Research Article

Sir James Reid and the Death of Queen Victoria: An Early Model for End-of-Life Care

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Abstract

Purpose of the Study: An appraisal of the last ten days of Queen Victoria’s life, viewed primarily from the perspective of her personal physician, Sir James Reid, is presented. Design and Methods: Sir James’ clinical encounters with his patient and the Royal Family are examined to reveal his strategic and medical thinking and gauge his level of success in basic palliative aims. Results: It was found that the lack of effective medical interventions, tensions within the Royal Family, the importance of his post to Sir James’ professional career, and the political ramifications unavoidably connected with the illness of a head of state, all presented challenges to Reid’s efforts to ease the physical and emotional pain of Queen Victoria’s dying. Key features of Sir James’ approach included reliance on physician–patient and physician–family relationships, emphasis on emotional support for the patient, and the careful selection of interventions for the family. Implications: In the first years of the 20th century, an era when the contemporary concepts of palliative care, hospice, and family dynamics did not exist, Sir James’ management of the Queen’s final illness suggested an early model for end-of-life care. By the end of Queen Victoria’s life, Sir James was seen to have preserved his patient’s comfort and dignity, at the same time advancing family and societal acceptance of the death of this matriarchal figure.

Key Words: Depression, Palliation, Dying

On January 13, 1901, Sir James Reid, Queen Victoria’s principal physician for 20 years, confronted a dying patient: an elderly woman who was weakened, cachectic, and only intermittently alert. This account describes aspects of the actions Sir James took during the last ten days of the Queen’s life. In ways that anticipated contemporary approaches to end-of-life care, Sir James oversaw medical interventions and chose consulting physicians; he called upon the confidential relationship he had developed over many years with his patient to provide a terrified Queen Victoria with meaningful emotional support; and he overcame substantial obstacles to facilitate family acceptance of
Her Majesty's impending death. Without explicitly articulating principles of palliative care and hospice, and having access to few pharmacological options, Reid was nevertheless able to achieve the fundamental palliative aims that have changed little since his time. However, in 1901, Sir James alone assumed responsibility for the care provided to Queen Victoria and the attention given to her family. This all-encompassing role stands in contrast to the arrangement more frequently seen today, in which the physician works in concert with a multidisciplinary care team, with various tasks apportioned to its different members.

As the new reign began, Sir James also undertook the politically consequential assignment of explaining Queen Victoria's death to the world and safeguarding her image. Because of the unparalleled importance of his patient, Sir James' efforts affected not only the immediate Royal Family but also had geopolitical implications for his nation and its Empire.

**Background: Queen Victoria Before January 13, 1901: Geriatric Depression and Decline**

It has been proposed that Queen Victoria's death on January 22, 1901 at the age of 81 years was the indirect consequence of major depression (Abrams, 2010). She had already experienced a severe, protracted mourning for her husband Prince Albert 40 years earlier, but by the mid-1880s, she had largely recovered.

However, by the summer of 1900, Queen Victoria had become caught up in a new and irreversible cycle of suffering (Longford, 1964; Mallet, 1968; Packard, 1995; Strachey, 1921; Weintraub, 1988). She experienced further personal losses and declining health, both factors strongly associated with geriatric depression (Alexopoulos et al., 2002). By August 1900, she had weathered the deaths of three of her nine children and that autumn lost a much-loved grandson, while at the same time awaiting the death from cancer of her eldest child. She also agonized over the mounting casualties in the South African conflict. By November, she had become frankly melancholic. Her appetite waned drastically, so that by the time of her death, she had lost nearly half of her body weight (Packard, 1995).

Malnourished and weak, in pain from osteoarthritis, she was further exhausted by insomnia; fatigue in turn compounded the inanition she had begun to develop years earlier after a leg injury. Cataracts clouded her vision, and compounded the inanition she had begun to develop years years before.

Late-life depression, with underlying cerebrovascular disease, has been considered the most likely explanation for Queen Victoria’s decline in the last year of her life (Abrams, 2010). Geriatric depression may, however, be a default diagnosis, the notes of her principal physician, Sir James Reid, providing no substantive evidence for any other disease process. What is unmistakably clear is that by January 13, 1901, the endgame had begun, and Queen Victoria lay near death at Osborne House, her seaside retreat on the Isle of Wight.

**Sir James Reid, Queen Victoria’s Personal Physician**

Sir James Reid, Bt. (1849–1923) was born in Ellon, Aberdeenshire, the son of a rural Scottish veterinarian. Educated locally, he had briefly practiced privately in London and then, having learned German, undertook postgraduate medical studies in Vienna before being recommended for a post with Queen Victoria in 1881. At that time, the Queen had been seeking a physician native to Scotland who would also be sufficiently fluent in German to treat the visiting members of her extended family who spoke little or no English. Such a candidate pool was necessarily restricted, but James Reid was a seamless fit, and his blend of candor, tact, and humor helped him to quickly earn Her Majesty’s trust. In 1889, he was promoted to the ranking position of Physician-in-Ordinary, succeeding Sir William Jenner. The Queen had great confidence in him, and unlike previous “Ordinaries,” who were mostly consultants, Sir James remained with the Queen as her primary physician until her death, accompanying her both at home and abroad. Often the Queen “would open her heart to him in conversations varying from whether dogs had souls and an after-life to her hatred of [Prime Minister] Gladstone …” (Reid, 2001). Clearly, Sir James Reid had assumed a position of intimacy with Queen Victoria not evident from his actual title.

Traveling to Osborne on August 3, 1898 to receive a baronetcy from the Queen, the celebrated neurologist William Gowers, a colleague of Reid’s, wrote:

Knowing Sir James Reid well, made the visit especially full of interest. He has a baronetcy—well deserved, indeed, considering how the Queen went thro’ the Jubilee affair & his tremendous responsibility. She takes advice from no one else. He is [a] splendidly straightforward honest good Scotchman & has a very close personal position outside professional relations … . This profession owes more to him than will ever be known (Scott, Eadie, & Lees, 2012).

**Deathwatch: The Last Ten Days of the Queen’s Life (January 13–22, 1901)**

This review of Queen Victoria’s last ten days is based on Sir James Reid’s diary, with excerpts taken from the citations published by his biographer and granddaughter-in-law, Lady (Micheala) Reid (Reid, 1987). The limitations of the source material presented by Lady Reid must be acknowledged. Just as in the case of the Queen’s own Journal, the original Reid diaries were burned after his death pursuant to his explicit instructions.
It cannot, therefore, be known exactly what was lost in the conflagration or later redacted by Sir James’ executors and descendants. Nevertheless, what Lady Reid has released remains for historians the principal contemporaneous account of the days leading up to Queen Victoria’s death.

**Sir James Reid’s Medical Role in End-of-Life Care: Palliation or Stewardship?**

Sir James Reid’s management of the Queen’s illness during the last nine days of her life was not strictly palliative in the contemporary sense, at least not pharmacologically. The only documented medical intervention given to the semi-conscious Queen throughout her final days was the administration of oxygen. In contrast, during the last year of Her Majesty’s life, Reid had been called upon to prescribe analgesic and supportive measures typically used for elderly patients in the late-Victorian era (Snow, 2008). For example, when requested at night to provide relief for the Queen’s insomnia, Sir James gave chlorodyne, a vestigial version of the hypnotic chloral hydrate, or simply hot tea laced with whiskey (a concoction to which Her Majesty had previously been introduced by her servant John Brown and for which she had developed a lasting fondness).

Queen Victoria probably also took, as her daughter Princess Christian did habitually, either a form of opium or a barbiturate then available, such as Trional, to relieve her increasingly severe osteoarthritic pain (Packard, 1995). Further, Reid had attempted throughout the Queen’s last year to control her weight loss by augmenting her meager nutritional intake with Benger’s Food, a floury paste given as a dietary supplement to elderly or edentulous patients (Abrams, 2010; Weintraub, 1988).

By January 1901, the Queen was beyond the reach of most of these palliative geriatric interventions. There is no record of Her Majesty receiving either sleep-inducing or analgesic medications during the ten-day deathwatch period, possibly because her ability to swallow was beginning to fail, her level of alertness was fluctuating, or because Reid did not deem it politic to make that aspect of her care known.

Sir James’ purely medical activity during this time might be described as stewardship, fundamentally akin to that of a 21st-century primary care physician or clinical-care manager charged with coordinating the assistance of disparate specialists. On January 13, for example, Reid arranged for Queen Victoria’s eyes to be examined by the German ophthalmologist Hermann Pegenstecher, who had treated her failing vision in the past by pupillary dilation around bilateral cataracts. Dr Pegenstecher was widely known for his development of the then-innovative technique of intracapsular cataract extraction, but he had thus far been unable to persuade the Queen to undergo the risky surgery. During the last several years of her life, the Queen was therefore compelled to depend on her youngest daughter, Princess Beatrice, to read aloud the large daily cache of State documents that could be approved and executed only by the Sovereign.

On January 15, however, Dr Pegenstecher was not primarily interested in the Queen’s cataracts. He was instead concerned with fundoscopic evidence of microvascular pathology, consistent with Her Majesty’s “altered” disposition, which Reid had described several days earlier as “apathetic and childish.” According to Sir James, Dr Pegenstecher confirmed his own assessment of “cerebral degeneration” (Reid, 1987).

On January 17, realizing that he could not cope with the complex clinical situation unassisted, Reid sent for another of the Queen’s Physicians-in-Ordinary, Sir Richard Douglas Powell, to provide backup medical support. Then, a few days later, on January 20, with the Queen’s condition deteriorating steadily, Reid also called in a cardiologist, Sir Thomas Barlow (Physician Extraordinary, the courtesy title bestowed on retired “Ordinaries”). Sir Thomas in fact had nothing new to offer, but Reid and Powell, tense and vigilant, were grateful for the support. “We were very glad to have him with us” (Reid, 1987).

However, it should be noted that Sir James Reid had never been allowed to perform a physical examination on Her Majesty, for reasons of protocol, tradition, and the Queen’s personal preference, although she had apparently allowed at least some level of examination during the births of her nine children, having for her last confinement been one of the first women in Britain to deliver a child under general anesthesia (Snow, 2008). But presumably the cardiologist Barlow was now, like Reid, relegated to educated guesses based on observations of the patient at a distance.

**Sir James Reid as Manager of Family Dynamics During End-of-Life Care**

It can be argued that although Sir James’ ability to intervene medically was limited, his influence on both his patient and the Royal family was considerable. Reid was a deeply respected and admired figure. His judgment and reassuring temperament were appreciated by all members of the family except possibly Princess Christian of Schleswig-Holstein (Helena), the Queen’s third daughter; thus, although the children of Queen Victoria could agree on little among themselves, they were united in their acceptance of Sir James’ authority. Reid, moreover, provided a reliable and consistent presence throughout this ten-day period, literally so—sleeping little, he rarely left the Queen’s bedside.

Princess Christian, along with Princesses Beatrice and Louise, had been one of the three daughters of Queen Victoria at Osborne at this time. A conflict had arisen when Princess Christian became outraged at a telegram Reid sent to the Prince of Wales informing him that the Queen’s condition had become grave; in the telegram, Reid had also requested that the Prince spend the weekend in London, not at his remote Norfolk estate, so that he would be able to come to the Queen’s bedside on short notice. Reid was
unsuccessful in this request, and the Prince journeyed to Norfolk anyway. But Princess Christian hotly confronted Reid on January 19 for having sent the message, accusing him of alarming the family unnecessarily.

All three princesses on the scene were in fact having difficulty accepting that their august mother could actually die. Princess Christian had been the most unwilling to hear Reid’s assessment of the Queen’s dire state and was now proving to be a subversive influence. In the end, however, Reid stood his ground, and Princess Christian grudgingly gave way.

Another barrier to the Royal children’s acceptance of their mother’s impending death was Queen Victoria’s own expressed reluctance to die. Regarding the arrangements for after her death, Queen Victoria had left several memoranda dating from the 1870s that included instructions for a funeral featuring the role she intended for her much-loved servant John Brown. These instructions were not revised until 1897, by which time Brown had long since died. One of the original memoranda included an odd phrase which could read either as straightforward or conditional, the latter interpretation suggesting that the Queen may have fancied that she would not die for a very long time, perhaps never: “In case of the Queen’s death she wishes that her faithful and devoted personal attendant (and true friend) Brown should be in the room ….” (emphasis added) (Reid, 1987).

Either way, the Queen’s daughters were not alone in their reluctance to accept that Her Majesty could die. The prospect of the formidable Queen Victoria dying after a 63-year-old reign, at the height of Britain’s global influence and power, had about it an air of unreality for many. Yet even as that reality had begun to appear bleak, the Queen, as late as January 19, repeatedly asked Sir James: “Am I better?” and famously: “I should like to live a little longer, as I have still a few things to settle …” (Reid, 1987). These remarks imply that however much she may have longed to be reunited with Albert, Queen Victoria still recoiled from the prospect of imminent death.

Throughout these critical ten days, Reid maintained what would now be regarded as a well-established therapeutic alliance with Queen Victoria (Martin, Garske, & Davis, 2000). He also created sturdy working relationships with those of her children who were present, even with Princess Christian following their initial confrontation. The strength of these ties became apparent in the moments immediately after the Queen’s death on January 22, when the new King and Queen, and many of Queen Victoria’s surviving children and grandchildren spontaneously, one by one, went over to Reid to express their gratitude for all he had done during the fraught ten days just concluded.

It is difficult to envision that these fundamental relationships, physician–patient and physician–family, would be materially different under similar circumstances in present-day settings, particularly when, in the expectation of a patient’s death, a hospice-like approach is taken in lieu of interventions aimed to cure (Wetle et al., 2005). In fact, Reid’s emphasis on helping the Royal Family, especially the Prince of Wales and the trio of princesses, grasp and accept what was about to happen, has a distinctly contemporary quality.

Although it is not explicitly stated in his diary, judging from his actions Sir James seemed to feel that it was important, and squarely in his remit, to help Queen Victoria’s children understand their mother’s prognosis. They would otherwise find themselves emotionally unprepared for her death and for the changes in their own lives that would immediately follow. As events would prove, Reid’s bold opposition to Princess Christian had been a pivotal moment.

It was well known that the princesses despised each other and since childhood had communicated rarely (St Aubyn, 1979), but Sir James does not specifically mention that fact, either. He appeared to believe that these long-standing internecine rivalries posed too large a problem for him to address. But if the sons and daughters of the Queen could, after her death, recognize the shared aspects of their grief, all would benefit. That they agreed in the immediate aftermath of Her Majesty’s death that Reid had succeeded in his role brought them together on at least that point.

Sir James Reid and the Prince of Wales During the Queen’s Last Days

Throughout the ten-day deathwatch, Sir James Reid was seen to encourage and promote the leadership role of the Prince of Wales, Queen Victoria’s Heir Apparent and England’s future king. This was a secondary but nevertheless important aim, intended to help prepare members of the Royal Family for the accession of the next Sovereign, and therefore aligned with the national interest as well.

There was nothing obscure about the princesses’ preference to keep the Prince of Wales away from Osborne until the last possible moment (Princess Christian was not alone in this attitude), nor about Wales’ own reluctance to join his sisters promptly at their mother’s sickbed. Aside from the princesses’ disbelief that so vigorous, capable and enduring a monarch as Queen Victoria could cease to function as the symbolic center of the Empire as well as to intervene in their own lives, there were other considerations. The abilities of the Prince of Wales had not only been disparaged for most of his life by the Queen and the late Prince Consort, but also by the princesses, who considered themselves superior in intellect and character to their brother but knew that they faced diminishing rank and relevance in the next reign. Prince Edward himself, at age 59 and in uncertain health, had begun to doubt his own qualifications to assume the responsibility of kingship (St Aubyn, 1979).

As the Queen’s condition deteriorated, Reid increasingly involved the Prince in key decisions. The bulletins on Her Majesty’s health, for example, were cleared and edited by the Prince before being released, Reid and the Prince
Barriers to Sir James Reid’s Role as Geriatrician

The personal and confidential nature of Sir James’ friendship with the Queen, and the fact that his position as her primary physician for so many years had shaped the fortunes of his professional career, both presented potential challenges to his judgment at the death scene. However, using present-day standards, as there were then no geriatric or palliative care subspecialties, one cannot find in the extant record evidence of anything that Reid specifically failed to do (other than the physical examination he had never been allowed to perform) nor of anything that he did in egregious error during these critical days. But as Queen Victoria was no ordinary patient, Sir James had to have known that the world would soon scrutinize his actions, and that his own life was about to change abruptly.

These considerations were likely to have weighed heavily on the sleep-deprived Reid, especially as the Queen begged helplessly to be allowed to survive. However, to draw any firm conclusions about how Sir James’ conduct of his mission was or was not influenced by his own reactions to her decline, concerns about his career, Royal Family conflicts, or simply the extraordinary eminence of the patient, one must draw inferences from his diary accounts; and these writings deal with such matters obliquely at best.

However, the disparity in their backgrounds was clear enough; it could hardly have been greater. Reid, the son of a Scottish country veterinarian, was the chief physician for Victoria, Queen Regnant of Great Britain and Ireland, Empress of India, and holder of many other grand titles. Sir James, through his 20 years of service to the Queen and his unusual intimacy with her, had been raised to the Baronetcy. Moreover, he had married Susan Baring, one of the Queen’s ladies, an Honourable and member of an aristocratic family. The Queen had initially been outraged when she heard of their engagement, not because of the difference in social standing, but because Reid might be less readily available when she needed him (Mallet, 1968). Also, for life in the Royal Household, Reid had sacrificed his ongoing medical education. The Queen required that he be constantly on-call, and so he had been unable to attend Grand Rounds at hospitals in London, even when the Court was at nearby Windsor (Reid, 1987); neither could he conveniently consult with physicians outside of the Royal circle.

Although the extent to which his new social position, professional isolation, and emotional attachment to the Queen influenced his behavior cannot be captured precisely, Reid himself seemed to be deeply affected by Her Majesty’s final decline. When, on January 16, Sir James for the first time saw the Queen in bed (previously his preceptor had never entered her chamber), he wrote: “She was lying on her right side huddled up and I was struck by how small she appeared” (Reid, 1987). Evidently, Reid was shaken by this image of a physically and cognitively diminished Queen Victoria.

Sir James recognized the Queen’s high regard for him, but he was not so flattered as to miss the aspect of her fear of dying, and most disturbing, the breakdown of her consciousness of position. All traces of her customary hauteur were now missing. When, on January 19, the Queen had told Reid that she wanted to live “a little longer,” he wrote: “She appealed to me in this pathetic way with great trust as if she knew—yet did not wish to know—that she was dying. Her Majesty will soon be better” (Reid, 1987).
Even at this late hour, her self-assessment that she had been “very ill” still implied a chance of survival.

Here again was the hitherto commanding Queen-Empress now attributing to James Reid powers over life and death. The subtext of the Queen’s repetition of her “very ill” state was that she could recover and live to reign on, if he but saw to it. Thus, to the Queen, Reid seemed perhaps to be in need of reminders of his life-saving duties, to which in her last moments she redirected him by her pleas. In those last hours of her life, the messages between the dying monarch and her doctor, messages both spoken and unspoken, had taken on the greatest import for both. As Reid wrote to his wife that same day:

I can’t help admiring her determination not to give up … She often smiles when she hears my voice, and says she will do ‘anything I like.’ The whole thing is most pathetic, and rather gives me a lump in the throat (Reid, 1987).

Earlier, on January 17, Lady Reid had expressed concern about how the death of the Queen would affect her husband: “... If the end comes, I know it will be a wrench to him …” (Reid, 1987).

Now, with death closing in, as many physicians have done before and since, Sir James chose to give the Queen the reassurance for which she seemed to be pleading. Having thus committed himself, he did so abundantly, promising again and again, in his baritone brogue, that she would recover. Reid’s words, while patently false, were intended to console. There is no suggestion in his writings that he had wrestled uncomfortably, in 21st-century mode, with the ethics of responding to the Queen in this way. Faced with a patient who in her last moments of relative clarity was expressing her wish to survive, Reid, with time to react but not to reflect on ethical considerations, allowed truth to be trumped by compassion.

**Sir James Reid and the Aftermath of Queen Victoria’s Death**

Queen Victoria died at 6.30 on the evening of January 22 as her children softly called out their own names. A few hours later, helping to prepare the Queen’s body, Reid observed with surprise that she had a ventral hernia and a prolapse of the uterus. He ought not to have been surprised, since these were not unexpected conditions, as Michaela Reid correctly noted, for an elderly woman who “had borne nine children” (Reid, 1987). Sir James also found that her body, dressed and adorned, was “looking beautiful, surrounded by loose flowers and palms strewn on the bed” (Reid, 1987). The right-sided facial flatness observed for the past five days was no longer visible.

Responsible for the Queen’s person in death as in life, Reid was not to rest completely until the body was embalmed and the coffin’s lid sealed on January 25. On February 2, the day after he joined the Royal family as they transported the Queen’s coffin off of the Isle of Wight, he wrote to Susan: “My last journey with Bipps [Baring family code for Queen Victoria] is over, and I feel rather sad” (Reid, 1987).

But for now, there was no time for Sir James to mourn. One of his many obligations between the 22nd and 25th of January was to compile a summary of the events leading to the death of Queen Victoria. His “Medical Report on the Queen’s Death,” issued on January 23, 1901, referred to the gradually weakening effects of poor nutrition, weight loss, and insomnia. By November and December of 1900, Reid wrote, there were also “… occasional slight and transitory attacks of aphasia, the latter indicating that the cerebral circulation had become damaged …”. These aphasic episodes were described as “always of an ephemeral kind and unattended by any motor paralysis” (Reid, 1987).

Sir James’ deceptively uncomplicated account was crafted to make the Queen’s neurological changes appear to have been milder and more recent than they actually were. For example, although he acknowledged that the Queen experienced considerable fatigue after traveling to Osborne on December 18, he added that she had seemed to rally until her last days. It was not until January 17, according to Reid’s official statement, that the Queen’s alertness had significantly waned. However, the doctor’s personal notes describe apathy and confusional episodes appearing at least four days before that, on January 13, and further support that these developments had an even earlier, more insidious onset.

In his official summary, Reid seemed to have been constrained by a nearly blatant effort to uphold the prestige of the monarchy, which he previously had done for twenty years by safeguarding the health and buoying the spirits of Queen Victoria. Now, he was attempting to depict for public consumption the ending of the long reign of Queen Victoria as implausibly abrupt, with Her Majesty functioning fully until very nearly the moment of death. To this end, Sir James’ post-hoc pronouncements read as if they were intended to minimize any hint of depression or dementia, two socially stigmatizing conditions. Reid also cited, euphemistically, the effects of “Royal responsibilities and the Imperial events, domestic sorrows and anxieties which have crowded into her life of later years” (Reid, 1987).

Even in 1901, “royal responsibilities” would not have been considered to be “bona fide” causes of death. Reid might have been anticipating the criticism that he ought to have alerted the government to the need for a Regency. It would not do for the nation and Empire to realize that its head of state had been incapacitated for weeks before her death. So, Sir James ended his summary on the following note: “Beyond the slight right facial flattening there was never any motor paralysis and except for occasional lapses mentioned, the mind cannot be said to have been clouded ...” (Reid, 1987).

**Conclusion**

By January 13, 1901, the clinical picture of geriatric depression initially presented by Queen Victoria had given way to
reveal the cerebrovascular disease that had been all along the probable primary diagnosis. But since little could be done in 1901 to directly address the disease process, nor even to palliate pharmacologically, during the final phase of the Queen's illness diagnosis was essentially superfluous.

Nevertheless, in presiding over Queen Victoria's deathwatch at the beginning of the 20th century, Sir James Reid had to contend with personal and intrafamilial obstacles similar to those faced in any age by the primary care physicians of dying patients. There is no clear Victorian “best practice” in geriatric medicine or palliative care against which to evaluate Sir James' effectiveness. However, the available evidence, even from a heavily redacted source, suggests that what Sir James provided for the dying Queen and her family was conceptually, if not concretely, the precursor of a present-day palliative care or hospice model, with the critically important physician–patient and physician–family relationships at its core. Further, although there were no active-treatment medications to stop, no specific interventions, such as patient-controlled analgesic devices, to install, and no antidepressant medications to prescribe, the patient's comfort was always paramount.

What Sir James fell back on, repeatedly, was his ability to reassure and console his frightened patient, based on a therapeutic alliance created and reinforced over a twenty-year period. Such alliances remain equally valued in current medical practice, although the falseness of Reid's reassurances might prove more controversial today. Also important were his clarity, reliability, and consistent presence.

For the Royal Family, Reid was able to channel the positive working alliance he had made with them toward engagement with a reality that they, for various reasons, had been reluctant to accept. Although he could not hope to heal longstanding family disputes, Reid found a graceful niche for the much-disliked Kaiser, possibly averting an international crisis; and he was able to help both the princes and the Prince of Wales himself understand that he was soon to become the senior member of the Royal Family. Thus, for the new King Edward VII, Reid had created opportunities to flex decisional muscles that had long been atrophied by a Sovereign who doubted her heir's abilities and who was generally disinclined to share her prerogatives (St Aubyn, 1979).

The lessons from these historical anecdotes would suggest, for contemporary end-of-life clinical situations, that the primary physician make thoughtful use of his therapeutic alliances with both the patient and family. He or she need not take on role of family therapist per se, but might identify the most pressing of family conflicts and apply the authority of position toward their resolution.

Reid's greatest problem may have been the fact that his patient had become so important to him personally, emotionally, and professionally. This was a circumstance that had the potential at key points to derail him from his task, even if, based on the surviving historical record that did not actually occur. (His feelings toward the Queen may have contributed to the exaggerated tone of his reassurances to the dying monarch, but that is entirely speculative.) Singular to this clinical story was the social rank of Sir James' patient, a circumstance that in itself contributed to unrealistic expectations of survival and a strained, pressured atmosphere at the death scene; the stature of his patient also propelled Reid briefly into an unwanted public position as medical spokesman after her death, when he was tasked with helping the waiting world understand why and how Queen Victoria had died while at the same time presenting her as having been “compos mentis” until the end. All considered, however, from January 13, 1901 until the actual moment of death on January 22, and beyond, it can be said that, with a mostly successful outcome, affection and respect for the person and office of Queen Victoria underlay all that was done for her.

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References


