

A Short History of Hospice Care: From the Middle Ages to the 21st Century

Source: Hospice Education Institute, 2008, <http://www.hospiceworld.org/history.htm>

Middle Ages: Religious orders establish “hospices” at key crossroads on the way to religious shrines like Santiago de Compostela, Chartres and Rome. These shelters helped pilgrims, many of whom were traveling to these shrines seeking miraculous cure of chronic and fatal illnesses, and many of whom died while on their pilgrimages.

16th-18th Centuries: Religious orders offer care to the sick (including the dying) in locally or regionally based institutions. Most people die at home, cared for by the women in the family.

1800s: Madame Garnier of Lyon, France opens a “calvaire” to care for the dying. In 1879 Mother Mary Aikenhead of the Irish Sisters of Charity opens Our Lady’s Hospice in Dublin, caring only for the dying. By the late 19th Century, the increase in municipal or charitably-financed infirmaries, almshouses and hospitals, and the expansion of medical knowledge, begins the process of “medicalizing” dying. (By the mid-20th Century, almost 80% of people in the U.S.A. die in a hospital or nursing home.)

1905: The Irish Sisters of Charity open St. Joseph’s Hospice in East London, to care for the sick and the dying.

Early 1900s: In London, St. Luke’s Hospice and the Hospice of God open to serve the destitute dying.

1935-1990s: Interest grows in the psychosocial aspects of dying and bereavement, sparked by the work of Worcester, Bowlby, Lindemann, Hinton, Parkes, Kubler-Ross, Raphael, Worden and others.

1957-67: Cicely Saunders, a young physician previously trained as a nurse and a social worker, works at St. Joseph’s Hospice, studying pain control in advanced cancer. Here Dr. Saunders pioneered in the regular use of opioid analgesics given “by the clock” instead of waiting for the pain to return before giving drugs. This is now standard practice in good hospice and palliative care.

1967: Dr. Saunders opens St. Christopher’s Hospice in London, emphasizing the multi-disciplinary approach to caring for the dying, the regular use of opioids to control physical pain, and careful attention to social, spiritual and psychological suffering in patients and families.

1968-75: Many hospice and palliative care programs open in Great Britain in the years following, adapting the St. Christopher’s model to local needs, offering in-patient and home care.

1974: New Haven Hospice (now Connecticut Hospice) begins hospice home care in the United States, caring for people with cancer, ALS and other fatal illnesses.

1974-78: Hospices and palliative care units open across North America. These include Hospice of Marin in California, the Palliative Care Unit at the Royal Victoria Hospital in Montreal, the Support Team at St. Luke’s Hospital in New York City, and Church Hospital Hospice in Baltimore.

1980s: Hospice care, usually emphasizing home care, expands throughout the United States. Medicare adds a hospice benefit in 1984. Hospices begin to care for people with advanced AIDS.

1990-2000: Over 3,000 hospices and palliative care programs serve the United States. There is well-established hospice and palliative care in Canada, Australia, New Zealand, and much of Asia and Western Europe. Hospice and palliative care is now available in over 40 countries worldwide, including many less-developed nations. World Health Organization sets standards for palliative care and pain control, calling it a “priority.” But studies show that most patients still receive little or no effective palliative care, and pain is often very poorly controlled, primarily due to lack of medical knowledge, to unfounded fears of addiction, and (in less-developed nations) to shortage of opioids.

21st Century: The principles of good hospice and palliative care are understood and accepted, and all patients with advanced illness, and their families, are assured of competent and compassionate care in their homes, in nursing homes and in hospitals.