completing his medical studies on the continent in Paris, Berlin and Vienna. After graduating, he became Resident Physician to John Halliday Croom, Professor of Midwifery at the Edinburgh Royal Infirmary, but later set up in general practice in Glasgow. He also had a post of clinical tutor at Queen Margaret College where he taught the first women medical students at Glasgow University. He later became Senior Surgeon and Medical Superintendent at Queen Margaret College a post he retained until three years before he died in 1937.

several possible explanations, including the lower level of sickness amongst patients following the First World War. It may also indicate that the higher level of medical supervision of patients by the trained nurses was replacing that supplied by doctors. The annual reports from both Corstorphine House and the GCH also suggest a fall in interest towards the convalescent homes following the First World War. At the GCH, the medical reports became bland and contained only statistics on aspects of the patients, such as the annual number admitted, gender and age.⁵⁹ Similarly, until the First World War, reports on Corstorphine House in the annual reports for the RIE usually amounted to several paragraphs, but after 1914, this declined to only a sentence or two.

Doctors in other Convalescent Homes

The involvement of doctors in other convalescent homes followed a similar pattern to those at Corstorphine House or GCH, with doctors having two functions. The first was to assess the suitability of patients for admission and the second to attend to them while in the convalescent home. Sometimes, one doctor undertook both tasks but on other occasions there was one doctor for each function. At Broughty Ferry CH, (attached to the Dundee Royal Infirmary), patients were first examined by an infirmary doctor before admission to the convalescent home. These patients were admitted from patients both inside and outside the infirmary. A general practitioner rather than an infirmary doctor was appointed as Visiting Medical Officer at Broughty Ferry CH.⁶⁰ At non-hospital convalescent homes such as the Dunoon Homes, the organisation was similar to the GCH, but with one Visiting Medical Officer and one Examining Medical Officer. However, the Directors of Seamill expected their Visiting Medical Officer to examine the patients beforehand. This may have been the case at the Dundee Convalescent House, Kilmun, Seamill and the Mission Coast Home as their annual reports do not refer to an examining Medical Officer. However, during the 1930s, before dispatching children to Ashgrove CH, a

⁵⁹ ML G.362.160941435, *Fifty-Eighth AR, GCH*, 1922, p. 9; *Seventy-Second AR, GCH*, 1936, p. 9.

⁶⁰ 'Dundee Convalescent Home', *Dundee Advertiser*, 18 February 1884.

medical officer examined the children beforehand in Glasgow.⁶¹ Although their duties therefore varied, overall most convalescent homes employed either one or two a medical officers to examine patients before admission and attend them when in the Home.

Doctors as Managers

Despite a generalised apathy from doctors towards convalescence as an aspect of medicine, many still took a social interest in the convalescent homes. According to David Stewart and Monica Burnett, Dr Brodie Cruikshank, spent twelve years promoting the Nairn CH, from 1897 until his death in 1925.⁶² Dr James Finlayson's interest in promoting Ravenscraig CH was such that, following his death in 1906, the Home named a ward in his memory.⁶³ Other doctors were also found on the management committees of several convalescent homes. As mentioned in Chapter Two, in 1895, James Burn Russell was on the Management Committee of the Hozier Home.⁶⁴ Further examples of doctors within the management of convalescent homes included the MOH for Aberdeen, between 1888 and 1923, Dr Mathew Hay. Hay was one of the founding members of the Children's Fresh Air Fortnight and Ailing Children's Home, (the organisation that established Linn Moor).⁶⁵ At Newhills, Dr Walter Reid was Chairman of the Management Committee from 1908 until 1945.⁶⁶ At Ravenscraig CH in 1937, Drs R. Barclay Ness and Archibald Young were on the Board of Directors.⁶⁷ In addition, at the Scottish Children's Convalescent Home in 1937, Drs Chalmers Smith and William Cullen were on the Board of Directors and

⁶¹ ML G.362 7809411435, *Forty Sixth Annual Report of the Glasgow Poor Children's Fresh-Air Fortnight and Cripple Children's League*, 1930, p. 5. [Ashgrove CH].

⁶² D. Stewart and M. Burnett, *100 years of the Convalescent Home, Nairn* (Nairn, 1993), p. 3.

⁶³ 'Trinity Church Children's Convalescent Home', *GMJ*, July 1907, p. 37.

⁶⁴ GGHB HB 7/1/1, *AR of the Lady Hozier Convalescent Home*, 1895, p. 1.

⁶⁵ ACL 362/78/L64, *Children's Fresh Air Fortnight Report of the First Seasons Work*, 1899, p. 2; ACL 362/78/L64, *AR of the Children's Fresh-Air Fortnight and Ailing Home*, 1882, p. 2; The involvement of Matthew Hay is also mentioned in L. A. Wilson, 'Matthew Hay, 1855-1932', in George P. Milne, ed., *Aberdeen Medico-Chirurgical Society, A Bicentennial History* (Aberdeen, 1989), p. 194.

⁶⁶ GRHB 9/3/2, Historical Note, for Newhills Sanatorium and Convalescent Home, 1908 -1954.

⁶⁷ ML G.362.1676360, *Annual Report of the Ravenscraig Children's Convalescent Home*, 1936-37, p. 2.

the House Committee.⁶⁸ At the Gilmerton CH in Edinburgh in 1940, Drs R. A. Fleming and George MacKay were on the Management Committee and were also Trustees for the Home.⁶⁹ The presence of doctors within the management of convalescent homes indicates that the regime was not entirely within lay control. The doctors could have influenced changes, but there is no evidence that they attempted to alter the methods or practice within the convalescent homes. This was especially so at the GCH where several influential and eminent doctors were on the Board of Management.⁷⁰ They included: Drs William Lyon, John Coats, Scott Orr, James Steven, Ebenezer Watson, George Buchanan, W. K. Chalmers and Professor Joseph Lister. Despite the inclusion of elite members of the medical profession on the Board, there is little evidence to suggest that they used their influence to direct policy decisions. Lack of concern was indicated by the low turnout of doctors on the Board of Management at their AGM's. Typically, in 1867, when John Coats, Joseph Lister, Scott Orr, George Buchanan and George Macleod were on the Board of Management at the GCH, only George Macleod attended the AGM.⁷¹

This was also the case at Corstorphine House where there were numerous influential doctors involved in the management. Although they had the opportunity to suggest changes in the methods of treating patients, they did not use their influence. Instead matters discussed by the doctors on the Special Committee were mostly non-medical. For example, in 1895, the Committee discussed the alteration of one of the windows in the smoking room and the separation of the croquet and bowling greens with an iron fence rather than any aspect of treatment for patients.⁷² Although apathy towards convalescence may have played a part in the lack of initiative from the managers to

⁶⁸ ML G.362.1676360, *AR, Ravenscraig*, 1936-37, p. 3.

⁶⁹ NLS GD.409/25/1, *AR for the Gilmerton Convalescent Homes*, 1940, p. 2.

⁷⁰ GUL Sp. Coll, BG54-c.1, 'Rules of the Constitution of the Glasgow Convalescent Home'. The managers included: one manager by the Town Council of the City of Glasgow, two managers by the directors of the Glasgow Royal Infirmary, two managers of the medical officers of the Glasgow Royal Infirmary, one manager by the Senatus of the University of Glasgow, one manager by the Faculty of Physicians and Surgeons in Glasgow, one manager by the Merchants House of Glasgow; One manager by the Trades House of Glasgow and six managers from the Subscribers to the Convalescent Home.

⁷¹ ML G.362.160941435, *Second AR, GCH*, 1867, p. 2.

⁷² LBH 1-2/9, Minutes, Corstorphine House, 23 April 1894.

initiate changes, the high demand for admission suggested satisfaction of the existing situation. This may have given the managers further cause to resist change. In 1897 the committee reported that 'they were of the opinion that every care should be taken that the convalescent house be not transformed into an infirmary and they are not prepared to recommend any alteration in the rules of admission to the Home'.⁷³

However, changes within organised convalescence did eventually take place when the funds from David Ainslie's bequest became available to the managers of the RIE to build a new convalescent home. The immense wealth of the bequest enabled the Infirmary to employ far greater numbers of staff. The doctors employed were also full time and had far greater control over the treatment offered to the patients.⁷⁴ There was also greater interest from doctors on the Board of Management, particularly Sir Robert Philip (1857-1939) and Alexander Miles (1865-1953). Miles and Philip were far more active as managers of the AAI than doctors in most other convalescent homes. It was perhaps because they were both retired and therefore had the time, plus interest to play major role in shaping the initial policy at AAI.⁷⁵ The first Medical Superintendent, Lt Colonel Cunningham, was far more involved than any of the Medical Officers in traditional convalescent homes. Cunningham also wrote extensively about the AAI and aspects of convalescence.⁷⁶ In addition, the structure of his appointment was entirely different because it was a full-time, resident and senior appointment. In contrast, most medical officers in other convalescent homes

⁷³ LBH 1-2/9, Minutes, Corstorphine House, 12 March 1897.

⁷⁴ Ibid.

⁷⁴ The Board of Management contained: five persons representing the Royal Infirmary; one person appointed by the Senators of the College of Justice; one person appointed by the Royal College of Physicians in Edinburgh; one person appointed by the Royal College of Surgeons in Edinburgh; one person appointed by the Chamber of Commerce; one person appointed by the Society of Accountants, one person appointed by the Edinburgh Presbytery of the Church of Scotland; one person appointed by the London Provost, Magistrates and Councillors of the City of Edinburgh.

⁷⁵ C. F. Paterson, 'The Development of Occupational Therapy in Scotland 1900-1960', unpublished PhD thesis, (University of Aberdeen, 2002), p. 7.

⁷⁵ Paterson, 'Occupational Therapy', pp. 126-132.

⁷⁶ Quoted in C. Paterson, 'Occupational Therapy', p. 7; Articles written by J. Cunningham included, 'Occupational Therapy: Methods used in a Convalescent Hospital', *British Journal of Physical Medicine*, July (1936), pp. 53-55; 'Recovery and Rehabilitation', *EMJ*, 45 (10), (1938), pp. 712-725; 'Occupational Therapy', *EMJ*, 47 (1940), pp. 96-109; 'Rehabilitation of the War Worker', *Nursing Times*, 21 March 1942, pp. 192-195.

were mostly part time and non-resident.⁷⁷

However, the AAI did not appoint Cunningham as Medical Superintendent until 1929. When the Home first opened in 1923, the managers appointed a Resident Medical Officer, Dr Mary Mears. She was at the beginning of her medical career, having qualified only in 1921.⁷⁸ When Cunningham, a senior ex-army medical officer, was appointed as Medical Superintendent in 1929, they promoted Mary Mears to Assistant Medical Superintendent. Then in 1934, the AAI appointed another Resident Medical Officer, Dr W.H.F. Wilson. Wilson had just completed his first two-year residency at the Royal Infirmary of Edinburgh.⁷⁹ The AAI therefore had three full-time medical officers whereas at Corstorphine House, there was only one part-timer. In addition to the doctors, the AAI had two masseuses and a dispenser in the pharmacy. There were far more nurses at the AAI than traditional convalescent homes. By the 1930s, they employed a matron, assistant matron, three sisters, two staff nurses and ten probationers. They also appointed an occupational therapist, Amy de Brisay, in 1933.⁸⁰ The AAI therefore represented a sharp contrast to Corstorphine House and the GCH, which were without such new specialists and where medical attendance of doctors declined after the First World War. It is therefore not surprising that the higher staffing levels and opportunities for their greater involvement in the methods used meant that doctors grasped the concept of the new convalescence with enthusiasm. Yet they did so without fully considering the effectiveness of the treatment in the traditional convalescent homes.

Domestics and Nurses

Matrons

Although the medical skills of doctors were important to the convalescent homes, the Matron was the key person responsible for care of patients, supervision of domestic

⁷⁷ Smith, *Streamlet and the Town*, p. 37. An exception was the post full time medical officer at Corstorphine House from the end of the nineteenth century to 1914.

⁷⁸ Paterson, 'Occupational Therapy', pp. 11-12.

⁷⁹ *Ibid.*, p. 25.

⁸⁰ *Ibid.*

and nursing staff, and general running of the home. During the period 1860 to 1939, convalescent homes made various changes in the practice of nursing. A major change that took place was in the importance attached to nurse training. For instance, in the 1860s and 1870s few convalescent homes employed a trained nurse but by 1939, most homes had at least one. Also, in the mid-nineteenth century, when appointing a new matron, both convalescent homes and infirmaries considered housekeeping more important than medical skills. In 1853, for instance, Miss Wardroper's superior housekeeping skills clinched her appointment as Matron of St Thomas', not her knowledge of nursing.⁸¹ The emphasis upon housekeeping rather than nursing meant it was not unusual to refer to the matron in a convalescent home as 'Housekeeper'.⁸² For example, in 1871, the annual reports of Corstorphine House refer to Sarah Coombes, as a 'Housekeeper', although the census returns for 1871 recorded her title as the 'Matron'.⁸³ Subsequently, the Managers at Corstorphine House dropped 'Housekeeper', and thereafter used the term 'Matron'. The Aberdeen Royal Infirmary also referred to the Matron of their new Home as 'Housekeeper'. They also appeared to value housekeeping skills above those of nursing.

The Committee were prepared to engage a married couple without encumbrance to be resident at the Convalescent Hospital and take charge thereof – the duties of the man to consist of keeping the grounds with a general care of the premises, the duties of the wife to partake of the nature of housekeeping. Salary per annum £45 with rations fire and light.⁸⁴

This extract also indicates that the Convalescent Home Committee was seeking a husband and wife team. The appointment of a married couple in several convalescent homes was common practice during the nineteenth century, but later it declined. An

⁸¹ R. Dingwall, A. M. Rafferty and C. Webster, *An introduction to the Social History of Nursing* (London, 1998), p. 51.

⁸² Matrons of the voluntary hospitals were also given a variety of different titles, before the mid-nineteenth century including, 'housekeeper'. Rona Gaffney notes the emphasis on housekeeping in the matron's duties in the voluntary hospitals in R. Gaffney, 'Women as Doctors and Nurses', in O. Checkland and M. Lamb, eds., *Health Care as Social History* (Aberdeen, 1982), p. 143.

⁸³ LHB1/4/71, 'Managers Report', AR, RIE, 1871, p. 4.

⁸⁴ GRHB 10/1/1, Minute Book of the Aberdeen Convalescent Hospital, 15 October 1873.

exception was the Dunoon Homes, where the tradition of appointing a married couple as Superintendent and Matron continued until at least 1933. Most convalescent homes had dropped the title of 'Housekeeper' by the end of the century. The last matron identified as a 'Housekeeper' was Elizabeth Massie of the Northern Infirmary Convalescent Home at Bona. The Home gave her this title despite her nurse training at the Cumberland Infirmary, Carlisle.⁸⁵

In common with Bona, many other convalescent homes began to appoint trained nurses during the later part of the nineteenth century. During the 1890s, when the three voluntary hospitals in Glasgow, the GRI, the Western Infirmary and the Victoria Infirmary, opened their convalescent homes, all their matrons were trained nurses. The Schaw Home incorporated the appointment of a trained nurse into its rules, but still stressed the importance of her role as housekeeper.

A matron who is a trained nurse will be appointed by the managers. She will be in charge of the housekeeping and general management of the home, the appointment and dismissal of servants and shall consult with the superintendent about the appointment and dismissal of nurses and night duty alternately.⁸⁶

From the beginning of the twentieth century many non-hospital convalescent homes also appointed trained nurses as matrons. For instance, in 1905, the new Matron at Kilmun was Mary Brown, a nurse trained at the Western Infirmary, Glasgow.⁸⁷ Around the same period in 1908, Newhills also decided to appoint a trained nurse as their new matron.⁸⁸ Even the smaller non-hospital homes, such as the Lady Ailsa's Convalescent Home, with only ten beds, appointed a trained nurse as Matron.⁸⁹

⁸⁵ *British Journal of Nursing*, 3 January 1903, p. 7. Before Elizabeth Massie was appointed as Housekeeper/Matron at Bona, she was the night superintendent at the Northern Infirmary in 1903.

⁸⁶ GGHB HB 52/1/7, 'Rules of the Schaw Convalescent Home'.

⁸⁷ *British Journal of Nursing*, 29 April 1905, p. 328.

⁸⁸ GRHB 9/1/1, Minute Book for Newhills Convalescent Home and Sanatorium 1908.

⁸⁹ LHB 1/4/86, *Annual Report of the Royal Infirmary of Edinburgh*, 1886-1887, p. 9. This appointment was mentioned in the annual reports of the RIE.

Women appointed as matrons were usually from a higher social background. This perhaps explains why hospitals and convalescent homes, such as the Brooksby (attached to the Victoria Infirmary), sometimes gave their matrons the title of 'Lady Superintendent'.⁹⁰ Mary Coats, one of the first 'Lady Superintendents' at the Brooksby, had a typical middle class background. Her father was Allan Coats, a Renfrewshire merchant related to the wealthy Scottish cotton-manufacturing firm of J. and P. Coats. Mary Coat's niece suggested that her aunt took up nursing because she blamed the death of her brother from diphtheria on the family's ignorance of nursing, rather than through the necessity to secure paid employment.⁹¹

The backgrounds of another three convalescent home matrons provide further evidence of their higher social status. These three matrons received only one year of nurse training at the RIE before taking up a permanent post. This was significant because, until around 1900, lady probationers undertook only one year of training. This was instead of the usual two years that hospitals required for other nurses.⁹² The brief biographical details of these three matrons indicate that the appointment to convalescent home matron was a promotion, not merely a semi-retirement post for an older nurse. The first of the matrons was Emma Nutchley. Following her nurse training from 1888 to 1889, she remained at the RIE in a variety of posts. In 1896, she was appointed to the superintending staff. In April 1897, the Infirmary authorities appointed her as Day Assistant Superintendent in charge of the Nurses' Home. In April 1898, they promoted her again to the post of Matron of the Corstorphine House. Her reference from the Lady Superintendent of Nurses reported:

Miss Nutchley had proved thoroughly capable in her housekeeping and management, takes a great interest in all her work and maintains good

⁹⁰ Dingwall, et al, *Social History of Nursing*, p. 15.

⁹¹ I. Macdonald, *A Family in Skye* (Stornoway, 1980), p. 7.

⁹² S. McGann, *The Battle of the Nurses* (London, 1992), p. 161.

discipline among the nurses and servants, keeps the Nurses Home in excellent order and shows considerable powers of organisation.⁹³

Remarks in the Nurses' Register also described her thus: 'Very capable, thorough, highly conscientious, gentle and kindly, managed ward work and patients quietly and well. Altogether an excellent nurse.'⁹⁴

The Nurses Register described the second of these matrons, Isabel Fergusson, as 'single and formerly a dressmaker'. Fergusson underwent training at the RIE from 30 May 1876 to 6 July 1877. Remarks made in the Register included: 'She is slow to learn but learned well. Has a kindly manner and is much liked. Conduct excellent. She did very good service in charge of wards 20 and 21 and left us to become Night Superintendent at the Western Infirmary Glasgow, in 1886.' Later the Dundee Royal Infirmary appointed Miss Fergusson as Matron of Broughty Ferry CH. However, this appointment did not last very long, because she left to marry after only a few years.⁹⁵

Finally, the third matron was Elizabeth Hird, who underwent training from 1 July to 20 June 1902. She was then aged 29, single, and with a parental home in Montrose. The Nurses Register commented: 'She proved a very sensible conscientious and dependable nurse, methodical and thorough in her work, kindly and devoted to the care of patient and of excellent conduct.'⁹⁶ Miss Hird became a staff nurse in 1902, and after several posts in the RIE, became Sister at Corstorphine House in 1905. Two years later, she left to take up a post as assistant matron at a private nursing institute in Swansea in 1907. She returned in 1909 to Corstorphine House, was appointed Matron in 1920, and retired in October, 1931.⁹⁷

⁹³ LHB 1/2/9, Minutes, Corstorphine House, 14 February 1898.

⁹⁴ LHB 194/23, Register of Nurse Training at Royal Infirmary of Edinburgh.

⁹⁵ Ibid. Broughty Ferry was the convalescent home of the Dundee Royal Infirmary.

⁹⁶ Ibid.

⁹⁷ Ibid.

The relatively long periods served by matrons suggest that the post of matron in a convalescent home was equal in popularity to that of a Medical Officer. There were occasional exceptions, such as Elizabeth Massie, who remained at Bona for only four years and left for another appointment at Morningfield Hospital.⁹⁸ The isolation of Bona and the small size of the home may have prompted her to move. Nurses or matrons were also far more likely than men to resign their posts through marriage or family obligations. Mary Coats was appointed Matron to the Brooksby in 1903, and remained in this post until 1918, when she resigned in order to care for her family.⁹⁹ Examples of other convalescent home matrons that stayed for relatively long periods were: Mary Blair, Matron at Kilmun from 1878 to 1906 (twenty-eight years), Miss MacGregor, matron at Nairn CH from 1897 to 1924 (twenty-seven years), Jessie Lemmon, who served from 1909 to 1926 (seventeen years) at Newhills and Miss Campbell, who was Matron at Seamill from 1912 to 1931 (nineteen years). Miss Nutchley was associated with Corstorphine House for twenty-six years; she was Matron for eleven of these years. At the Dunoon Homes there were only three married couples appointed jointly as Matron and Superintendent during the period 1867 to 1933. For the first eighteen years, John and Janet Campbell, were Matron and Superintendent. They were followed, firstly by Mr and Mrs Andrew Wilson, and secondly, by Mrs and Mrs Scott Wilson.¹⁰⁰ Further indication of the popularity of the appointment is shown by the ninety-five replies received to the advertisement for a superintendent and matron/housekeeper at the Aberdeen Convalescent Hospital in 1874.¹⁰¹

However, the post of Matron in a convalescent home demanded most, and probably more, of the supervisory skills necessary to be a hospital matron. Given that most patients at convalescent homes were relatively young adults who had sufficiently recovered to be tempted to ignore the rules and regulations, control of patients was a

⁹⁸ Northern Counties Convalescent Home, Visitors Book, 2 April 1907.

⁹⁹ Macdonald, *Family in Skye*, p. 7.

¹⁰⁰ ML G.362.160941435, ARs WSCSH, 1885, 1894, 1901, and GWSCSH, 1933. [Dunoon Homes].

¹⁰¹ Another example occurred in 1925, when Linn Moor, the children's convalescent home near Aberdeen, experienced big response to an advertisement for a matron in 1925.

major issue in most convalescent homes.¹⁰² A description of Mary Coats when she was District Nurse at Tarbet suggests the time she spent in this Argyllshire fishing village was an ideal training ground for the duties of a convalescent home matron. Her niece noted: 'It is easy to imagine Aunt Mary moving in the shore-background of Para Handy, delivering babies, patching up after festive evenings when the boats were in, and giving good advice or scoldings in broad and pungent Scots'.¹⁰³

The matron expected to have absolute authority over patients, staff and the running of the household. For instance, when a new Resident Medical Officer challenged the authority of Miss Fergusson, Matron at Corstorphine House, she resigned. This was despite a statement from the Managers at Corstorphine House that the 'Resident Medical Officer should have no concern with the general management of the house which should remain with the Matron. He should concern himself solely with the medical and surgical care of the patients'.¹⁰⁴ According to the managers, Miss Fergusson eventually resigned because:

She had experienced great difficulty in keeping up the discipline of the house owing to the fact that the power of dismissing patients for fault and allowing patients out on pass was now exercised by the resident medical officer - several cases having occurred where that gentleman's views did not coincide with her own.¹⁰⁵

Miss Fergusson therefore believed that the convalescent home authorities had allowed the Medical Officer to undermine her authority. However, this was an unusual incident and at other convalescent homes relations between medical staff and the matron appeared harmonious. Convalescent homes also incorporated strict obedience to the Matron into their rules. For example, at Seamill, the Matron had the power to dismiss any servant or patient under her charge without previous warning for any

¹⁰² Macdonald, *Family in Skye*, p. 7.

¹⁰³ Ibid.

¹⁰⁴ LBH 1-2/9, Minutes, Corstorphine House, 7 October 1897.

¹⁰⁵ LBH 1-2/9, Minutes, Corstorphine House, 20 January 1898.

breach of the rules of the home, or for any other misbehaviour.¹⁰⁶ There is evidence that the Matron used her authority. For example, in 1898, the matron at Seamill reported that she had expelled patients on two occasions for being under the influence of drink.¹⁰⁷

By the outbreak of the First World War, their professionalisation was developing and most matrons were hospital trained. Furthermore, in the hospital convalescent homes they were often responsible for training other nurses and still responsible for running of the household. Nevertheless, although the Matron had considerable responsibility both in terms of authority, management and care of the patients, it was usually the convalescent home doctor (normally non-resident and part-time) who wrote the medical report for the annual report.¹⁰⁸

Nurses and Domestics

Until the later nineteenth century many convalescent homes did not employ any nurses apart from the Matron. This was the case at the Dunoon Homes, despite its position as the largest convalescent home in Scotland.¹⁰⁹ Yet, as indicated in Chapter Four, patients in convalescent homes during the nineteenth century were often quite sick. Many patients were suffering from tuberculosis, or were debilitated after long illnesses or drastic surgery. Who then nursed the weaker convalescent patients? The Matron's responsibilities for management of the household would have left little time for extensive nursing of patients, although she might have undertaken some limited nursing duties. It is likely that the stronger patients helped those in a weaker condition because this was common practice in hospitals.¹¹⁰ However, it is also possible that some of the domestic servants also performed some nursing duties.

¹⁰⁶ GCA, CWS1/33/3/1, Rule 21, Bylaw's to be Observed at the Co-operative Homes' c.1900.

¹⁰⁷ GCA, CWS1/33/3/1, Co-operative Seaside Homes, Minute Books, 26 February 1898 and 2 August 1898.

¹⁰⁸ Kilmun was the only convalescent home identified as having the medical report written by the Matron, but even here, only relevant sections were published in their annual report.

¹⁰⁹ The section on domestic staff continues the discussion on implications of the lack of nurses.

¹¹⁰ B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), p. 4.

Florence Nightingale believed that nursing was the responsibility of all women. In her *Notes on Nursing* she stressed that 'every women, in England [presumably Scotland too], has, at one time or another of her life, charge of the personal health of somebody, whether child or invalid – in other words, every women is a nurse'.¹¹¹

Isabella Beeton's popular book on *Household Management* that included a chapter on 'Duties of the Sick Nurse' under the section on 'Domestic Servants' also highlighted the association between nursing and women.¹¹² In this book Mrs Beeton echoed remarks made by Florence Nightingale that 'all women are likely, at some period of their lives, to be called on to perform the duties of a sick-nurse, and should prepare themselves as much as possible.'¹¹³ She also commented that there were occasions when 'some of the female servants of the establishment must give their attendance in the sick room.'¹¹⁴ It is therefore entirely possible that, given the expectations of nursing duties from women and servants, some domestic staff in convalescent homes were involved in the nursing care of patients.

Florence Nightingale's widely read *Notes on Nursing* also revealed the difficulties of differentiating between nursing and domestic work. Most of the topics featured in this book were strongly associated with domestic work such as how to clean properly, ventilation, fresh air and diet. The only subject she discusses that has more to do with nursing than domestic work is the section on 'observation of the sick'. Recent histories also comment on the overlap between domestic work and nursing. R. Dingwall *et al*, for example, comments that the low level of technology during the nineteenth century meant that duties of the forerunners of modern nurses were similar to those associated with domestic servants.¹¹⁵

¹¹¹ F. Nightingale, *Notes on Nursing* (first published, 1859, Glasgow, 1974 edition) p. 4.

¹¹² Isabella Beeton, 'Duties of the Sick Nurse', in Beeton's *Book of Household Management*, (sixth edn. 1991), pp. 1071-1020. Despite the title, the Chapter focussed on the organisation of the sick room rather than the duties of the sick nurse.

¹¹³ Beeton, 'Duties of the Sick Nurse' p. 1017.

¹¹⁴ *Ibid.*

¹¹⁵ Dingwall *et al*, *Social History of Nursing*, p. 18; See also, Abel-Smith, *History of Nursing*, p. 4; W. Hector, *The Work of Mrs Bedford Fenwick and the Rise of Professional Nursing* (London, 1973), p. 27.

Table 6.3, draws attention to the fact that in 1871, when the GCH admitted five hundred and twelve patients annually, they employed only four domestic servants. These comprised one male assistant and three domestic servants.¹¹⁶ After the GCH had moved to Lenzie, and with an annual intake of 1381 patients, there were still only eight servants. The census of 1881 described these as a male assistant, one cook, four housemaids, a kitchen maid and a house joiner. Although half their patients came from the GRI in 1881, and had undergone serious operations, they still did not employ any nurses other than the Matron.

Table 6.3

Resident staff at Corstorphine House, GCH and Dunoon Homes, 1871 and 1881

	1871	1871	1881	1881
Name of convalescent home	Resident staff	Total patients per annum	Resident staff	Total patients per annum
Corstorphine House	8 (includes 2 nurses and matron)	486	8 (includes 3 nurses and Matron)	872
GCH	5 (includes Matron)	512	9 (includes Matron)	1381
Dunoon Homes	7 (includes Matron)	1235	13 (includes Matron)	2599

Sources: *Census Enumerator Books*, 1871, 1881

Table 6.3 also indicates that a similar situation existed at the Dunoon Homes. In 1871, when 1235 patients were admitted, there were seven domestic staff members. It comprised the matron and the superintendent, a cook, two housemaids, a gardener and a boot boy.¹¹⁷ By 1881, when the annual number of patients had risen to 2,367, the number of domestic staff had risen to twelve. This included a cook, eight housemaids, a gardener, and a male assistant, plus the matron, but still no nurses. The absence of nursing staff at the GCH and the Dunoon Homes suggests that domestic staff and the Matron must have undertaken some nursing duties. By 1897, Burdett's did not record the employment of nurses at the Dunoon Homes and the GCH one nurse in addition to the matron.¹¹⁸

¹¹⁶ Census enumerator books, 1871.

¹¹⁷ Census enumerator books, 1881.

¹¹⁸ *Burdetts', Hospitals and Charities* (London, 1899).

Corstorphine House was one of the few convalescent homes to employ nurses during the nineteenth century. Table 6.3 indicates that in 1871, there were two nurses, the Matron plus five resident domestic staff. These consisted of a porter, a cook, two housemaids and a laundry maid. In 1881, when the annual patients admitted to Corstorphine House rose to 872, the number of nurses increased to three, but the servants were one housemaid, a laundry maid, cook and a porter.¹¹⁹ The replacement of one of the servants by a nurse suggests that servants might previously have undertaken nursing duties.

By the latter part of the nineteenth century many convalescent homes were employing at least one trained nurse, in addition to the Matron. As trained nurses became more common in convalescent homes, the distinction between the work undertaken by nurses and domestic staff became clearer. The trained nurses took over some responsibilities formerly undertaken by junior doctors such as taking temperatures and the dressing of wounds.¹²⁰ The annual report for the GCH in 1888 revealed that the employment of a trained nurse was a new venture for the Directors, requiring their careful consideration. Remarks in their annual report indicate that the initiative for this action came from outside the home. They stated that:

During the year a representation had been made to the Directors that, by admitting into the Home, a little earlier than formerly, patients recovering from surgical diseases and operations whose complaints only required such attention and dressing as in Hospital are given by the nurses, a great benefit would be conferred on such patients and would have the effect from the change of air and otherwise of healing their wounds much quicker, and thereby enable them to get sooner back to their work. To make this change it was pointed out that a trained nurse would be required at the Home. After due consideration and keeping in view the benefits that would accrue to the

¹¹⁹ There may also have been non-resident staff employed.

¹²⁰ M. E. Baly, 'The Nightingale Nurses: The Myth and the Reality', in C. Maggs, ed., *Nursing History: The State of the Art* (London, 1987), pp. 41-42.

patient, the Directors resolved to give the new system a trial. They therefore in the month of September engaged a trained nurse and since then the new arrangement has given great satisfaction.¹²¹

Although the GCH did not reveal the source of the suggestion that they might employ a trained nurse, it is possible that COS was involved, because at the time they were campaigning for higher levels of nursing supervision in convalescent homes. The GCH did not increase the number of nurses beyond one nurse, despite the rise in the bed numbers. In 1928, the nursing staff still consisted of only the Matron and one nurse.¹²²

By the end of the nineteenth century, the number of nurses employed by Corstorphine House had risen to six. This was due mainly to the introduction of probationer nurses. The reason underlying the decision to send probationers from the Infirmary to Corstorphine House might have resulted from increasing number of nurses in training at the RIE. In addition, the 'management of convalescents' was amongst the listed duties of a nurse at St Thomas' Hospital. They often took the lead in initiating policies on nurse training at other hospitals, particularly at the RIE.¹²³ Probationers were also a source of cheap labour and therefore an attractive proposition for managers.

Several other convalescent homes attached to infirmaries such as the Muirfield CH and the Aberdeen Convalescent Hospital also used probationers. In 1897, the Aberdeen Convalescent Hospital was still a very small home, and had only one probationer. By 1912, the number of probationers had risen to two, plus a sister.¹²⁴ At Muirfield, the convalescent home attached to Edinburgh Sick Children's Hospital, a sister worked under the direction of the Matron of the Children's Hospital. In addition, there was one staff nurse and two probationers that changed every two

¹²¹ ML G.362.160941435, *Twenty-Fifth AR, GCH*, 1889, p. 6.

¹²² *Burdett's Hospitals and Charities* (London, 1930), p. 794.

¹²³ Dingwall et al, *Social History of Nursing* (London, 1988), p. 55.

¹²⁴ *Burdett's Hospitals and Charities* (London, 1914), p. 611.

months.¹²⁵ The number of probationers at Corstorphine House, at between three and five, was therefore one of the highest.¹²⁶ However, not all the convalescent homes attached to infirmaries used probationers. There was no evidence of probationers at any of the convalescent homes attached to three Glasgow Hospitals: the GRI, the Victoria Infirmary or the Western Infirmary of Glasgow.

Despite the pleasant location of Corstorphine House, which might have attracted probationers, the dropout rate was as high as nursing in the infirmaries. This was a common problem elsewhere in Britain, due mainly to the long hours and hard work.¹²⁷

Table 6.4

Reason for probationers leaving Corstorphine House between 1910 and 1921

Reason for Leaving	Number of nurses
Went home	6
Unsuitable	4
Left because of ill health	5
Further training or another hospital	11
No reason given	11

Source: Nurses' Register Book – Corstorphine House

Table 6.4 indicates that, out of 37 probationers sent to Corstorphine House, only 11 went on for further training or to another hospital between 1910 and 1921. Others left because of ill health, went home or were considered by the Matron as 'unsuitable'. Many of the probationers came from middle-class backgrounds and were unfamiliar with the hard physical labour and long hours demanded by nurse training.

Although there were numerous missing entries in the records, Table 6.5 indicates that 'farmer' was the most commonly recorded paternal occupation amongst probationers.

¹²⁵ *British Journal of Nursing*, 11 December 1909, p. 485.

¹²⁶ *Burdett's Hospitals and Charities* (London, 1899), p. 621.

¹²⁷ Baly, 'Myth and the Reality', pp. 38-39; Hector, *Bedford Fenwick*, p. 30-34.

Table 6.5 Paternal occupation of probationer nurses at Corstorphine House between 1910 and 1921

Occupation of Father	Number
Farmer	13
Schoolteacher	3
Shopkeeper or merchant	3
Doctor	1
Clergyman	1
Organist	1
Cashier	1
Gamekeeper	1
Not recorded	15

Source: Nurses' Register Book, Corstorphine House

The daughters of small farmers were favoured as suitable candidates for nurses as they were more familiar with household work.¹²⁸ Apart from the gamekeeper, the remainder of the paternal occupations on the list was predominantly middle-class. They included a doctor, clergyman, organist, and a cashier.

Although the number of servants in domestic households declined after the First World War the same did not happen at Corstorphine House. The decline of domestic servants in general household resulted mainly from the increased opportunities for work with less social stigma and drudgery, fewer restrictions and shorter working hours in offices, shops and catering industry. There was less of a decline in domestic service in clubs, hotels or restaurants.¹²⁹ It is possible that domestic work in a convalescent home, like catering, had less of a social stigma than work in a domestic household. However, Corstorphine House was only one convalescent home and comparative figures were not available for domestics at other convalescent homes.

¹²⁸ B. Abel-Smith, *History of the Nursing Profession* (London, 1960), p. 4.

¹²⁹ P. Horn, *The Rise and Fall of the Victorian Servant* (Dublin, 1975), pp. 167-183.

Table 6.6

Nursing and domestic staff at Corstorphine House in selected years between 1871-1929

Year	Nurses (inc. Matron)	Domestics	Patients
1871	3	5	486
1881	4	4	872
1890 (1891 low figure due to construction of a new extension)	4 (1891)	5 (1891)	1101 (1890) 620 (1891)
1912	7	12	1189
1917	6	14	1178
1923	7	14	1474
1929	7	14	1637

Sources: 1871,1881,1891, census enumerator books/annual reports of the Royal Infirmary of Edinburgh: 1912, 1917, 1923 and 1929, staff registers and annual reports of the Edinburgh Royal Infirmary.

Table 6.6 indicates the steady rise in the number of servants and nurses at Corstorphine House. This increase continued during and after the First World War. By 1912, Corstorphine House employed seven nurses, including the matron and twelve domestic servants, despite the annual intake of patients remaining the same. Table 6.6 indicates that the number of servants at Corstorphine House rose even higher for the years 1917 to 1929. This can be partly explained by the appearance of several new job titles such as matron's maid, nurse's maid and ward maid.¹³⁰ The allocation of a maid for the nurses is a further sign of the increased status of nurses and the growing demarcation between nursing and domestic work. The increased numbers of domestic staff may have enabled the trained nurses to concentrate on nursing rather than domestic chores, thereby making attendance by doctors even less necessary.

Conclusion

During the nineteenth century, although usually part-time, the post of Medical Officer in a convalescent home was a coveted position. This was despite a generalised lack of interest from doctors in convalescence as a specialist area of medicine. One reason for the popularity of the post during the nineteenth century was that it often supplemented a meagre income in an overcrowded profession. Many of the Medical Officers in convalescent homes were well-established doctors who took up the post to

¹³⁰ LHB 1/194/44, Corstorphine House Servants Book.

enlarge their practice and deter competition from others. The appointment also often allowed access to influential members of the community such as the aristocracy and elite of the medical profession, thus improving their career prospects, or possibilities of attracting lucrative clientele. Many doctors were also interested in the social and managerial aspects of convalescent homes. However, they did not generally use their position to make changes. This, together with the continuing demand for places in convalescent homes, suggests that the success of their existing regime made alterations appear unnecessary. However, it may also illustrate the apathy of doctors towards convalescence as a topic of interest within medicine.

Following the First World War, interest from the medical profession in the convalescent homes declined, partly because of an increase in other opportunities both in general practice and in hospitals. In addition, patients in the convalescent homes were generally less sick during the inter-war period, thus reducing the need for medical skills. By contrast, there was far more interest from the medical profession in the new AAI, which employed new and potentially more interesting interventionist methods of rehabilitation. It was also vastly wealthy, enabling the full-time employment of doctors, therapists and numerous nurses.

Although the doctor was important to the convalescent home, the matron was the key figure. She was selected from women of relatively high social status. During the nineteenth century, her housekeeping skills were valued above those of nursing but by the turn of the century most convalescent homes employed trained nurses as their Matron. Apart from the Matron, many convalescent homes did not employ additional nurses until the end of the century, despite the poor physical condition of many patients. It is therefore likely that domestic staff undertook some nursing duties. However, more trained nurses and nurses in training were introduced during the twentieth century and they gradually took on tasks previous undertaken by junior medical staff. The trained nurses to some extent displaced the doctor. This gave the medical elites of the medical profession even more reason to suggest that most

convalescent homes were no longer medical institutions.¹³¹ This was consistent with their beliefs that only institutions where doctors were prominent were entitled to be called medical institutions. Other places of healing, however effective, were designated with other titles.

¹³¹ See Chapter Three for discussion on the medical elites that authored numerous influential government reports on Scottish Health Services and Hospitals.

Conclusion

As part of a general trend throughout Britain during the 1970s, the majority of convalescent homes in Scotland closed down. The few that remain are normally open only during the summer months.¹ Although precise reasons for their closure are beyond of the scope of this thesis, it is generally believed that they closed because majority of patients no longer needed institutionalised convalescent care.² This assumption arose from factors such as the greater effectiveness of drug therapies, resulting in faster recovery, less pollution and an overall improvement in social conditions. Consequently, convalescence at home became more viable.³

One result of their obsolescence is that few younger people have any direct or indirect experience of convalescent homes. This, together with the deficiency of literature on their history, has led to misunderstandings over their original purpose and function.⁴ A common misconception is that the hospitals owned or ran most convalescent homes. For instance, the *Oxford Medical Companion* defined convalescent homes as 'intermediate-care hospitals or nursing homes for the reception and supervision of patients recovering from illness and surgical operations who are not yet considered fit enough to return home'.⁵ Yet, as this thesis has shown, the hospitals were not the main providers of care in convalescent homes. Instead, a variety of individuals and organisations were responsible for this provision of care. Another misunderstanding is that convalescent homes were mainly for the elderly or those suffering from tuberculosis. However, evidence suggests that most patients in convalescent homes

¹ For instance, the Miners Convalescent Home at Culross still opens during the summer months.

² The assumption that convalescent homes are no longer required has been disputed in recent years. See: D. Fallows, *Convalescence, A Neglected Need* (London, 1988).

³ J. Wilson-Barnett and M. Fordham, *Recovery from Illness* (Chichester, 1982), p. 22. J. Wilson-Barnett and M. Fordham use the faster recovery of patients from cardiac surgery in recent years as an example of expectations of speedier convalescence.

⁴ See Introduction to this thesis.

⁵ J. N. Walton, J. A. Barondess, S. Lock (eds.) *Oxford Medical Companion* (Oxford, 1994), p. 169. The *Oxford Medical Companion* is described as 'a comprehensive reference book covering the knowledge base and the practice of medicine for both health professionals and laymen.'

were relatively young⁶ and by the twentieth century they excluded those suffering from pulmonary tuberculosis.⁷ A fresh examination of their past is therefore timely.

A general survey of the Scottish convalescent homes provided the background for this thesis.⁸ It focused on issues relating to their sponsorship, distribution and chronological changes. The survey identified around sixty new convalescent homes established between 1860 and 1939. They were classified into six different categories, according to the source of sponsorship. These were: convalescent homes organised independently; by the hospitals; religious/temperance organisations; Co-operative and friendly societies or through occupational schemes. Once opened, the majority of the convalescent homes continued to operate at least until the beginning of the Second World War. Those that closed were mostly small, and in some cases, this may have been a contributing factor.⁹ Overall, the number of patients admitted annually to convalescent homes in Scotland rose from 4,000 in 1871, to over 33,000 in 1939.

Two major issues emerged from an analysis of the survey. The first was the variation in provision of convalescent care between the different sponsorship groups. As already mentioned, hospitals were not the dominant providers of convalescent facilities. Overall, they provided less than a third of all the convalescent homes established in Scotland. When assessed by the annual number of patients this figure was even less, and averaged only 23%.¹⁰ The hospital convalescent homes also took longer to establish: usually about five years whereas the non-hospital homes required only one or two years. A major reason identified was that managers of the infirmaries tended to seek funding from a sole benefactor. This often involved a lengthy process of appeals to find one person sufficiently generous, wealthy and willing to fund the project. In contrast, the providers of non-hospital convalescent homes used a variety

⁶ See Chapter One, pp. 43-44.

⁷ See Chapter Four, pp. 171-172.

⁸ See p. 13-15 of this thesis and Appendix A.

⁹ See Chapter One, pp. 45-48.

¹⁰ See Chapter One, p. 38.

of methods to establish their convalescent homes. Although a single benefactor provided the finance for some non-hospital convalescent homes, most were either financed from a general fund or used a slow start method, gradually building up support from the community or organisation. Similarly, financial support for the mutual assurance convalescent homes arose from either within their parent organisation or a designated fund, such as the Miners' Welfare Fund.¹¹

The hospitals also found it more difficult to find financial support to maintain their convalescent homes than non-hospital convalescent homes. One reason for their difficulties was that hospital convalescent homes had to compete with the parent infirmary for financial support from subscribers. However, there were other reasons. The buildings used for hospital convalescent homes were also often elaborate and cost more to build and maintain. Moreover, not all benefactors of hospital convalescent homes provided an endowment for maintenance. When they did it was rarely sufficient and managers found it difficult to generate enough further income to balance their books. Although infirmaries usually made up the shortfall in income, they did not do so willingly.¹²

The financial situation of hospital convalescent homes contrasted with the non-hospital convalescent homes; few of these experienced major difficulties in balancing their books. When deficits occurred they were usually small. Fundraisers in the non-hospital convalescent homes were also more active in promoting support from the community or members within the supporting organisation. Many homes also acquired substantial additional income from the interest on the accumulation of surplus funds. By the twentieth century, the finances of many non-hospital convalescent homes were buoyant, but at the hospital homes it was weak. The stronger financial position of the non-hospital convalescent homes enabled them to undertake various programmes of expansion well into the twentieth century. In contrast, there was a reduction in growth and development in most hospital

¹¹ See Chapter Three, pp. 115-120.

¹² See Chapter Two, pp. 65-66

convalescent homes. Although the infirmary managers recognised the contribution of their convalescent homes towards the recovery of the patients, they also regarded them as a drain on the financial resources of the main hospital.

Another difference in the sponsorship of convalescent homes was the geographical distribution. The area around the Glasgow contained the highest proportion of convalescent home provision, even allowing for the higher population. Yet, until the 1890s, independent or religious/temperance organisations sponsored all the convalescent homes around Glasgow.¹³ This effectively reduced any incentive for the managers of Glasgow infirmaries to establish their own homes. It represented a significant difference to the convalescent home provision in Edinburgh, Dundee and Aberdeen. In these areas, there were few places for patients in non-hospital sponsored convalescent homes. The lack of convalescent facilities encouraged their managers to provide convalescent homes for their patients' twenty years before the Glasgow infirmaries.

A second major issue that emerged from this study is the changes that occurred in the sponsorship, perception and definition of convalescent homes between the nineteenth and twentieth centuries. During the nineteenth century, sponsorship was exclusively through independent charities, hospitals or religious/temperance organisations. Many individuals within these sponsorship groups became enthusiastically involved, although the philanthropist Beatrice Clugston clearly led the field. She generated activity from all sections of the community to establish convalescent homes.¹⁴ High profile figures, including Florence Nightingale, James Burn Russell and Henry Burdett, also boosted the status of convalescent homes as institutions worthy of charity. By the end of the century, the visible success of convalescent homes in returning the poor to productivity and health made them a popular focus for philanthropy.

¹³ The only exception was the first Paisley Convalescent Home. This remained opened for only eight years.

¹⁴ See Chapter 2, pp. 57-59.

During the nineteenth century, a variety of moral or practical ideals motivated the sponsors, such as redemption or increasing the turnover of beds in voluntary hospitals. However, the common goal of their sponsors was to provide institutionalised convalescent care for the sick poor. During this period, the convalescent homes were therefore careful not to jeopardise their charitable image, and admitted only those perceived as genuinely recovering from illness; not those merely seeking a holiday. Within this framework, few doubts existed over their ideal type of convalescent home patient. Although the majority of the convalescent homes established in the nineteenth century excluded patients without any previous illness, their managers were even less keen to admit patients who required extensive nursing. Most convalescent homes therefore directed their admission policies towards filtering out patients with chronic or acute illnesses. In addition, because of the fear concerning spread of disease, most convalescent homes banned or restricted patients known to be recovering from infectious illnesses.¹⁵ Despite these exclusions, there were a few diversions from official policies. Some were intentional, such as admission of pre-operative patients and those suffering from pulmonary tuberculosis, but on other occasions more seriously or chronically ill patients were unintentionally admitted. There were many patients admitted to non-hospital convalescent homes with illnesses directly linked to poverty or poor social conditions. One prominent example was the high percentage of patients suffering from anaemia where the likely cause was malnutrition. In such cases the robust diet provided by the convalescent homes represented both a cure and convalescence.

During the nineteenth century, the definition and perception of convalescent homes as a type of medical institution remained unchallenged since most fell within the criteria of a medical institution. Their rules admitted only those recovering from illness, and most homes required a medical certificate and examination before admission. While in a convalescent home, doctors and nurses supervised the patients within an informal but therapeutic regime. Support from a number of distinguished doctors, such as

¹⁵ See Chapter 4, pp. 150-154.

Joseph Lister, George McLeod and George Buchanan, further enhanced their credibility as medical institutions. Other doctors who benefited either socially or financially through association with the eminent doctors, infirmaries or upper echelons of society connected to the convalescent homes were equally reluctant to challenge their status as medical institutions. The post of medical officer in the nineteenth century was therefore popular. Equally so was the post of convalescent home matron. There was nothing in the evidence to suggest that this was a post for a nurse not strong enough for hospital nursing as Heckman believed might be the case amongst English nurses.¹⁶

During the twentieth century, several changes took place within the development of convalescent homes that affected their definition and perception. First, although independent sponsors and hospitals continued to establish some new convalescent homes, a new and more dominant type of sponsorship arose from mutual assurance organisations. This sponsorship came from the Co-operative Society, friendly societies and occupational groups. The mutual assurance societies did not establish convalescent homes to alleviate poverty, but rather as a benefit for their members. The Co-operative Society also preferred to associate their convalescent homes with middle-class hydropathics than institutions for the sick poor, thus also elevating their status.¹⁷

Secondly, the lines of definition between convalescent home and a type of holiday establishment became less clear. One reason for this was that the Co-operative Society, and at least one friendly society, the Scottish Foresters', allowed the admission of some patients for recuperative holidays. The new convalescent homes for children also reinforced the association between holidays and convalescent homes. Their sponsors, motivated by the increased concern for child welfare, were often reluctant to differentiate between children in need of a country or seaside break to prevent or complete the curative process of an illness. Many of these convalescent

¹⁶ See Introduction, p. 11.

¹⁷ See Chapter Three, pp. 122.

homes admitted children who were not necessarily convalescing from any specific illness, but were either malnourished or ailing.

A third significant factor affecting the convalescent homes were the advances in physical and occupational therapy, developed during and after the First World War. However, the high demand for places in the traditional convalescent homes gave their managers little incentive to introduce this type of treatment, particularly as they required a far higher level of staff, expertise and equipment. Yet, there was one prominent exception. The immense wealth of a bequest that established the AAI in 1923 enabled their governors to experiment with new methods of physical and occupational therapy. The AAI therefore developed as an entirely different type of convalescent home. Unlike traditional convalescent homes, where doctors were mostly non-resident and part-time, the AAI employed numerous resident full-time doctors, nurses and therapists. The AAI also accepted patients at a far earlier stage of convalescence and allowed them to remain for long periods. The type of patients admitted to the AAI were quite unacceptable to the traditional convalescent homes

By the Inter-war period, some changes had taken place within the convalescent homes, but in other respects they remained the same. They continued to use informal treatment based on fresh air, nutritious diet, exercise and rest, and patients remained only for two or three weeks. Most convalescent homes still required a medical certificate or examination before admission, and the supervision of patients was still strict. However, medicine, particularly within the hospitals, had also undergone changes with an increasingly scientific and interventionist approach. This was incompatible with an institution perceived as providing a type of holiday. It was compounded by the reduction in attendance by doctors, fewer sick patients, and their reluctance to adopt new scientific methods of convalescence. It prompted the authors of several government reports published during the inter-war period to question the validity of traditional convalescent homes as medical institutions. These reports made various proposals regarding convalescent homes, mostly along the lines of their re-classification into either a medical institution or a recuperative holiday home.

However, the government reports provided little evidence of systematic investigation into the function or effectiveness of the convalescent homes or the criteria for this re-classification. For instance, the authors of the *Scottish Hospital Survey* neither visited nor commented on Kilmun or the Dunoon Homes, despite the fact that they were by far the largest convalescent homes in Scotland. The perception of traditional convalescent homes, where the regime emphasised diet, fresh air and exercise rather than treatment with drugs or experimental occupational and physical therapy, no longer fitted into the concept of a medical institution. This was despite that fact that during the inter-war period approximately 33,000 Scottish people annually spent two or three weeks in a convalescent home. Those admitted to the convalescent homes mostly did so at a vulnerable stage of the health or illness, enabling many to return to health or preventing illness in others. However, because most convalescent homes used 'natural' rather than 'scientific' methods, the health authorities of the twentieth century gave them far less credit than they deserved for the lives either saved or improved.

Before this thesis, Olive Checkland's half chapter in *Philanthropy in Victorian Scotland* was the only study of Scottish convalescent homes. Although a useful starting point, Checkland relied solely on Burdett's for her information and only reviewed the convalescent homes established before 1914.¹⁸ This study has taken Checkland's initial investigations much further and enabled a far broader understanding to emerge of the extent of convalescent home provision between 1860 and 1939, over the whole of Scotland. The wide range of source material allowed an extensive overall view of convalescent homes. Examining the convalescent homes through a relatively long timescale has allowed the observation of changes in the convalescent homes, particularly in types of sponsorship, patients and attitudes of the medical profession. It has reversed some previously held views about convalescent homes. For example, Checkland suggests that hospitals provided most of the convalescent care, whereas this study has established that although significant, on an annual basis they provided less than one third of the total. This thesis has established

¹⁸ O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p. 214.

new quantitative as well as qualitative ground, showing the scale and enormous growth in the numbers of patients recovering from illness in convalescent homes, which rose from 4000 in 1871 to over 34,000 in 1934. This large number of annual patients considerably raises the significance of convalescent homes in the history of health care.

This thesis also builds upon the study of philanthropic women in Frank Prochaska's *Women and Philanthropy in 19th Century England*.¹⁹ Although Prochaska's book is very thorough, it takes a general view of women in philanthropy. This study is complementary to Prochaska's, focusing in depth on one area of female philanthropic endeavour – the establishment and maintenance of convalescent homes – and illustrating the powerful force of women in this area of philanthropy. Furthermore, it reveals that women often established a convalescent home independently because they lacked power on hospital management boards.

However, the most important contribution of this thesis is that it provides a firm basis for further exploration of issues surrounding convalescent homes and convalescence. For example, even greater understanding could be achieved if, using oral history as a methodology, the structural background to convalescent homes offered by this thesis were expanded to include more personal experiences of patients and their attitudes towards the convalescent homes. This would still be possible for the inter-war period and afterwards. Similarly, the thesis provides a case study of issues relating to charity and the organisation of voluntarism that offer a comparison for studies of other charitable institutions. It will contribute to the increasing attention historians are paying to the continuing importance of philanthropy alongside the development of state welfare.²⁰ The thesis has also drawn attention to the extent of regional differences in philanthropic activity. Higher levels of convalescent provision were provided by charity in the area surrounding Glasgow during the nineteenth century. This gives some substance to the commonly held, but mainly anecdotal belief, of

¹⁹ F. K. Prochaska, *Women and Philanthropy in 19th Century England* (Oxford, 1980). Prochaska's work relates to women and philanthropy in general, not specifically convalescent homes.

²⁰ For example see: Dupree, M. W., 'The Provision of Social Services' in M. Daunt ed., *The Cambridge Urban History of Britain, Vol III 1840-1950* (Cambridge, 2000).

'generous Glasgow'.²¹ Although this does not present conclusive evidence that the citizens of Glasgow were more generous towards charity than the rest of Scotland, for it might be observed that this 'shock city' was characterised by more severe social problems than other areas, it does provide a basis for further investigation.

Another topic arising from the thesis that deserves further scrutiny is the miners' convalescent homes and the Miners' Welfare Fund. As this thesis has shown, the Miner's Welfare Fund not only financed miners' convalescent homes but also supported other important areas of miner's welfare such as education and recreation. Yet, despite the social benefits to miners' from the Miners' Welfare Fund, it has received little attention from historians. This is in sharp contrast to the vast amount of scholarship on the coal mining industry generally and particularly the economics of mining and their trade unions. If the Miners' Welfare Fund is mentioned at all within the literature, it is merely incidental. Yet the importance of the Miners' Welfare Fund to miners' welfare is surely essential to a greater understanding of the social life of miners and offers a comparison for welfare measures in other trades and industries.

Although further research into philanthropy and the Miners' Welfare Fund is important, this thesis also offers an essential background for understanding the complex issues involved in the development of convalescent services following the Second World War. This was a period when many convalescent homes were absorbed into the newly established National Health Service (NHS). Other convalescent homes, not taken over by the NHS, often undertook contractual arrangements with health authorities. Their integration into the NHS depended mainly on whether or not the authorities involved believed they offered medical treatment or were a type of holiday home.²² Yet, as this thesis explains, there were few differences detected in the treatment or the level of nursing among the various convalescent homes until 1939. (The AAI was the only exception to this.) Max Sorsby, author of a guide for general practitioners about the *National Health Service*

²¹ O. Checkland, *Philanthropy in Victorian Scotland* (Edinburgh, 1980), p. 214.

²² *Report of a Working Party, Convalescent Treatment*, HMSO (London, 1959), p. 7.

in 1953, remarked that 'the borderline between convalescent and recuperative holidays is a difficult one to define in practice with any exactitude, as some of the so-called holiday homes give as much or more care than do some of the convalescent homes.'²³ In 1959, *the Almoner* also commented that 'it was all rather chancy, anyway, as in some instances the homes which were taken over were essentially inferior to some of the homes which were classed as holiday ones'.²⁴ Although this thesis has discussed the ambiguity of classification of medical and non-medical convalescent homes, the post-Second World War integration of the homes into the NHS is yet to be explored.

Although this thesis is principally about the origins and development of Scottish convalescent homes, it did not ignore the topic of convalescence itself. It uncovered a subject with issues that require far greater understanding within a medical and social context, both historically and during the present day. As the thesis reveals, although the medical profession expressed some enthusiasm towards both convalescence and convalescent homes during the nineteenth century, their interest declined during the twentieth century. A major reason for this was that orthodox medicine became increasingly interventionist and scientific, in opposition to the natural therapies, considered appropriate for the care of convalescent patients, such as dietetics and a healthy environment. Moreover, it was compounded by developments that directed medical services towards the acute phase of illness and the division of medicine into specialities. These specialities mostly focus on body parts or systems (for example, neurology, cardiology or haematology), or type of patient, (for example, paediatrics and geriatrics) rather than a phase of illness. Nevertheless, there are some areas of medicine that relate to the general treatment of illness and disease, including public health, general practice, the various pathology services and more recently, health promotion and palliative care. Thus, there are no theoretical reasons why convalescence could not, or should not, develop as a medical speciality.

²³ M. Sorsby, ed., *The National Health Service* (Edinburgh, 1953), p. 217.

²⁴ 'Convalescent Treatment. Report of a Working Party,' *Almoner*, 12, (1959-60), p. 420.

Unfortunately, a speciality such as convalescence, that requires few scientific, diagnostic or interventionist skills, is unlikely to attract ambitious doctors or other medical professionals, anxious to demonstrate their knowledge of science or skills in surgery. This is despite the fact that convalescence and full recovery, often benefits greatly from the confidence given by supervision from the healer (doctor, nurse or other medical professional) who cared for them when they were acutely ill.²⁵

Although doctors assume the dominant role in all specialist areas of medicine, other professionals including nurses, social scientists, educators and therapists are involved. Referring specifically to convalescence, Jenifer Wilson-Barnett and Morva Fordham emphasise that 'recovery from illness is often a co-operative venture involving any number of participants – family, friends, employers, medical and para-medical personnel and society at large'. Despite the ideal of a multi-team responsibility, Wilson-Barnett and Fordham comment further that each of those involved 'may have differing views of health and illness'.²⁶ This suggests that there is still conflict among professionals over the management of convalescence. It also raises the question of the extent of agreement among professional groups over responsibility for convalescent patient since the 1930s. During that time, Elizabeth Gardiner wrote that the problems of patients in convalescent homes were 'partly due to the fact that the medical profession as a whole has considered such institutions as part of the social field, and the socially minded lay person has thought of convalescent homes as lying in the medical field'.²⁷

A fading of convalescence from the current medical agenda has not passed without expressions of concern in medical and nursing journals.²⁸ Concern over chronically ill patients taking up valuable bed space has also initiated policies that advocate a

²⁵ Some might argue that convalescence developed within medicine as 'rehabilitation' during the 1930s. However, because it involved interventionist or scientifically studied methods treatment such as physical and occupational therapy, patients treated in rehabilitation units were, and still are, usually in the early stages of recovery.

²⁶ J. Wilson-Burnett and M. Fordham, *Recovery from Illness* (Chichester, 1982), p. 1.

²⁷ E. G. Gardiner, *Convalescent Care in Great Britain* (Chicago, 1935), p. 8.

²⁸ A. Ferriman, 'Convalescence to Make a Comeback', *BMJ*, 12 February 2000, p. 401; T. Smith, 'Convalescence', *BMJ*, 10 February 1996, p. 383.

return to residential convalescent care.²⁹ This takes us back to the situation in the 1860s when authorities raised concerns over the long-stay patients at the Edinburgh Infirmary who they saw as blocking beds. Their subsequent action eventually led to the founding of the first hospital convalescent home, Corstorphine House. However, the new residential care planned for convalescents is only for the elderly, whereas the traditional convalescent homes were originally for much younger patients. Yet, is it only the elderly who now need convalescent care? Tony Smith, writing in the *BMJ*, looks back to the traditional convalescent homes that provided ‘a safe setting in which pale faced convalescents could recover strength, mobility and confidence’.³⁰ Although Smith does not advocate the restoration of rambling convalescent homes, he believes that ‘patients recovering from serious illness should surely be provided with a safe setting in which they can be helped to potter about in their dressing gowns until the colour has come back into their cheeks’.³¹ Smith also notes that convalescent care has not disappeared in Europe and that ‘many European countries provide convalescent care in spas and former sanatoriums, financed by health insurance’.³² Professor George Castledene also believes that ‘the subject of convalescence should be brought back into the health care curriculum and be updated and emphasised as a key concept’.³³ There is therefore a need to re-evaluate the concept and treatment of convalescence within a medical and social context. This thesis provides a basis upon which to understand the current issues as well as the historical treatment of convalescence.

²⁹ Ferriman, ‘Convalescence to Make a Comeback’, p. 401.

³⁰ Smith, ‘Convalescence’, p. 383.

³¹ Ibid.

³² Ibid.

³³ G. Castledene, ‘The Value of Convalescent Care’, *British Journal of Nursing*, Vol 3, 10 August 1994, pp. 278-9. George Castledene is Professor of Nursing and Community Health at University of Central England in Birmingham, and Vice President of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

Appendices

Appendix A

Database Design

The purpose of this database was to compare the size of homes, year of foundation, patient and bed numbers together with the location and types of organisations involved in the convalescent homes. The field names used for this database are as follows:

ID	Identifying number from my filing system
PID	Personal identification number (computer only)
CH	Name of convalescent home
Source	Source of information for the number of patients, beds, eg <i>Burdett's, newspapers, journals, annual report</i>
Source yr	Year the information was published
Real yr	Year to which the information relates. The data found in <i>Burdett's Hospitals and Charities Year Book</i> , was usually two years out of date because it took that long for the information to filter through their system
Found yr	Year of foundation
Yr code	Foundation year coded in 10 year age bands (see category coding*)
Size	Size of the home, based on patient numbers (see coding on size**)
Oversize	This varied from year to year so I took an average over the eighty-year period.
Close yr	The year the home closed
Cat	The homes were categorised according to sponsorship
Cat Code	Sponsorship category code (see category coding***)
No pats	Number of patients, e = estimated. In a very few cases the exact figure was not available. In such cases I used an estimated figure based on either bed numbers and/or previous admission figures.
No beds 2	Number of beds available for convalescent homes. This was not always known.
Lenstay	Average length of stay of patients in the convalescent home – one to six weeks
Nurses	Number of nurses
Location	Nearest large urban centre, eg. Glasgow, Edinburgh, Dundee Aberdeen

Explanation of category systems

***Foundation year**

- A - up to and including 1870
- B - up to and including 1880
- C - up to and including 1890
- D - up to and including 1900
- E - up to and including 1910
- F - up to and including 1920
- G - up to and including 1930
- H - up to and including 1939

****Size (based on the annual number of patients)**

- | | |
|-----------------|----------------|
| VS (very small) | up to 200 |
| S (small) | 200-500 |
| M (medium) | 500-1000 |
| L (large) | 1000-2000 |
| VL (very large) | more than 2000 |

*****Category coding**

1. Hospital
2. Religious/Temperance
3. Independent
4. Friendly Society
5. Occupational
6. Co-operative Society

Appendix B

Convalescent homes in Scotland established between 1860 and 1939

Name of Convalescent Home (first title)	Found yr	Category	Nearest Village/Town	Nearest Urban Centre
Aberdeen Convalescent Hospital	1872	Hospital	Cults	Aberdeen
Ailsa Convalescent Home	1888c	Independent	Maidens, Ayr	Glasgow
Alderston Convalescent Home	1925	Occupational	Haddington	Glasgow
Arbroath Convalescent Home	1891	Hospital	Arbroath	Dundee
Armitstead Convalescent Home	1930	Independent	Broughty Ferry	Dundee
Ashgrove Convalescent Home	1897	Religious/temperance	Maybole	Glasgow
Ashgrove House	1903	Friendly Society	Kirn, nr Dunoon	Glasgow
Astley Ainslie Institution	1923	Hospital	Edinburgh	Edinburgh
Balgavies Convalescent Home	Not Known	Hospital	Forfar	Forfar
Bandrum Children's Country Home	1928	Independent	Saline, Dunfermline	Dunfermline
Bannatyne House	1892	Independent	Newtyle	Dundee
Brooksby Convalescent Home	1897	Hospital	Largs	Glasgow
Broomfield Convalescent Home	1914	Occupational	Shandon	Glasgow
Calderbank House and Convalescent Home	1920c	Hospital	Ballieston	Glasgow
Charles Carlow Convalescent Home for Miners	1927	Occupational	Culross	Edinburgh
Convalescent Cottage Homes for Children [Helensburgh]	1884	Independent	Helensburgh	Glasgow
Convalescent Home of the Royal Northern Infirmary [Bona]	1895	Hospital	Bona	Inverness
Co-operative Convalescent Home [Abbotsview]	1905	Co-operative	Galashiels	Dumfries
Co-operative Convalescent Home [Airdmhor]	1914	Co-operative	Dunoon	Glasgow
Co-operative Convalescent Home [Seamill]	1896	Co-operative	West Kilbride	Glasgow
Corstorphine House	1867	Hospital	Corstorphine	Edinburgh
Cottage Convalescent Home for Leith Infirmary	1903	Hospital	Corstorphine	Edinburgh
Dundee Convalescent Home [Broughty Ferry]	1876	Hospital	Barnhill	Dundee
Dundee Convalescent Hospital	1860	Religious/temperance	Dundee	Dundee
Dundonald Convalescent Home	1885	Independent	Kilmarnock	Glasgow

Edzell Convalescent Home	1897c	Hospital	Brechin	Dundee
Eidda Convalescent Home	1880	Independent	Cultar	Aberdeen
Forteviot Convalescent Home	1934	Hospital	Edinburgh	Edinburgh
Garscube Convalescent Home	1922	Hospital	Glasgow	Glasgow
Gilmerton Children's Convalescent Home	1881	Independent	Gilmerton	Edinburgh
Glasgow Convalescent Home [GCH]	1865	Independent	Lenzie	Glasgow
Glencapel Convalescent Home	1894	Independent	Dumfries	Dumfries
Hawthornbrae Convalescent Home	1895	Religious/temperance	Haddington	Edinburgh
Kilmun Seaside Home for the Convalescent Poor	1867	Religious/temperance	Kilmun (nr. Dunoon)	Glasgow
Lady Hozier Convalescent Home [Hozier CH]	1893	Hospital	Lanark	Glasgow
Leith Infirmary Children's Convalescent Home	1935	Hospital	North Berwick	Edinburgh
Linn Moor Children's Fresh Air Fortnight and Ailing Home	1905	Independent	Peterculter	Aberdeen
Manderston Convalescent Home	1908	Independent	Coldingham	Edinburgh
Miners' Convalescent Home, Kirkmichael	1923	Occupational	Kirkmichael	Glasgow
Miners' Convalescent Home, Troon	1924	Occupational	Troon	Glasgow
Mission Coast Home, Saltcoats	1866	Religious/temperance	Saltcoats	Glasgow
Muirfield Children's Convalescent Home	1906	Hospital	Gullane	Edinburgh
Nairn Convalescent Home	1882	Independent	Nairn	Inverness
National Miners' Convalescent Home	1927	Occupational	West Kilbride	Glasgow
Newhills Convalescent Home	1874	Independent	Buckburn	Aberdeen
Newport Children's Convalescent Home	1893	Independent	Leuchars	St Andrews
Ochiltree Convalescent Home	1881	Independent	Cumnock, Ayr	Glasgow
Orwell House	1908	Friendly Society	Kinbuck	Stirling
Paisley Convalescent Home (Second)	1886	Independent	West Kilbride	Glasgow
Paisley Convalescent Hospital [First]	1869	Hospital	Paisley	Glasgow
Railway Convalescent Home [Ascog House]	1924	Friendly Society	Haddington	Glasgow
Ravensraig Children's Convalescent Home	1890	Religious/temperance	Ravensraig	Glasgow
Ravenscroft Convalescent Home	1879	Independent	Gilmerton	Edinburgh
Schaw Convalescent Home	1895	Hospital	Bearsden	Glasgow
Scottish Convalescent Home for Children	1905	Independent	Milngavie	Glasgow

St Leonards Convalescent Home	1907	Independent	St Andrews	St Andrews
Sunnybank Children's Convalescent Home	1935c	Hospital	Greenock	Glasgow
The Grove	1938	Hospital	Dumfries	Dumfries
Thorngrove Babies Home	1935c	Hospital	Aberdeen	Aberdeen
Victoria Convalescent Home [Chartershall]	1906	Hospital	Largs	Stirling
West of Scotland Seaside Convalescent Homes [Dunoon Homes 1869		Independent	Dunoon	Glasgow

Note: The name of the convalescent home did not necessarily remain the same throughout the period. As far as possible, the first name given to convalescent home was used. See Appendix C for alternative names.

Appendix C

Other names for convalescent homes

One of the challenges encountered in the research for this study was that many convalescent homes changed their title between 1860 and 1939. This created the potential for considerable confusion. For example, during this period Kilmun changed their name five times. Linn Moor also changed their title on numerous occasions. During the 1930s, the convalescent homes in the West of Scotland saw financial advantages in including the word 'Glasgow' within the title. Consequently, during the same period the Dunoon Homes changed their title from the 'West of Scotland Convalescent Seaside Homes' to the 'Glasgow and West of Scotland Convalescent Seaside Homes'. The West of Scotland Seaside Convalescent Home was more commonly known as the 'Dunoon Homes'. Similarly, the Mission Coast Home altered their title of 'the Mission Coast Home, Saltcoats', to the 'Glasgow Mission Coast Home' and Kilmun became the 'Glasgow-Kilmun Convalescent Home'.

Many convalescent homes also had several unofficial titles. For example, although the Glasgow Convalescent Home (GCH) kept the same official title throughout the period, it was also commonly known as Bothwell Convalescent Home, when it was situated at Bothwell. When the Home moved to Lenzie, it became known as the Lenzie Convalescent Home. The Dundee Convalescent Home, situated at Barnhill near Dundee was sometimes called Barnhill Convalescent Home. However, it also bordered on the area known as Broughty Ferry and perhaps because of the superiority of this neighbourhood was more often called Broughty Ferry Convalescent Home. The Dundee Convalescent Home was also called David Baxter Home, after the major benefactor.

To overcome the difficulties of inconsistency of titles and their often cumbersome length, I used either an abbreviated or shorter form of the title when referring to the convalescent homes in the thesis. However, I retained the long title if shortening it was likely to cause confusion. For example. For instance I did not attempt to shorten or abbreviate Dundee Convalescent House because it might be confused with the Dundee Convalescent Home. As far as possible I have consistently used the first title given to the convalescent home (where known), other names and also the name used in this thesis. The following table gives the first title given to the convalescent home (where known), the second column lists the short title used in the thesis and the third column indicates the various other titles given to the convalescent homes.

Titles of Convalescent Homes

First titles (As far as possible the titles given below are the first titles of the convalescent homes)	The shortened title of the convalescent home used in this thesis.	Further titles given to the convalescent homes
Aberdeen Convalescent Hospital	Aberdeen Convalescent Hospital	Convalescent Hospital, Cults
Ailsa Convalescent Home	Ailsa CH	The Maidens Convalescent Home
Alderston Convalescent Home	Alderston CH	
Arbroath Convalescent Home	Arbroath CH	Convalescent Home, Jennyswell
Armitstead Convalescent Home	Armitstead CH	Armitstead Children's Convalescent Home
Ashgrove Convalescent Home	Ashgrove CH	Maybole
Ashgrove House	Ashgrove House	
Astley Ainslie Institution	AAI	Astley Ainslie Convalescent Home
Balgavies Convalescent Home	Balgavies CH	
Bannatyne Home	Bannatyne Home	Buchanan House of Recovery
Bandrum Children's Country Home	Bandrum	Bandrum Country Home
Brooksby Convalescent Home	Brooksby	The Brooksby
Broomfield Convalescent Home	Broomfield House	Broomfield

Calderbank House and Convalescent Home	Calderbank House	
Charles Carlow Convalescent Home for Miners	Charles Carlow Home	Miners Convalescent Home, Culross
Convalescent Cottage Homes for Children	Convalescent Cottages Homes at Helensburgh	
Convalescent Home of the Royal Northern Infirmary	Bona	Bona Lochend
Co-operative Convalescent Home, Abbotsview	Abbotsview	Scottish Co-operative Convalescent Seaside Homes Association Limited
Co-operative Convalescent Home, Airdmhor	Airdmhor	Scottish Co-operative Convalescent Seaside Homes Association Limited
Co-operative Convalescent Home, Seamill	Seamill	Scottish Co-operative Convalescent Seaside Homes Association Limited
Corstorphine House	Corstorphine House	Corstorphine Convalescent Home
Cottage Convalescent Home for Leith Infirmary	Cottage Home, Leith	Cottage Hospital, Corstorphine
Dundee Convalescent Home	Broughty Ferry CH	Broughty Ferry Barnhill David Baxter Convalescent Home
Dundee Convalescent Hospital	Dundee Convalescent House	Dundee Convalescent House
Dundonald Convalescent Home	Dundonald CH	
Edzell Convalescent Home	Edzell CH	
Eidda Convalescent Home	Eidda CH	
Fortevoit Convalescent Home	Fortevoit Home	
Garscube Convalescent Home	Garscube CH	Garscube Cottage Hospital
Gilmerton Children's Convalescent Home	Gilmerton CH	Gilmerton
Glasgow Convalescent Home	GCH	Lenzie Convalescent Home Bothwell Convalescent Home
Glencapel Convalescent Home	Glencapel CH	
Hawthornbrae Convalescent Home	Hawthornbrae CH	
Kilmun Home for the Convalescent Poor	Kilmun	Kilmun Seaside Home for the Convalescent Poor (1867-1905) Kilmun Seaside Home for Convalescents (1905-1914) Kilmun Seaside Home (1915-1920) Kilmun Convalescent Home (1921-1937)

		Glasgow-Kilmun Convalescent Home (1938 onwards) The Kilmun Convalescent Home was also and most commonly known as Kilmun
Lady Hozier Convalescent Home	Hozier Home	Lady Hozier Home Hozier Convalescent Home
Leith Infirmary Children's Convalescent Home		
Linn Moor Children's Fresh-Air Fortnight and Ailing Home	Linn Moor	Linn Moor Children's Fresh-Air Fortnight and Ailing Home Children's Fresh Air Fortnight and Ailing Home Home for Ailing Children and Fresh Air Fortnight Aberdeen Home for Ailing Children and Fresh-Air Fortnight, Linn Moor Linn Moor Home Linmoor Convalescent Home Linnmoor
Manderston Convalescent Home	Manderston CH	
Miners' Convalescent Home, Kirkmichael	Kirkmichael	Kirkmichael House
Miners' Convalescent Home, Troon	Troon	
Mission Coast Home, Saltcoats	Mission Coast Home	The Saltcoats Convalescent Home Saltcoats Home Glasgow Mission Coast Home
Muirfield Children's Convalescent Home	Muirfield	
Nairn Convalescent Home	Nairn CH	The Convalescent Home, Nairn Northern Counties Convalescent Home,
National Miners' Convalescent Home	National Miner's Home	
Newhills Convalescent Home	Newhills	Newhills Convalescent Home and Sanatorium Cottage home for Convalescents and Sanatorium for Consumptives at Newhills

Newport Children's Convalescent Home	Newport	Newport Children's Home
Ochiltree Convalescent Home	Ochiltree CH	
Orwell House	Orwell House	Scottish Foresters' Convalescent Home
Paisley Convalescent Home (First)	Paisley CH (First)	Paisley Convalescent Hospital
Paisley Convalescent Home (Second)	Paisley CH (Second)	
Ravenscraig Children's Convalescent Home	Ravenscraig CH	Ravenscraig Trinity Church Convalescent Home for Children
Ravenscroft Convalescent Home	Ravenscroft CH	Liberton Convalescent Home
Schaw Convalescent Home	Schaw Home	Schaw Homes
Scottish Convalescent Home for Children	Scottish Children's CH	Scottish Convalescent Home
Scottish Railway Convalescent Home	Ascog Mansion	Ascog
St Leonards Convalescent Home	St Leonard's CH	
Sunnybank Children's Convalescent Home	Sunnybank House	Sunnybank Convalescent Home, Sunnybank House
The Grove	The Grove CH	
Thorngrove Babies Home	Thorngrove Home	Thorngrove Convalescent Home
Victoria Convalescent Home	Chartershall	Chartershall
West of Scotland Seaside Convalescent Homes	Dunoon Homes	Dunoon Homes Dunoon Dunoon Seaside Home Dunoon Convalescent Homes The West of Scotland Seaside Homes The West of Scotland Convalescent Seaside Homes The Glasgow and West of Scotland Convalescent Seaside Homes, Dunoon

Appendix D

Members of Board of management at GCH between 1867-1936

Year	Town Council	Directors of GRI	Med. Officers of GRI	Senatus of Glasgow University	Faculty of Physicians and Surgeons of Glasgow	Merchant's House	Trades House	Subscribers
1867	William Wilson	Dr John Coats John Bell	Dr Scott Orr Dr George Buchanan	Professor Lister	Dr George HB Macleod	William Holms	Charles Malloch	James Campbell George Martin William Ker Anthony Hannay Dr W. G. Blackie William Davie
1869	William Wilson	Dr William Lyon Thomas Warren	not given in AR	Professor Lister	Dr Robert Perry	James Arthur	James Neilson	James Campbell George Martin William Kerr D. S. Cargill Dr W. G. Blackie Rev Dr Walter C Smith
1870	Bailie James Watson	Dr William Lyon	Dr Donald Dewar Dr James Steven	Professor Gairdner	Dr Robert Perry	James Arthur	James Neilson	James Campbell William Kerr D. S. Cargill Dr W. G. Blackie Rev Dr Walter C. Smith William Wilson
1871	Bailie James Watson	Dr William Lyon Thomas Warren	Dr James Steven Dr Ebenezer Watson	Professor Gairdner	Dr Robert Perry	James Arthur	James Neilson	James Campbell William Kerr D. S. Cargill Dr W. G. Blackie Rev Dr Walter C. Smith
1872	Bailie James Salmon	Dr William Lyon James Neilson (Deacon Convener)	Dr Ebenezer Watson Dr Scott Orr	Professor Gairdner	Dr Robert Perry	James Arthur	Archd. Gilchrist	James Campbell William Kerr D. S. Cargill Rev Dr Walter C Smith Thomas Warren William Wilson

1873	Bailie James Salmon	Dr William Lyon James Neilson (Deacon Convener)	Dr Scott Orr Dr James Morton	Professor Gairdner	Dr Robert Perry	Lawrence Robertson, Jun	Archd. Gilchrist	James Campbell William Kerr D. S. Cargill Rev Dr Walter C. Smith Thomas Warren
1874	Bailie James Salmon	Dr William Lyon William Smith	Dr Ebenezer Watson Dr Scott Orr	Professor Young	Dr Alexander Paterson	Lawrence Robertson, Jun	Archd. Gilchrist	William Kerr D. S. Cargill Rev Dr Walter C. Smith Edward Collins William Smith
1885	Bailie Crawford	Dr E. Duncan T. R. Johnstone	Dr Alex Paterson Dr John A Lothian	Professor George Buchanan	Dr Hugh Thomson,	Sir William Collins	James Wilson	Preceptor Wilson John Pirrie David Sandeman John Farquhar RA Bryden
1890	Councillor John Firshell	Dr Archd Neilson, Mr John Glen	Dr James Dunlop Dr James W Fleming	Professor George Buchanan	Dr Hugh Thomson,	Sir William Collins	Mr John Phillips	Wm Wilson William Kerr John Pirrie John Farquhar Robert A Bryden James Downie
1922	Councillor Mary Bell	Mr Wm Cross, Mr Robert Robertson	Mr Thomas Kay Dr W R Jack	Professor Walker K Hunter	Mr Donald Duff,	Mr Charles Kerr,	Mr George F Paisley	Mrs Wordie Major James Hope Messrs Hugh Blain Samuel Marks James G Spiers Hugh M'Intosh
1936	Councillor James MacDougall	Mr J. MacDougall Mrs J. D. Hedderwick	Mr David Smith, George C. Swanston	Professor JAG Burton	Dr A. K Chalmers	Mr Charles Kerr	Mr Peter White	Mrs Higginbotham Samuel Marks James G Spiers Mr J Craig George Ferguson Neil Livingston

Source: *Annual Reports for the Glasgow Convalescent Home*, 1867, 1869, 1870, 1871, 1872, 1873, 1874, 1885, 1890, 1922, 1936

Bibliography

PRIMARY SOURCES

Aberdeen Central Library (ACL)

362.78. L64 Annual Reports for Linn Moor Ailing Children and Fresh-Air Fortnight,
1889-1948. [Linn Moor].

Argyle and Bute District Archives

Plans in the Dunoon Dean of Guild Series,

Ashgrove House.

Dunoon Homes.

Glasgow City Archives (GCA)

CWS.33/3/1-8 Scottish Co-operative Convalescent Seaside Homes House Committee
Minute Books.

CWS.33/3/9-10 Scottish Co-operative Convalescent Seaside Homes General Committee
Minute Books.

TD.432/20 bundle Photograph of Kilmun Convalescent Home. Correspondence and press
cuttings about the expulsion of Catholic patients admitted to the
home when they refused to attend Protestant worship, 1921. Letter
from Directors of Kilmun to supporters requesting further funds.

TD.432/13 Annual Reports of the Kilmun Seaside Home for Convalescents,
1876-1940.

TD.432/13 Annual Reports for the Glasgow Abstainers Union, 1867, 1894, 1871.

T.Par.1.5-32 Annual Reports of the Mission Coast Home, Saltcoats, 1906-1920.

T.Par.1.20 Annual Report for the Scottish Foresters' Convalescent Home Benevolent
Society, 1913.

Glasgow University Library, Special Collection

MU26-f.44. BG54 c.11 Rules for the Constitution and Byelaws of the Glasgow Convalescent
Home, 1865.

DTC 6/84/5 Letter from Robert Hillhouse, Secretary to the Dunoon Homes requesting
signature for the nomination of a patient.

Greater Glasgow NHS Board Archives

HB 6/3/1-13 Annual Reports for the Western Infirmary, Glasgow, 1891-1939.

HB 6/4/55 Annual Reports of the Scottish Co-operative Seaside Homes Association
Limited, 1900, 1902. [Seamill, Abbotsview and Airdhmr].

- HB 6/4/55 Annual Report of the Glasgow Convalescent Home, 1890. [GCH].
- HB 7/1/1 Annual Reports for the Lady Hozier Convalescent Home,
1894-1914. [Hozier Home].
- HB 23/2/1-8 Annual Reports of the Victoria Infirmary of Glasgow, 1881-1939.
- HB 14/2/7-15 Annual Reports of the Glasgow Royal Infirmary, 1890-1939.
- HH/70/2/7-14 Annual Reports of the Paisley Infirmary 1860-1940 [later Royal
Alexandria Hospital].
- HB 52/1/7 Schaw Convalescent Home - Rules.

Northern Health Services Archives

- GRHB 1/5/2-4 Annual Reports of the Royal Northern Infirmary 1889-1918.
- GRHB 1/7/3-8 Annual Reports of the Aberdeen Royal Infirmary 1872-1939.
- GRHB 5/3/14-16 Annual Reports of the Aberdeen Children's Hospital, 1880-1925.
- GRHB 9/1/1-4 Minute Books for Sanatorium and Newhills Convalescent Home,
1908-1938.
- GRHB 9/3/2 Historical Note, for Newhills Sanatorium and Convalescent Home,
1908 –1954.
- GRHB 9/3/8 'Rules at Cottage Home for Convalescents and Sanatorium for
Consumptives at Newhills', c.1908.
- GRHB 10/1/1-2 Minute Books of the Aberdeen Convalescent Hospital, 1871-1948.
- HHB 2/1/1 Minute books of the Managing Committee of Convalescent Home of Royal
Northern Infirmary (Bona), 1894-1896.
- HHB 2/2/1 Visiting Book of Managers of Convalescent Home of Royal Northern
Infirmary (Bona), 1896-1914.
- HHB 2/2/1 Admission Form for the Convalescent House at Bona.
- HHB 2/2/1 Letter to the Matron of the Convalescent House, Bona, 9 April, 1903.

Greater Glasgow NHS Board Archives (GGHB)

- HB 2/3/5 'Memorandum of Agreement between the Directors of the Royal Hospital
for Sick Children, Glasgow and the Committee of Management of
Trinity Church Convalescent Home for Children at Ravenscraig,
Renfrewshire', 1911-13.
- HB 52/2/5 Schaw Convalescent Home - Register of Nursing Staff, 1936-52.
- HH 67/1-26 Ward Journals of the GRI.
- HH 70/1/6-15 Minutes of the Board of Management of Paisley Infirmary, 1866/69.

Lothian Health Services Archives (LHB)

- LHB 1/129/3 General Register of Patients, Royal Infirmary of Edinburgh, 1895-1939.
- LHB 1/194/1 Managers Book, 1892-1939, Corstorphine House.
- LHB 1/194/2 Board of patients, 1869-1920, Corstorphine House.
- LHB 1/194/3-4 Disbursement books, September 1867-1873, and January 1912-24,
Corstorphine House.
- LHB 1/195/5 Patients Register, Corstorphine House, 1883-1940.
- LHB 1/194/6 Ledger, October 1926-June 1930, Corstorphine House.
- LHB 1/194/8 Cash Books. Nos. 1-8, 1867-1924, Corstorphine House.
- LHB 1/194/16 Salaries and Wages Book, 1912-1929, Corstorphine House.
- LHB 1/194/21 Inventory and Valuation of Furniture, August 1905, Corstorphine House.
- LHB 1/194/23 Register of Nurse Training at RIE, 1891-1938.
- LHB 1/194/24 Visitors Books (1933-1972).
- LHB 1/194/25 *Description and Plans of the Corstorphine Home*, Printed Pamphlet,
(Edinburgh, 1894).
- LHB 1/194/44 Servants Register 1900-1946, Corstorphine House.
- LBH 1/2/9 Minute Books of the House Committee, Corstorphine House.
- LHB 1/4/55-138 Annual Reports of the Royal Infirmary of Edinburgh, 1855-1939.
- LHB 5/5/33 Questionnaire sent by the managers of the Children's Hospital in Edinburgh
to several convalescent homes, 1906.
- LHB 5/5/33 Bequest of Muirfield Estate, 1906.
- LHB 5/5/33 Rules of Muirfield Convalescent Home, 1906-33.

Mitchell Library, Glasgow (ML)

- G.362.780941435 Annual Reports of the Glasgow Poor Children's' Fresh-Air Fortnight and
Cripple Children's' League, 1930, 1932, 1949. [Ashgrove CH].
- G.362.160941435 Annual Reports of the Glasgow Convalescent Home, 1866-73, 1882, 1889,
1893, 1922, 1925, 1936. [GCH].
- G.362.780941435 Annual Reports of the Hospital for Sick Children, Glasgow, 1886-1933.
- G.362.160941435 Annual Reports of the West of Scotland Seaside Homes, Dunoon, 1885,
1894, 1901, 1933, 1939. [Dunoon Homes].
- G.362.506241435 Annual Report of the Council of the Glasgow Association for Organising
Charitable Relief and Repressing Mendicity, 1882.
- G.362.160941435 Annual Reports of the Mission Coast Home, Saltcoats, 1921, 1928, 1936,
1937, 1939.
- G.361.760941435 Annual Report of the Glasgow Charity Organisation Society, 1919.
- G.362.16476368 Annual Report of the Scottish Convalescent Home for Children, 1938.

G.362.1647360 Annual Report for Ravenscraig Children's' Convalescent Home, 1936-37.
Glasgow Pamphlets, Vol. 30. 312453-70, *Glasgow Charitable and Philanthropic Institutions*
(Glasgow, 1892).

National Archives of Scotland (NAS)

GD 409/25/1 Annual Report of the Gilmerton Convalescent Homes, 1940.

National Library of Scotland (NLS)

GMC. 11 Annual Reports of the Miners' Welfare Fund, 1922-1939.

Tayside Health Board (THB) Archives

THB 1/7 Minutes of the Dundee Convalescent Home 1872-1877.

THB 1/2/5-11 Annual Reports for the Dundee Convalescent Home in Annual Reports of
the Dundee Royal Infirmary, 1872-1939.

THB 13/1/1 Annual Reports of the Dundee Convalescent House 1861-1882.

Correspondence

Personal correspondence from patient in Miners' Convalescent Home at Troon in 1938. JL/JC.

Personal correspondence from patient at Co-operative Home, Airdmhor during 1930s. JC/JC.

Personal correspondence from patient at Maybole in 1938. JD/JC.

Personal correspondence from patient at Bandrum in 1930. GS/JC.

Personal correspondence with reminiscence from resident of Edzell GH in pre-war period. PM/JC.

Personal correspondence from patient at AAI in 1931. DM/JC.

Government Reports and Conference Proceedings

'Convalescent Care'. Proceedings of a Conference held under the Auspices of the Committee on
Public Health Relations of the New York Academy of Medicine, November 9 and 10'
(New York, 1949).

A Scheme of Medical Service for Scotland, 1920. Cmd. 1039 (MacAlister Report).

Chelmsford, Rt. Hon. Viscount, 'The Miners' Welfare Fund'.

Cunningham, A., *Report of the Opening Ceremony of the Charles Carlow Convalescent Home*, (1927).

Report of a Working Party, Convalescent Treatment, HMSO (London, 1959).

Report of the Committee on Scottish Health Services, 1936, Cmd. 5204 (Cathcart Report).

Report of the Hospital Services (Scotland) Committee, HMSO (London, 1926) (Mackenzie Report).

Scheme for Maternity and Child Welfare (Glasgow, 1926).

Scottish Hospital Survey, HMSO (1949).

Newspapers and Periodicals

Almoner

Arbroath Herald

Ardrossan and Saltcoats Herald

BMJ

British Journal of Nursing

Dundee Advertiser

Dumfries and Galloway Standard

EMJ

Glasgow Daily Herald

Glasgow Herald

Glasgow Observer

GMJ

Helensburgh and Gareloch Times

Illustrated Edinburgh News

The Hospital

Lancet

Nursing Record and Hospital World

Nursing Times

Nursing Mirror

People's Journal

School Hygiene,

Scottish Co-operator

Stirling Observer

Sunday Mail

Sunday Observer

Published Books and Articles - Pre-1939

Anon, *Dainty Dishes for the Sick and Invalid* (Glasgow, 1893).

Beeton, I., 'Duties of the Sick Nurse', in *Beeton's Book of Household Management* (First pub. 1861, reprinted, London, 1991).

Blaikie, W. G., *Miss Clugston and her Work* (Glasgow, 1875).

Bosanquet, B., 'The Principles and Chief Dangers of the Administration of Charity', *International Journal of Ethics*, 3 (April, 1893), pp. 323-336.

Boyd Orr, J., *Food Health and Income* (London, 1936).

Bryant, J., *Convalescence, Historical and Practical* (New York, 1927).

Buchan, A., *History of the Scottish Women's Co-operative Guild* (Glasgow, 1913).

- Burdett's Hospitals and Charities*, 1890-1830.
- Burdett, H. C., *How to Become a Nurse* (London, 1905).
- Burdett, H. C., *Cottage Hospitals, General Fever and Convalescent* (London, 1880).
- Burdett, H. C., *Hospitals and Asylums of the World* (London, 1893).
- Burdett, H. C., *Nursing Profession: How and Where to Train* (London, 1899).
- Burdett, H. C., *Hospitals and Asylums of the World, Vol III* (London, 1893).
- Burdett, H. C., *Burdett's Hospitals and Charities* (1899).
- Chalmers, A. K., *The Health of Glasgow 1818-1926* (Glasgow, 1930).
- Christie, J., *Medical Institutions of Glasgow* (Glasgow, 1888).
- Clay, R. A., *The Medieval Hospitals of England* (London, 1909).
- Clugston, B., *London and its Hospitals* (Glasgow, 1866).
- Clugston, B., *West of Scotland Convalescent Seaside Homes, Dunoon. A Short Account of their Present Position and Capabilities of Extension and Use* (Glasgow, 1871).
- Clugston, B., *Six Sabbaths in the Hospitals* (Glasgow, 1876).
- Clugston, B., *Missing Links in Scotland's Charities* (Glasgow, 1880).
- Clugston, B., *Speak to the Clock* (Glasgow, 1881).
- Comrie, J. D., *Black's Medical Dictionary*, (eighth edn, London, 1928).
- Comrie, J. D., *History of Scottish Medicine* (London, 1932).
- Davidson, W., 'Observations on the Climate of Largs, with Notices of the Other Principal Watering Places on the Clyde and their General Characteristics', *Edinburgh Medical and Surgical Journal*, 69 (1848) pp. 32-50.
- Delemare, Edmund S., *Wholesome fare: or the Doctor and the Cook* (London, 1886).
- Drummond, W. B., *A Medical Dictionary* (London, Toronto and New York, 1915).
- Fothergill, J. M., *Food for the Invalid, the Convalescent and the Dyspeptic and the Gouty* (London, 1880).
- Glasgow Post Office Directories*, 1880-1939.
- Gardiner, E. G., *Convalescent Care in Great Britain*, (Chicago, 1935).
- Gee, P., *The Other Side of the Miners' Life* (London, 1936).
- Groom, F., ed., *Ordnance Gazetteer*, Vol 2 (1895).
- Handbook of Glasgow Charitable and Beneficent Institutions* (Glasgow, 1888).
- Helensburgh Directory, 1913-14* (Helensburgh, 1913).
- Hillhouse, R., *Bygone years of the West of Scotland Convalescent Seaside Homes, Dunoon* (Glasgow, 1909).
- Lewis, P. G., *Nursing. Its Theory and Practice* (London, 1910).
- Lowth, A., *The Invalid and Convalescent Cookery Book* (New York, 1914).
- Mackay, D., *Bishop Forbes, a Memoir* (London, 1888).
- Macleod, G., 'Reasons Why Sanatoria should be Established on the Clyde for the Sick Poor of

- Glasgow', *GMJ*, (July, 1859), pp. 147-156.
- Macpherson, W. G., *History of the Great War. Medical Services General History, Vol. II* (London, 1923).
- Maxwell, W., *History of Co-operation in Scotland. It's Inception and it's Leaders* (Glasgow, 1910).
- Medical Directories, 1880, 1818, 1891.*
- Morrison, A. D., *The Story of Free St David's* (Kirkintilloch, 1926).
- Nightingale, F., *Notes on Hospitals* (Third edition. London, 1863).
- Nightingale, F., *Notes on Nursing* (first published, 1859, Glasgow, 1974 edition).
- Orwell, G., *Road to Wigan Pier* (First edition, 1937, Penguin edition, 2001).
- Radcliffe, F., 'Hydrotherapy as an Agent of the Treatment of Convalescents', *BMJ*, 21 October 1916.
- Russell, J.B., 'The Children of the City. What can we do for them?' *Health Lectures for the People* (Edinburgh 1886).
- Russell, J. B., 'Overlapping of Charitable Funds'. A paper given at conference organised by the COS in 1882.
- Roberts, Frederick T., 'Convalescence', in Richard Quain, ed., *Dictionary of Medicine*(London, 1890).
- Ryan, C., *Convalescent Cookery. A Family Handbook* (London, 1881).
- Sandell, T. E., 'Treatment of the Convalescent Soldier', *Lancet*, 26 June 1920, pp. 1352-56.
- Senn, C. H., *Cookery for Invalids and the Convalescent* (London & Melbourne, 1928).
- Swan, Annie. S., *The Child-Angel, An appeal on behalf of Children's Summer Trips and Children's Country Homes* (c.d. 1895).
- Tait McKenzie, R., 'The Treatment of Convalescent Soldiers by Physical Means', *BMJ*, 12 April 1916, pp. 215-218.
- Thomson, B., *Cookery for the Sick Cookery for the Sick and Convalescent with Directions for the Preparation of Poultices, Fomentation's* (London, 1886).
- Thomson, S., *A Dictionary of Domestic Medicine and Household Surgery* (London, 1866).
- Tully, A. and Urie, E. M., 'A Study of the Diets and Economic Conditions of Labouring-Class Families in Glasgow', *GMJ*, VI, (December, 1922), pp. 353-368.
- Ward and Lock's Popular History and Illustrated Guide to Glasgow, Dunoon and Rothesay* (London, 1880).
- Watson, T., *Kirkintilloch: Town and Parish* (Glasgow, 1894).

SECONDARY SOURCES

Unpublished Theses and dissertations

- Logan, Norma Davies, *Drink and Society in Scotland, 1870-1914*, unpublished PhD Thesis, University of Glasgow, 1983.
- Gaffney, Rona, *Development of Hospital Provision in Glasgow between 1867 and 1897*, unpublished PhD thesis, University of Glasgow, 1980.

- Heckman, Catherine, *Convalescence*, Unpublished MA Dissertation, Kings College, London, 1995.
- Ewan, James, *The School Health Service, Glasgow*, MD thesis, University of Glasgow, 1956.
- McFarlane, Neil Munro, *Tuberculosis in Scotland, 1870-1960*, unpublished PhD thesis, University of Glasgow, 1990.
- Paterson, Catherine F., 'The Development of Occupational Therapy in Scotland 1900-1960', unpublished PhD thesis, University of Aberdeen, 2002.
- Robinson, Jan. 'The Royal Sea Bathing Hospital at Margate', unpublished MSc, dissertation 1996.
- Thomson, Elaine, *Women in Medicine in the Late Nineteenth and Early Twentieth-Century Edinburgh, A Case Study*, unpublished PhD thesis, University of Edinburgh, 1996.

Books and Articles - post 1939

- Anon, 'Convalescent Treatment. Report of a Working Party', *The Almoner*, 12 (1959-60), p. 420.
- Abel-Smith, B., *A History of the Nursing Profession* (London, 1960).
- Abel-Smith, B., *The Hospitals* (London, 1964).
- Arnot, R. P., *The History of Scottish Miners* (London, 1955).
- Baly, M., *Nursing and Social Change* (London, 1977).
- Baly, M., 'The Nightingale Nurses: The Myth and the Reality', in C. Maggs, ed., *Nursing History: The State of the Art* (London, 1987).
- Best, G., *Mid-Victorian Britain 1851-75* (Third Edition, London, 1985).
- Bollet, A. J., *Plagues and Poxes, The Rise and Fall of Epidemic Disease* (New York, 1987).
- Bradley, J., Dupree, M. and Durie, A., 'Taking the Water-cure: The Hydropathic Movement in Scotland, 1840-1940', *Business and Economic History*, 26 (1997), pp. 426-37.
- Brotherston, J., 'Scottish Health Services in the Nineteenth Century', in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987).
- Brown, C. G., 'Popular Culture', in T. M. Devine and R. J. Finlay, eds., *Scotland in the 20th Century* (Edinburgh, 1996).
- Brown, C., 'Religion, Class and Church Growth' in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990).
- Brown, I., *A Summer in Scotland* (London, 1952).
- Bruce, M., *The Coming of the Welfare State* (Fourth Edition, London, 1968).
- Bryder, L., 'Buttercups, Clover and Daisies', in R. Cooter, ed., *The Name of the Child* (London, 1992).
- Bryder, L., *Below the Magic Mountain* (Oxford, 1988).
- Burnett, J., *A Social History of Housing* (London, 1980).
- Burnett, J., *The Scots in Sickness and in Health* (Edinburgh, 1997).
- Bynum, W. F., 'Medical Values in a Commercial Age', in *Victorian Values*, ed., T. C. Smout (Oxford, 1992).
- Bynum, W. F., *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994).

- Bynum, W. F., 'Medical Philanthropy after 1850' in eds., W. F. Bynum and Roy Porter, *Companion Encyclopaedia of the History of Medicine* (London and New York, 1993).
- Campbell, R. H., *Scotland Since 1707. The Rise of an Industrial Society* (Edinburgh, 1985).
- Campbell, A., *The Scottish Miners, 1874-2939. Industry Work and Community* (Aldershot, 2000).
- Campbell, A., *The Lanarkshire Miners* (Edinburgh, 1979).
- Cage, R. A., *The Working Class in Glasgow 1750-1914* (London, 1987).
- Carlin, M., 'Medieval English Hospitals' in L. Granshaw and R. Porter, eds., *The Hospital in History* (London and New York, 1989).
- Castledine, G., 'The Value of Convalescent Care', *British Journal of Nursing*, Vol. 3, 10 August 1994, pp. 278-9.
- Catford, E. F., *The Royal Infirmary of Edinburgh, 1929-1979* (Edinburgh, 1984).
- Checkland, O. and S., *Industry and Ethos* (Edinburgh, 1989).
- Checkland, O., *Philanthropy in Victorian Scotland* (Edinburgh, 1980).
- Cherry, S., *Medical Services and the Hospitals in Britain 1860-1939* (Cambridge, 1996).
- Coleman, B. I., *The Idea of the City* (London and Boston, 1973).
- Cooter, R., *Surgery and Society in Peace and War. Orthopaedics and the Organisation of Modern Medicine* (Basingstoke and London, 1993).
- Copeman, W. S. C., 'The Royal Hospitals before 1700', in F.N.L. Poynter, ed., *The Evolution of Hospitals in Britain* (London, 1964).
- Crowther, M. A., 'Poverty, Health and Welfare' in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990).
- Crowther, M. A., *Social Policy in Britain 1914-1939* (London, 1988).
- Cunningham, A. S., *The Charles Carlow Convalescent Home, Report of the Opening Ceremony of the Home* (1927).
- Cunningham, H., *Leisure in the Industrial Revolution* (London, 1980).
- Dennis, N., Henriques, F. and Slaughter, C., *Coal is our Life* (London, 1956).
- Devine, T. M., *The Scottish Nation 1700-2000* (London, 1999).
- Dicks, B., 'Choice and Constraint: Further Perspectives Socio-Residential Segregation in Nineteenth-Century Glasgow with particular reference to the West End', in G. Gordon, ed., *Perspectives of the Scottish City* (Aberdeen, 1985).
- Digby, A., *Making a Medical Living* (Cambridge, 1994).
- Dingwell, R., Rafferty, M. and Webster, C., *An introduction to the Social History of Nursing* (London, 1998).
- Doherty, J., 'Dundee – A Post Industrial City', in C. Whatley ed., *The Re-making of 'Juteopolis' – and How It Was* (Dundee, 1992).
- Dow, D., *Paisley Hospitals, The Royal Alexandra Infirmary and Allied Institutions 1786-1986* (Glasgow, 1988).

- Dow, D., *The Rotton Row, The History of the Glasgow Maternity Hospital, 1834-1894* (Carnforth, 1984).
- Dow, D., *The Royal Samaritan Hospital for Women, Glasgow* (Glasgow, 1986).
- Drummond, A. and Bulloch, J., *The Church in Victorian Scotland, 1843-1874* (Edinburgh, 1975).
- The Dumfries and Galloway Royal Infirmary, A Brief Pictorial Survey, 1776-1948*, n.d.
- Duncan, B., 'The Development of Hospital Design and Planning', in F. N. L. Poynter, ed., *The Evolution of Hospitals in Britain* (London, 1964).
- Dupree M. W. and Crowther, M. A., 'A Profile of the Medical Profession in Scotland in the Early Twentieth Century: The Medical Directory as a Historical Source', *Bulletin of History of Medicine*, 65 (1991), pp. 223-231.
- Dupree, M. W., 'Other than Healing: Medical Practitioners and the Business of Life Assurance during the Nineteenth and Early Twentieth Centuries', *Social History of Medicine* (1997), p. 81.
- Dupree, M. W., 'The Provision of Social Services' in D. M. Palliser, P. Clark, and M. Daunton, eds. *The Cambridge Urban History of Britain, Vol III 1840-1950* (Cambridge, 2000).
- Dwork, D., *War is Good for Babies and other Young Children* (London, 1987).
- Dyos, H. J., *Exploring the Urban Past* (Cambridge, 1982).
- Fallows, D., *Convalescence, A Neglected Need?* (London, 1989).
- Fergusson, T., *Scottish Social Welfare, 1864-1914* (Edinburgh & London, 1958).
- Ferriman, A., 'Convalescence to Make a Comeback', *BMJ*, 12 February, 2000, p. 401.
- Finlayson, G., *Citizen, State and Social Welfare in Britain 1830-1990* (Oxford, 1994).
- Fraser, D., *The Evolution of the British Welfare State* (London and Basingstoke, 1975).
- Fraser, H., 'Developments in Leisure', in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990).
- Gibson, H. C., *Dundee Royal Infirmary 1798 to 1948* (1948).
- Golden, J., ed., *Infant Asylums and Children's Hospitals*, (New York and London, 1989).
- Goldie, F., *A Short History of the Episcopal Church in Scotland* (London, 1951).
- Goldman, M., *Lister Ward* (Bristol, 1987).
- Gordon, E., 'Women's Spheres', in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990).
- Gorsky, M., Mohan J. and Powell, M., 'British Voluntary Hospitals 1871-1938: the Geography of Provision and Utilization', *Journal of Historical Geography*, 25 (1999), pp. 463-482.
- Gosden, P. H., *Self-Help. Voluntary Associations in the 19th Century* (London, 1973).
- Gould, T. and Uttley, D., *A History of the Atkinson Morley Hospital* (London, 1996).
- Granshaw, L., *St Mark's Hospital, London* (London, 1985).
- Gray, G. R., and Ross, W., 'Ancillary and Paramedical Staff', in S. Slater and D. Dow, eds., *The Victoria Infirmary of Glasgow, 1890-1900* (Glasgow, 1990).
- Gray, J. A., *The Edinburgh City Hospital* (East Lothian, 1999).

- Guthrie, D., *The Royal Edinburgh Hospital for Sick Children, 1860–1960* (Edinburgh, 1960).
- Hart, H. W., 'Some Notes on the Sponsoring of Patients for Hospital Treatment under the Voluntary System', *Medical History*, 24 (1980), pp. 447-460.
- Haeger, K., *History of Surgery* (London, 1988).
- Harris, J., *Private Lives, Public Spirit. A Social History of Britain 1870-1914* (Oxford, 1993).
- Hamilton, D., *The Healers* (Edinburgh, 1987).
- Hamish Fraser, W., 'The Working Class', in I. Maver and W. Hamish Fraser (eds.) *Glasgow, Volume II, 1830-1912* (Manchester, 1996).
- Hardy, A., 'Whooping Cough' and 'Scarlet Fever', in Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease* (Cambridge, 1993).
- Hardy, A., *Medicine in Britain since 1860* (Basingstoke, 2001).
- Harrington, W. G., *Stirling Royal Infirmary 1874-1974* (Stirling, 1974).
- Harvey, B., *Living and Dying in England, 1100-1540* (Oxford, 1993).
- Harvie, C., *No Gods and Precious Few Heroes* (Edinburgh, 1981).
- Hay, J. R., *The Origins of the Liberal Welfare Reforms* (London and Basingstoke, 1975).
- Hector, W., *The Work of Mrs Bedford Fenwick and the Rise of Professional Nursing* (London, 1973).
- Hembry, P., *British Spas from 1815 to the Present. A Social History* (London, 1997).
- Hendrick, H., 'Child Labour, Medical Capital and the School Medical Service, c.1890-1918' in R. Cooter, ed., *The Name of the Child* (London and New York).
- Hobday, R. A., 'Sunlight Therapy and Solar Architecture', *Medical History*, 42 (1997), pp. 455-72.
- Horn, P., *The Rise and Fall of the Victorian Servant* (Dublin, 1975).
- Howe, G. M., *People, Environment, Disease and Death* (Cardiff, 1997).
- Howie, W. B. and Black, S. A., 'Hospital Life a Century Ago', *BMJ*, 28 August 1976, p. 516.
- Gaffney, R., 'Women as Doctors and Nurses', in O. Checkland and M. Lamb, eds., *Health Care as Social History* (Aberdeen, 1982).
- Jenkins, W. *Memories of St Ninians* (Stirling, 1999).
- Jenkinson, J., Moss, M. and Russell, I., *The Royal* (Glasgow, 1994).
- Jenkinson, J., 'Social Health Policy 1918-1948 – Paving the Way into a National Health Service?' in Jones, H., *Health and Society in Twentieth Century Britain* (London and New York, 1994).
- Kerr, A. and McQueen, L., *The Western Infirmary in Glasgow, 1874-1974* (Glasgow, 1974).
- Kidd, A. J., 'Philanthropy and the Social History Paradigm', *Social History*, 21 (1996), pp. 180-191.
- Kim-Farley, R. J., 'Measles', in Kenneth F. Kiple, ed., *The Cambridge World History of Human Disease* (Cambridge, 1993).
- Kinnaird, J., 'The Hospitals' in G. McLaughlin, ed., *Improving the Common Weal* (Edinburgh, 1987).
- Lawrence, C., *Medicine in the Making of Modern Britain 1700-1920* (London and New York, 1994).
- Lenman, B., *An Economic History of Modern Scotland 1660-1977* (London, 1977).
- Levack, I. D., and Dudley, A. F., *Aberdeen Royal Infirmary* (London, 1992).

- Levitt, I., *Poverty and Welfare in Scotland, 1890-1948* (Edinburgh, 1988).
- Lewis, J., 'The Boundary between Voluntary and Statutory Social Service in the Late Nineteenth and Early Twentieth Centuries', *The Historical Journal*, Vol. 39 (March, 1996), p. 166-7.
- Logan Turner, A., *Story of a Great Hospital, The Royal Infirmary of Edinburgh* (Edinburgh, 1979).
- Lomax, E., 'Small and Special: The Development of Hospitals for Children in Victorian Britain', *Medical History, Supplement No 16* (1996).
- Lundh, U., 'The Challenges of Improved Discharge Planning in Sweden and the UK: Different but the Same', *Journal of Clinical Nursing*, Vol. 6, (November 1997).
- Goldman, M., *Lister Ward* (Bristol, 1987).
- McConnell, J. K., 'Shorter Convalescence', *Lancet*, 12 July 1930, p. 86.
- Macdonald, I., *A Family in Skye* (Stornoway, 1980).
- McKenna, H., 'Discharge Planning: an Exploratory Study', *Journal of Clinical Nursing*, 9 (July 2000).
- Mackenzie, T. C., *The Story of a Scottish Voluntary Hospital* (Inverness, 1946).
- MacGregor, A., *Public Health in Glasgow 1905-1946* (Edinburgh and London, 1967).
- MacQueen, L. and Kerr, A., *The Western Infirmary, 1874-1974* (Glasgow, 1974).
- Marland, H., *Medicine and Society in Wakefield and Huddersfield, 1780-1870* (Cambridge, 1987).
- McBride, T., *The Domestic Revolution*, (London, 1976).
- McCaulay, J. S. A., *St Leonard's School* (St Andrews, 1977).
- McGann, S., *The Battle of the Nurses* (London, 1992).
- McGrew, R., ed., 'Diphtheria' in *Encyclopaedia of Medical History*, (London and Basingstoke, 1985).
- McIvor, A. J., *A History of Work in Britain 1880-1950* (Basingstoke, 2001).
- McSherry, R. and M., *Old Saltcoats* (Ochiltree, 1995).
- Mercer, A., *Disease, Mortality and Population in Transition* (Leicester, 1990).
- Miles, A. and Cunningham, J., *The Convalescent-Rehabilitation Hospital as an Integral Part of the National Health Service* (Edinburgh, 1951).
- Miri, R., 'Development and Change in English Hospitals, 1100-1500' in L. Granshaw and R. Porter, eds., *The Hospital in History* (London and New York, 1989).
- Moore, J., *A Zeal for Responsibility* (Athens and London, 1988).
- Morgan, N. J., 'Building the City' in: I. Maver and W. Hamish Fraser (eds.) *Glasgow, Volume II, 1830-1912* (Manchester, 1996).
- Morris, R. J., 'Urbanisation and Scotland' in W. Hamish Fraser and R. J. Morris, eds., *People and Society in Scotland, Vol. II, 1830-1914* (Edinburgh, 1990).
- Morris, R. J., 'Structure, Culture and Society in British Towns', in M. Daunton ed., *The Cambridge*
- Mowat, C. L., *Britain Between the Wars, 1918-1940* (London, 1955).
- Murray, W. A., *A Life Worth Living* (n.d).
- Nottingham, C., ed., *The NHS in Scotland* (Hampshire, 2000).

- Oliphant, E., 'Newhills Convalescent Home and Sanatorium' in David Rorie, ed., *The Book of Aberdeen*, (Aberdeen, 1939).
- Orme, N. and Webster, M., *The English Hospital 1070-1570* (London and New Haven, 1995).
- Palliser, D., Clark, P. and Daunton M., *Urban Britain, Vol III 1840-1950* (Cambridge, 2000).
- Patrick, J., *A Short History of the Glasgow Royal Infirmary*, (Glasgow, 1940).
- Pennington, C., 'Tuberculosis', in O. Checkland and M. Lamb, eds., *Health Care as Social History* (Aberdeen, 1982).
- Perry, W., *Alexander Penrose Forbes* (London, 1939).
- Pickstone, J., *Medicine and Industrial Society* (Manchester, 1985)
- Price, R., 'Hydrotherapy in England 1840-70', *Medical History*, 25 (1981), p. 269.
- Prochaska, F., *Philanthropy and the Hospitals of London* (Oxford, 1992).
- Prochaska, F., *Women and Philanthropy in Nineteenth-Century England* (Oxford, 1980).
- Prochaska, F., *The Voluntary Principle* (London, 1973).
- Richardson, H., *English Hospitals 1660-1948* (Swindon, 1998).
- Reid, L., *Scottish Midwives* (East Linton, 2000).
- Riley, J. C., *Sick, not Dead. The Health of the British Working Man* (London, 1997).
- Risse, G. B., *Hospital Life in Enlightenment Scotland* (Cambridge, 1986).
- Risley, M., *The House of Healing* (London, 1962).
- Robertson, E., *Glasgow's Doctor, James Burn Russell, 1837-1904* (East Lothian, 1998).
- Robertson, E., *The Yorkhill Story* (Glasgow, 1972).
- Rodger, R., 'Employment, Wages and Poverty in the Scottish Cities, 1841-1914', in George Gordon ed., *Perspective of the Scottish City* (Aberdeen, 1985).
- Rorie, D., ed., *The Book of Aberdeen* (Aberdeen, 1939).
- Salmon, J., *The Proud Heritage, The Story of the Railway Convalescent Homes* (London, 1954).
- Scott Marshall, J., *Leith's Greatest Charity* (Edinburgh, 1978).
- Slater, S. and Dow, D., *The Victoria Infirmary of Glasgow 1890-1990* (Glasgow, 1990).
- Smith, C., *Between the Streamlet and the Town* (Edinburgh, 1988).
- Smith, F. B., *The Retreat of Tuberculosis 1850-1950* (Beckenham, 1988).
- Smith, D. F. and M. Nicholson M., 'Poverty and Ill Health Controversies Past and Present', *Proc. R. Coll. Physicians Edin.* 22 (1982), pp. 190-99.
- Smith, I. and A. Swan, A., 'Medical Officers and Therapeutics, 1814-1921', in I. Smith, and J. Andrews, eds., *Let There Be Light* (1993).
- Smith, T., 'Convalescence', *BMJ*, 10 February 1996, p. 383.
- Smout, T. C., *A Century of the Scottish People, 1830-1950* (London, 1987).
- Sorsby, M., ed., *The National Health Service* (Edinburgh, 1953).
- Spring Rice, M., *Working Class Wives* (Second Edition, London, 1981).
- Stevens, M., *The Good Scots Diet, What Happened to it?* (Aberdeen, 1985).

- Stewart, D. and Burnett, M., *100 years of the Convalescent Home, Nairn* (Nairn, 1993).
- Strong, R., *Alexander Forbes of Brechin* (Oxford, 1995).
- Suchman, E., 'Stages of Illness and Medical Care', *Journal of Health and Human Behaviour*, 6 (1965), pp. 114-128.
- Taylor, J., *The Architect and the Pavilion Hospital* (London, 1997).
- Thane, P., *The Foundations of the Welfare State* (Sixth Edition, Harlow, 1889).
- Thompson, E. M. L., *The Rise of Respectable Society* (London, 1988).
- Thompson, R., 'Bothwell', in D. Burns, A. Reid and I. Walker, eds., *Hamilton and District. A History* (Hamilton, 1995).
- Treble, J. H., *Urban Poverty in Britain* (London, 1979).
- Vogal, M. J., *The Invention of the Modern Hospital* (Chicago and London, 1980).
- Walsh, L., 'From the Grampians to the Firth of Forth', the Development of the Dundee Royal Infirmary', in L. Miskell, C., Whatley and B. Harris, eds., *Victorian Dundee: Image and Realities* (East Lothian, 2000).
- Walvin, J., *Leisure and Society 1850-1950* (London, 1978).
- Warboys, M., 'The Sanatorium Treatment for Consumption in Britain, 1890-1914', in John V ed., *Medical Innovations in Historical Perspective* (New York, 1992).
- Warner, J. H. 'Therapeutic Explanation and the Edinburgh Bloodletting Controversy', *Medical History*, 24 (1980), p. 241.
- Weindling, P., 'From Medical Research to Clinical Practice: Serum Therapy for Diphtheria in the 1880s', in John V Pickstone, ed., *Medical Innovations in Historical Perspective* (New York, 1992).
- Weindling, P., 'Linking Self Help and Medical Science: The Social History of Occupational Health' in Weindling, P., ed., *The Social History of Occupational Health* (Beckenham, 1985).
- Weir, M., *Shoes were for Sunday* (London, 1970).
- Whatley, C., *Life and Times of Dundee* (Edinburgh, 1993).
- Whatley, C., *The Industrial Revolution in Scotland* (Cambridge, 1997).
- Whitehouse, J., *The Unfinished History of the Railway Convalescent Homes* (Portsmouth, 1986).
- Whiteside, N., *Bad Times* (London, 1991).
- Wilkinson, J., *The Coogate Doctors. The History of the Edinburgh Medical Missionary Society 1841-1991* (Edinburgh, 1991).
- Williams, J., *Art of Feeding the Invalid and Convalescent* (London, 1923).
- Wilson-Barnett, J. and Fordham, M., *Recovery from Illness* (Chichester, 1982).
- Wilson, L. A., 'Matthew Hay (1855-1932)', in George P. Milne, ed., *Aberdeen Medico-Chirurgical Society, A Bicentennial History* (Aberdeen, 1989).
- Wilson, S., 'The Public Health Services, in Gordon McLachland, ed., *Improving the Common Weal, Aspects of Scottish Health Services, 1900-1984* (Edinburgh, 1987).

- Withey, L., *Grand tours and Cook's Tours: A History of Leisure Travel, 1750 to 1915* (London, 1997).
- Woodward, J., *To the Sick Do No Harm* (London, 1974).
- Wordsall, F., *The Glasgow Tenement* (Glasgow, 1979).
- Wyllie, S. C. and Wilson J., *Troon in Old Picture Postcards* (Zaltbommel/Netherlands, 1991).
- Youngson, A. J., *The Scientific Revolution in Victorian Medicine* (London, 1979).